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

NOVEMBER 7, 2024
2:00 P.M.

505 CITY PARKWAY WEST, SUITE 108
ORANGE, CALIFORNIA 92868

BOARD OF DIRECTORS

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

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

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

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

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

Members of the public may attend the meeting in person. Members of the public also have the option of participating in the meeting via Zoom Webinar (see below).
Participate via Zoom Webinar at:
https://us06web.zoom.us/webinar/register/WN_gK3S9Jo4Sq2H5CJ1MCzAAw
Join the Meeting.
Webinar ID: **867 7449 3432**
Passcode: **632976** -- Webinar instructions are provided below.

CALL TO ORDER
Pledge of Allegiance
Establish Quorum

PRESENTATIONS/INTRODUCTIONS
1. Celebrating Employee Milestone Work Anniversaries

MANAGEMENT REPORTS
2. Chief Executive Officer Report

3. Fiscal Year 2025-2027 Strategic Plan Discussion Draft

ADVISORY COMMITTEE UPDATES
4. Joint Meeting of the Member Advisory Committee and the Provider Advisory Committee Update

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

CONSENT CALENDAR
5. Minutes
   a. Approve Minutes of the October 3, 2024 Regular Meeting of the CalOptima Health Board of Directors
   b. Receive and File Minutes of the June 12, 2024 Regular Meeting of the CalOptima Health Board of Directors' Quality Assurance Committee

6. Approve Modifications to CalOptima Policy AA.1207b and AA.1207c: Performance-based Heath Network and CalOptima Community Network Auto-Assignment Allocation Methodology and Performance-based Community Health Center Auto-Assignment Allocation Methodology

7. Approve CalOptima Health Measurement Year 2025 Medi-Cal and OneCare Pay-for-Value Programs

8. Approve Recommendations for the Chair and Vice Chair Appointments to the Whole-Child Model Family Advisory Committee

9. Ratify Amendment to CalOptima Health's Primary Agreement with the California Department of Health Care Services

10. Adopt Resolution No. 24-1107-02 Approving and Adopting Updated CalOptima Health Human Resources Policy

11. Authorize Amendments to Extend the Term of Contracts with Translation and Interpreter Services Vendors

12. Receive and File:
    a. September 2024 Financial Summary
    b. Compliance Report
    c. Federal and State Legislative Advocates Reports
    d. CalOptima Health Community Outreach and Program Summary

REPORTS/DISCUSSION ITEMS

13. Approve Award Recommendations for Workforce Development Initiative Round Two Grants

14. Adopt Resolution No. 24-1107-01 Approving the Revised 2025 CalOptima Health Compliance Plan, 2025 CalOptima Health Code of Conduct, 2025 CalOptima Health Anti-Fraud, Waste and Abuse (FWA) Plan, the 2025 CalOptima Health HIPAA Privacy and Security Program, and Authorizing Approval of Revised CalOptima Health Office of Compliance Policies and Procedures

15. Authorize the Chief Executive Officer to Use Reserve Funds to Make Payments to Primary Care Practices Participating in the Equity and Practice Transformation Payment Program Prior to Receipt of Funds Included in the State of California Fiscal Year 2024-25 Budget

16. Authorize the Chief Executive Officer to Execute Contract Amendments with Collective Medical Technologies, Inc., a PointClickCare company, and Safety Net Connect, Inc. to Improve Information Exchange for Members and Providers Across Care Settings

17. Approve Actions Related to the CalAIM Incentive Payment Program for Justice-Involved Services Learning Collaborative Selected Recipients

18. Approve Modifications to the CalOptima Health Mental Health (Non-Applied Behavior Analysis) Provider Pay-for-Value Program

CLOSED SESSION

CS-1. CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION Pursuant to Government Code Section 54956.9(d)(2): 1 Case.

CS-2. CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION Pursuant to Government Code Section 54956.9(d)(4): 1 Case.

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

ADJOURNMENT

TO REGISTER AND JOIN THE MEETING

Please register for the Regular Meeting of the CalOptima Health Board of Directors on November 7, 2024 at 2:00 p.m. (PST)

To **Register** in advance for this webinar:
https://us06web.zoom.us/webinar/register/WN_gK3S9Jo4Sq2H5CJ1MCzAAw

To **Join** this webinar:
https://us06web.zoom.us/s/86774493432?pwd=gQKDfqP2adsCHFx4i5qdMgiSlqwBx2.1

Or One tap mobile:
+16694449171,,86774493432#,,,,*632976# US
+17193594580,,86774493432#,,,,*632976# US

Or join by phone:
Dial(for higher quality, dial a number based on your current location):
US: +1 669 444 9171 or +1 719 359 4580 or +1 720 707 2699 or +1 253 205 0468 or +1 253 215 8782 or +1 346 248 7799 or +1 301 715 8592 or +1 305 224 1968 or +1 309 205 3325 or +1 312 626 6799 or +1 360 209 5623 or +1 386 347 5053 or +1 507 473 4847 or +1 564 217 2000 or +1 646 558 8656 or +1 646 931 3860 or +1 689 278 1000

Webinar ID: 867 7449 3432
Passcode: 632976

International numbers available: **https://us06web.zoom.us/u/kdChRfgsv**

CalOptima Health

Celebrating Employees' Milestone Work Anniversaries

December 2023–December 2024

Board of Directors Meeting
November 7, 2024

Steve Eckberg, Chief Human Resources Officer

Our Mission

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

Our Vision

By 2027, remove barriers to health care access for our members, implement same-day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.

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15 Years

- **Michelle Anderson**, Social Worker, MSSP–Direct Support
- **Elizabeth Baylis**, Medical Case Manager, MSSP–Direct Support
- **Fabiola Benitez-Rios**, Buyer, Procurement & Vendor Management
- **Anthony Bucag**, Programmer Sr., ITS–Application Development
- **Rick Cabral**, Associate Director II, ITS–Application Development
- **Alexander Coaile**, ITS Developer Advisor, ITS–Application Development
- **Kelly Diaz De Leon**, Medical Authorization Assistant, MSSP–Administrative Support
- **Jessica Jurado**, Medical Authorization Assistant, Utilization Management
- **Irma Munoz**, Project Manager III, Quality Analytics
- **Luther Myles**, Claims Examiner Sr., Claims Administration
- **Serene Nguyen**, Social Worker, MSSP–Direct Support
- **Judith Noh**, Grievance Resolution Specialist Sr., Grievance & Appeals
- **Geoff Patino**, Associate Director I, Communications

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15 Years (Cont.)

- **Luis Romero**, Grievance Resolution Specialist, Grievance & Appeals
- **Evelyn Rounds**, Manager, MSSP, MSSP–Administrative Support
- **Daryl Thomas**, Supervisor, Customer Service, Claims Administration
- **Sandra Toledo**, Data Analyst, Finance

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20 Years

- **Lorena Dabu**, Manager, Encounters, Finance
- **Evelyn Eleco**, Data Analyst Sr., Claims Administration
- **Gisela Gomez**, Sr. Manager I, Office of Compliance
- **Debra Gonzalez-Stone,** Contracts Specialists Sr., Contracting
- **Arefeh Heidari**, Supervisor Accounting, Accounting
- **Gary Kopko**, ITS Administrator Sr., ITS–Infrastructure
- **Claudia Orozco**, Personal Care Coordinator, Case Management
- **Dalila Pickell**, Personal Care Coordinator, Case Management
- **Francie Salazar-Craig**, ITS Analyst Sr., ITS–Infrastructure
- **Tamara Tavares**, Data Analyst Sr., Claims Administration
- **Tracy To**, Medical Case Manager, Case Management

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25 Years

- **Jennifer Kurth**, Program Manager, Pharmacy Management
- **Patrick Maez**, ITS Administrator Sr., ITS–Infrastructure
- **Hanh Nguyen**, Technical Analyst Sr., ITS–Applications Management
- **Tammy Nguyen**, Supervisor, OneCare Customer Service

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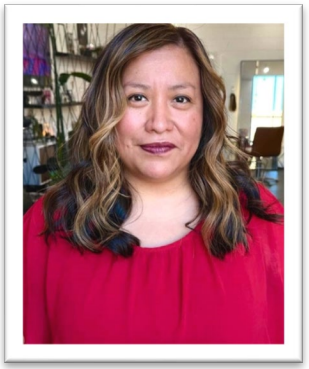
15-Year Service Awards

Michelle Anderson, LCSW
Social Worker
MSSP–Direct Support

Elizabeth Baylis
Medical Case Manager
MSSP–Direct Support

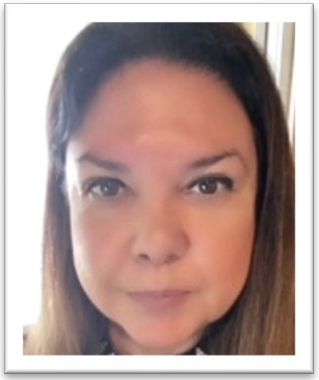


Fabiola Benitez-Rios
Buyer
Procurement &
Vendor Mgmt.

Anthony Bucag
Programmer Sr.
ITS–Application Development

Rick Cabral
Associate Director II
ITS–Application
Development

Alexander Caoile
ITS Developer Advisor
ITS–Application Development



Kelly Diaz De Leon
Medical Auth. Assistant
MSSP–Admin. Support

Jessica Jurado
Medical Auth. Assistant
Utilization Management

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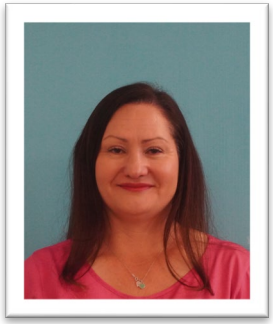
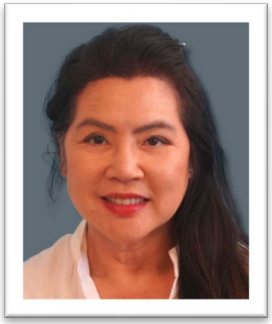
CalOptima Health

15-Year Service Awards

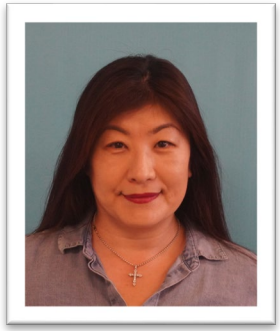


Irma Munoz
Project Manager III
Quality Analytics

Luther Myles
Claims Examiner Sr.
Claims Administration



Serene Nguyen
Social Worker
MSSP–Direct Support



Judith Noh
Grievance Resolution Specialist Sr.
Grievance & Appeals

Geoff Patino
Associate Director I
Communications

Luis Romero
Grievance Resolution Specialist
Grievance & Appeals

Evelyn Rounds
Manager, MSSP
MSSP–Admin. Support

Daryl Thomas
Supervisor, Customer Service
Claims Administration

Sandra Toledo
Data Analyst
Finance

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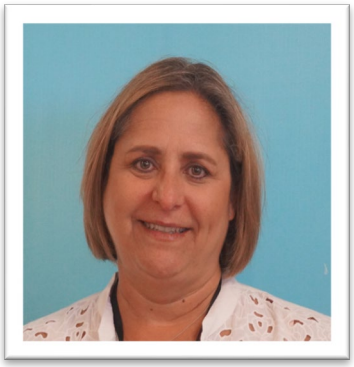
CalOptima Health

20-Year Service Awards

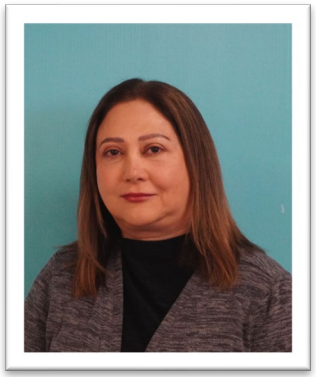
Lorena Dabu
Manager, Encounters
Finance

Evelyn Eleco
Data Analyst Sr.
Claims Administration

Gisela Gomez
Sr. Manager I
Office of Compliance



Debra Gonzalez-Stone
Contracts Specialist Sr.
Contracting



Faye Heidari
Supervisor, Accounting
Accounting

Gary Kopko
ITS Administrator Sr.
ITS–Infrastructure

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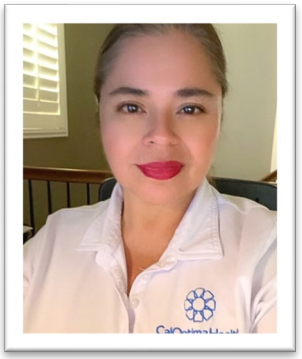
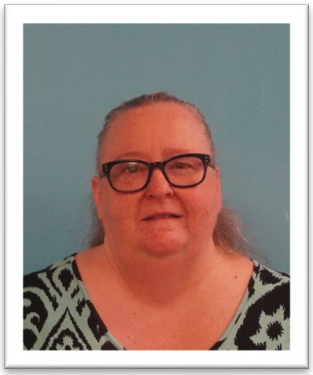
20-Year Service Awards



Claudia Orozco
Personal Care Coordinator
Case Management

Dalila Pickell
Personal Care Coordinator
Case Management

Francie Salazar-Craig
ITS Analyst Sr.
ITS–Infrastructure

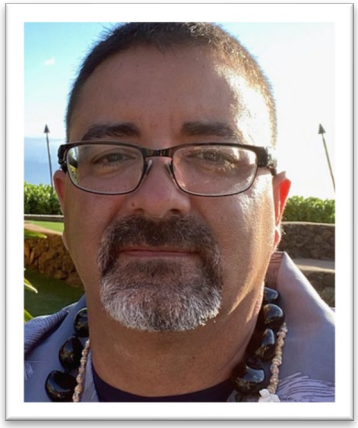


Tamara Tavares
Data Analyst Sr.
Claims Administration

Tracy To
Medical Case Manager
Case Management

25-Year Service Awards

Jennifer Kurth
Program Manager
Pharmacy Management



Patrick Maez
ITS Administrator Sr.
ITS–Infrastructure

Helen Nguyen
Technical Analyst Sr.
ITS–Applications Management

Tammy Nguyen
Supervisor, OneCare Customer Service
Customer Service

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Presented at Meeting on 11/7/2024

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MEMORANDUM

DATE:	November 1, 2024
TO:	CalOptima Health Board of Directors
FROM:	Michael Hunn, Chief Executive Officer
SUBJECT:	CEO Report — November 7, 2024, Board of Directors Meeting
COPY:	Sharon Dwiers, Clerk of the Board; Member Advisory Committee; Provider Advisory Committee; and Whole-Child Model Family Advisory Committee

A. State Audit Recommendations Fully Implemented; Audit Now Closed

On October 22, the California State Auditor (CSA) confirmed that CalOptima Health has fully implemented all audit recommendations and officially closed the audit with no further responses or actions required. CSA expects to formally publish the final audit status on its website soon. Previously, the CSA released a report on May 2, 2023, following a comprehensive nine-month audit of CalOptima Health that covered an eight-year period from January 2014 through June 2022. In accordance with the terms of the audit, CalOptima Health was required to submit 60-day, six-month and one-year status updates to CSA regarding the implementation of the report's seven recommendations. This closure announcement came after CSA completed its review of our one-year status update.

B. CalOptima Health Met/Exceeded All MCAS Measures for 2023

I am pleased to inform the Board that our Medi-Cal performance on the Department of Health Care Services (DHCS) quality measures for Measurement Year 2023, defined in the Managed Care Accountability Set (MCAS), exceeded the 50th percentile of the National Committee for Quality Assurance National Medicaid benchmarks. By exceeding the minimum benchmarks established by DHCS for the 18 MCAS measures, CalOptima Health averted sanctions and corrective action from DHCS. The MCAS measures cover important health domains, including children's health, chronic disease management, reproductive health and cancer screening. We continue to identify opportunities to ensure that members receive these services in a timely manner according to evidence-based practice guidelines. For example, we are currently promoting flu vaccines using text, email and phone outreach; identifying women who have not received a mammogram and conducting outreach for scheduling; and identifying members with diabetes who need coaching to control blood sugar levels. Please note that the MCAS includes two behavioral health measures (Follow-Up After Emergency Department Visit for Mental Illness and Follow-Up Emergency Department Visit for Substance Use) that DHCS did not subject to sanctions due to data issues. CalOptima Health, along with most health plans, did not meet the Minimum Performance Level for these measures. We continue to work with our county behavioral health partners to share data to resolve this data gap.

C. CMS Star Rating for OneCare Released; Quality Grants Offered

The Centers for Medicare & Medicaid Services (CMS) uses a five-star rating system to evaluate the quality of Medicare health plans. Each year CMS calculates an overall, Part C and Part D Star Rating for each Medicare Advantage health plan. Star Ratings comprise clinical quality, member experience, prescription drug and health plan administrative measures. On October 10, CMS released the Star Ratings for the 2025 display year. Although CalOptima Health OneCare scored 3.0 on Part C and 3.0 on Part D, the overall score is 2.5, a decrease from 3.0 in 2024. CalOptima Health has implemented quality improvement initiatives to raise our Star Ratings, including closing care gaps for annual wellness visits, breast cancer screening, colorectal cancer screening, diabetes care and flu vaccines. We are planning a series of community health fairs to provide these services directly to members in their own neighborhoods. In a separate effort, CalOptima Health announced a Quality Improvement Grant Program OneCare Program Year 1 (2024). This program is intended to support health networks in planning and implementing quality improvement activities for services to OneCare members. It empowers health networks to identify, implement and evaluate evidence-based practices that drive measurable improvements in health care quality. Grant funding will be for a one-year period starting from the grant issue date.

D. OneCare Annual Election Period Is Underway

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

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

Starting in 2025, CalOptima Health OneCare members now have two plan options to select from:

- CalOptima Health OneCare Complete — Our original plan offers $0 copays on medical and hospital services and all covered prescription drugs. It includes many extras, such as a fitness benefit, comprehensive dental, more vision care, a flex card for over-the-counter (OTC) items and groceries, and more.
- CalOptima Health OneCare Flex Plus — Our new low-cost plan is designed for flexibility, offering $0 doctor visits and hospital stays. It also includes generous extras, such as a larger flex card allowance for OTC items, more vision care, comprehensive dental, a fitness benefit, and more.

E. Covered California Ordinance Request Sent to Board of Supervisors

As directed by October's Board action, I recently sent a letter to the Orange County Board of Supervisors (BOS) to formally request the amendment of CalOptima Health's governing ordinance to allow our participation in Covered California. Amending the ordinance will require two successive majority votes, which will ideally be completed by December. Staff are also in the process of soliciting support letters from a wide range of providers and stakeholders to further reinforce our request to the BOS. Finally, to boost public transparency regarding our efforts, our website now has a dedicated Covered California resource page with FAQs, presentations, timelines and other materials.

F. Governor Completes Legislative Action

On September 30, Gov. Gavin Newsom finished signing or vetoing all 1,206 bills that were passed this year by the California State Legislature. He signed 1,017 bills into law and vetoed 189 bills, which is a veto rate of 15.7% — slightly higher than the 10-year historical average of 15%. Of note, 13 policy bills being monitored by CalOptima Health were signed into law, and seven were vetoed, reflecting a higher

veto rate for Medi-Cal-related legislation. According to an analysis by Capitol-watcher Chris Micheli, the governor rejected 30% of total bills due to budget concerns, 27% due to policy disagreements, and 22% that were unnecessary or impeded state agencies or local governments (among other reasons). Overall, CalOptima Health and our state trade associations had a largely successful year of advocacy with the Legislature and administration to defeat bills with potentially negative impacts. Government Affairs staff is now preparing analyses of signed legislation that may significantly affect CalOptima Health and our members, providers and stakeholders.

G. CalOptima Health Hosts Maternal Health and Wellness Event With UCI Health

On October 19, CalOptima Heath Chief Health Equity Officer Michaell Silva Rose, DrPH, LCSW, and the Equity and Community Health team partnered with UCI Health to host a health and wellness event specifically for women who had gaps in care related to their prenatal or postpartum care. The women who attended were hand-selected and invited to participate in this pilot "clinic day" and offered transportation to UCI Health Family Health Center in Santa Ana. Twenty-eight women received screenings and health education and participated in a survey that included questions on maternal mental health and social determinants of health.

H. County Supervisors Present Breast Cancer Awareness Month Proclamation

During the Orange County Board of Supervisors meeting on October 22, Chief Medical Officer Richard Pitts, D.O., Ph.D., was presented with a proclamation for Breast Cancer Awareness Month on behalf of CalOptima Health. Dr. Pitts also shared information with the supervisors about CalOptima Health's new cancer screening awareness campaign, which has the tagline "Screening Is About Life, not Cancer."

I. CalOptima Health Hosts First Senior Health and Wellness Fair

On October 19, approximately 350 seniors attended CalOptima Health's first Senior Health and Wellness Event and learned more about our OneCare and PACE programs. Attendees also received assistance with Medi-Cal and CalFresh enrollment, dental and vision screenings, and flu and COVID vaccines. The event also offered community resources for basic needs, mental health, and services for older adults and people with disabilities.

J. Response to Change Healthcare Cyberattack Complete

Eight months after the Change Healthcare cyberattack, CalOptima Health has reconnected with the health care technology company and has started processing new remittance advices (RAs). Following the announcement of the cyberattack in February, CalOptima Health proactively disconnected from Change Healthcare. We also added a 90-day grace period to the 365-day claims deadline and informed providers of alternative options for submitting claims and receiving electronic payments. CalOptima Health was part of a limited reconnection to Change Healthcare in May, but that did not include RAs. After fully reconnecting with Change Healthcare in August, we worked on processing the backlog of RAs submitted after the February disconnection. After we completed processing all RAs through the end of September, we returned to normal RA operations in early October.

CalOptima Health

Fast Facts
November 2024

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

Membership Data* (as of September 30, 2024)

Total CalOptima Health Membership	Program	Members
913,501	Medi-Cal	895,716
	OneCare (HMO D-SNP)	17,282
	Program of All-Inclusive Care for the Elderly (PACE)	503

*Based on unaudited financial report and includes prior period adjustment

Operating Budget (for three months ended September 30, 2024)

	YTD Actual	YTD Budget	Difference
Revenues	$1,255,951,660	$1,068,106,279	$187,845,381
Medical Expenses	$1,236,461,011	$1,059,866,014	($176,594,997)
Administrative Expenses	$56,486,311	$71,765,553	$15,279,242
Operating Margin	($36,995,66)	($63,525,288)	$26,529,626
Medical Loss Ratio (MLR)	98.4%	99.2 %	(0.8%)
Administrative Loss Ratio (ALR)	4.5%	6.7%	2.2%

Notes:
- **Totals may not add due to rounding**
- **Adjusted MLR is 96.1%, excluding estimated provider rate increases funded by reserves**

Reserve Summary (as of September 30, 2024)

	Amount (in millions)
Board Designated Reserves	$1,036.1*
Statutory Designated Reserves	$136.4
Capital Assets (Net of depreciation)	$103.9
Resources Committed by the Board	$485.7
Board Approved Provider Rate Increases	$473.6
Resources Unallocated/Unassigned	$242.5*
Total Net Assets	$2,478.3

Total of Board-designated reserves and unallocated resources can support approximately 119 days of CalOptima Health's current operations.

Total Annual Budgeted Revenue **$4 Billion**

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

CalOptima Health Fast Facts

November 2024

Personnel Summary (as of October 19, 2024, pay period)

	Filled	Open	Vacancy % Medical	Vacancy % Administrative	Vacancy % Combined
Staff	1,319.5	74.15	46.36%	53.64%	5.32%
Supervisor	81	2	50%	50%	2.41%
Manager	113	5	40%	60%	4.24%
Director	68.25	2.5	60%	40%	3.53%
Executive	20	2	0%	100%	9.09%
Total FTE Count	1,601.8	85.7	47.89%	52.11%	5.08%

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

Provider Network Data (as of October 10, 2024)

	Number of Providers
Primary Care Providers	1,319
Specialists	6,959
Pharmacies	523
Acute and Rehab Hospitals	40
Community Health Centers	72
Long-Term Care Facilities	207

Treatment Authorizations (as of August 31, 2024)

	Mandated	Average Time to Decision
Inpatient Concurrent Urgent	72 hours	32.83 hours
Prior Authorization – Urgent	72 hours	18.32 hours
Prior Authorization – Routine	5 days	2.27 days

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

Member Demographics (as of September 30, 2024)

Member Age	
0 to 5	8%
6 to 18	23%
19 to 44	36%
45 to 64	20%
65 +	13%

Language Preference	
English	54%
Spanish	31%
Vietnamese	9%
Other	2%
Korean	2%
Farsi	1%
Chinese	<1%
Arabic	<1%

Medi-Cal Aid Category	
Temporary Assistance for Needy Families	38%
Expansion	38%
Optional Targeted Low-Income Children	7%
Seniors	11%
People With Disabilities	5%
Long-Term Care	<1%
Other	<1%

CalOptima Health

Provider Network Trend

November 2024

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

CHCN and Health Networks

Total Providers [1]

Provider Type	2023 – Q3	2023 – Q4	2024 – Q1	2024 – Q2	2024 – Q3	YOY Net Δ
PCP [2]	1,309	1,307	1,296	1,297	1,307	-2
Specialist (Physicians)	6,528	6,463	6,503	6,754	6,945	417
Hospitals [3]	44	43	39	40	40	-4
Community Health Centers [4]	63	63	64	65	65	2
Long Term Care	196	197	201	200	207	11
Behavioral Health [5]	1,967	1,982	2,122	2,213	2,239	272
ECM	31	32	32	32	32	1
Community Support	72	77	95	99	102	30

Medi-Cal

Provider Type	2023 – Q3	2023 – Q4	2024 – Q1	2024 – Q2	2024 – Q3	YOY Net Δ
PCP [2]	1,113	1,118	1,108	1,100	1,082	-31
Specialist (Physicians)	5,772	5,752	5,856	6,129	6,348	576
Hospitals [3]	41	40	36	37	37	-4
Community Health Centers [4]	63	63	63	64	64	1
Long Term Care	192	193	197	196	203	11
Behavioral Health [5]	1,883	1,904	2,043	2,118	2,162	279
ECM	31	32	32	32	32	1
Community Support	71	77	95	99	102	31

OneCare

Provider Type	2023 – Q3	2023 – Q4	2024 – Q1	2024 – Q2	2024 – Q3	YOY Net Δ
PCP [2]	1,065	1,073	1,095	1,092	1,095	30
Specialist (Physicians)	4,746	4,809	4,934	5,132	5,331	585
Hospitals [3]	38	38	34	35	35	-3
Community Health Centers [4]	58	57	58	58	58	0
Long Term Care	66	70	68	68	69	3
Behavioral Health [5]	515	526	547	596	607	92

PACE

Provider Type	2023 – Q3	2023 – Q4	2024 – Q1	2024 – Q2	2024 – Q3	YOY Net Δ
PCP [2]	4	5	5	5	5	1
Specialist (Physicians)	3,114	3,106	3,109	3,253	3,405	291
Hospitals [3]	32	32	28	29	29	-3
Community Health Centers [4]	0	0	0	0	0	0
Long Term Care	63	67	67	65	65	2
Behavioral Health [5]	100	97	94	97	96	-4

Provider Network Trend

November 2024

CHCN Only

Total Providers [1]

Provider Type	2023 – Q3	2023 – Q4	2024 – Q1	2024 – Q2	2024 – Q3	YOY Net Δ
PCP [2]	666	685	674	672	677	11
Specialist (Physicians)	5,877	5,811	5,829	6,082	6,273	396
Hospitals [3]	40	39	35	36	36	-4
Community Health Centers [4]	52	52	56	56	56	4
Long Term Care	192	193	197	196	203	11
Behavioral Health [5]	1,955	1,969	2,104	2,189	2,215	260
ECM	31	32	32	32	32	1
Community Support	71	77	95	99	102	31

Medi-Cal

Provider Type	2023 – Q3	2023 – Q4	2024 – Q1	2024 – Q2	2024 – Q3	YOY Net Δ
PCP [2]	646	664	653	651	653	7
Specialist (Physicians)	5,358	5,346	5,427	5,717	5,939	581
Hospitals [3]	38	37	33	34	34	-4
Community Health Centers [4]	52	52	56	56	56	4
Long Term Care	192	193	197	196	203	11
Behavioral Health [5]	1,874	1,894	2,028	2,097	2,141	267
ECM	31	32	32	32	32	1
Community Support	71	77	95	99	102	31

OneCare

Provider Type	2023 – Q3	2023 – Q4	2024 – Q1	2024 – Q2	2024 – Q3	YOY Net Δ
PCP [2]	554	572	564	564	570	16
Specialist (Physicians)	4,056	4,108	4,195	4,385	4,588	532
Hospitals [3]	33	33	29	30	30	-3
Community Health Centers [4]	42	42	46	46	46	4
Long Term Care	192	193	197	196	203	11
Behavioral Health [5]	500	509	528	578	588	88

PACE

Provider Type	2023 – Q3	2023 – Q4	2024 – Q1	2024 – Q2	2024 – Q3	YOY Net Δ
PCP [2]	4	5	5	5	5	1
Specialist (Physicians)	3,114	3,106	3,109	3,253	3,405	291
Hospitals [3]	32	32	28	29	29	-3
Community Health Centers [4]	0	0	0	0	0	0
Long Term Care	63	67	67	65	65	2
Behavioral Health [5]	100	97	94	97	96	-4

Footnotes:

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

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

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

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

[5] Includes Practitioners and Behavioral Health Groups

FY 2025–2027 Strategic Plan Discussion Draft

Board of Directors Meeting
November 7, 2024

Donna Laverdiere, Executive Director, Strategic Development

Our Mission

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

Our Vision

By 2027, remove barriers to health care access for our members, implement same-day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.

Contents

- FY 2025-2027 Strategic Plan Development Process
- Components of the FY 2025–2027 Strategic Plan
- Revisiting Our Mission and Vision
- CalOptima Health Values
- Four Strategic Priority Areas
- Organizational Goals
- Next Steps

Back to Agenda

FY 2025-2027 Strategic Plan Development Process

Initial Draft Plan Development Spring 2024	Stakeholder Engagement Summer 2024	Board Review Fall 2024
• Best practices from other public Medi-Cal plans • Prior Strategic Priorities and results • CalOptima Health leadership and staff input • Upcoming regulatory requirements • In-flight strategic initiatives	• Member and Provider Advisory Committee • Health Network Forum • Whole Child Model Committee • Monthly Community Clinics forum • CalOptima Health Monthly All Staff Meeting • Community Network Virtual Learn	• Review with Board of Directors (November) • Vote on FY 2025-2027 Strategic Plan (December)

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Strategic Plan Components

Mission

A **mission statement** defines the organization's business, its objectives, and how it will reach these objectives.

Vision

A **vision statement** details where the organization aspires to go.

Values

Values articulate what the organization believes in and how it aspires to operate.

Strategic Priorities

Strategic Priorities are organizational priorities that provide guidance to leadership and signal the direction of the organization to the community.

Organizational Goals

Organizational Goals are a targeted set of goals for a three-year period that help prioritize activities and investments.

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CalOptima Health

Revisiting Our Mission and Vision

Discussion Draft

- **Mission**
  - To serve member health with excellence and dignity, respecting the value and needs of each person.
- **Vision**
  - By 2027, remove barriers to health care access for our members, implement same day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.
  - Options for updating the vision
    - ***Option 1:*** Through education and innovation, CalOptima Health will provide each member with the tools to own and improve their health behaviors and health outcomes and achieve a better quality of life.
    - ***Option 2:*** Enable all individuals to achieve optimal health and well-being through an equitable and high-quality health care system.
    - ***Option 3:*** Provide all members with access to care and supports to enable them to achieve optimal health and well-being through a prevention-focused, equitable and high-quality health care system.

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CalOptima Health

CalOptima Health Values

- We are **"Better. Together."**
  - By working together, we can make things better — for our members and community.
- CalOptima Health **C-A-R-E-S**
  - We believe that to best serve the people of Orange County, we will lead with **C**ollaboration, **A**ccountability, **R**espect, **E**xcellence and **S**tewardship.

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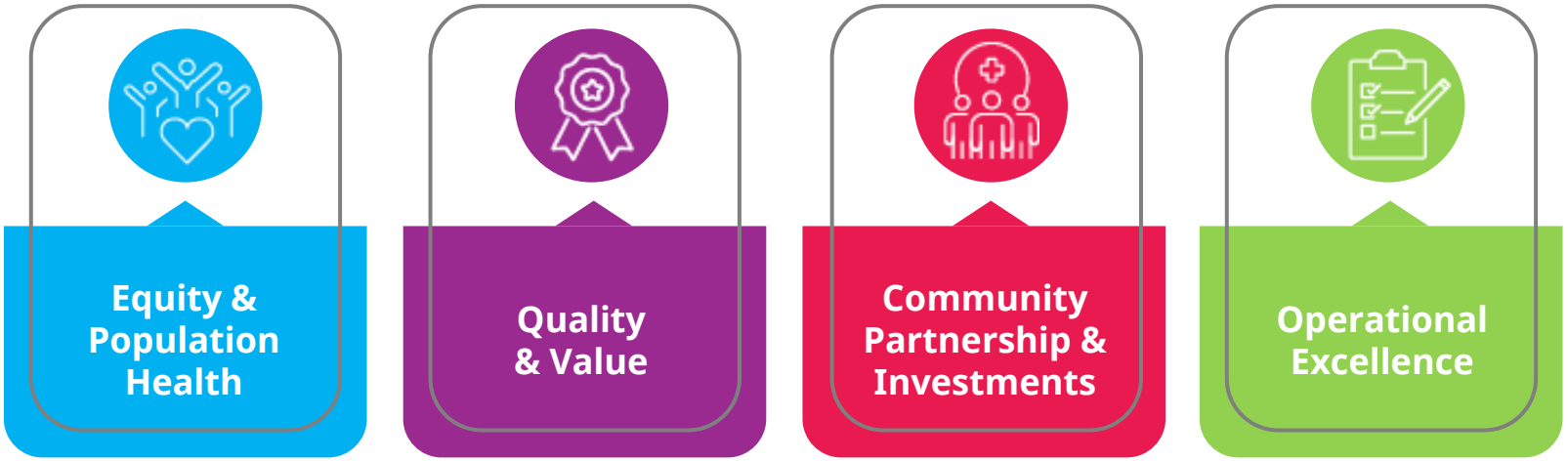
Four Strategic Priority Areas

- For FY 2025–2027, CalOptima Health will focus on four strategic priority areas to achieve our mission, vision and values.



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Equity & Population Health

Description	Organizational Goals
CalOptima Health will infuse the **pursuit of health equity** throughout our work and will continue to **innovate and develop tools** and interventions that advance the physical, behavioral and social health of our members.	1.1 Utilize technology and innovation to strengthen health equity and population health management programs.
	1.2 Implement a consistent model of care for population health and care management, including delegated networks.
	1.3 Annually assess members' health and social needs and utilize data to inform targeted interventions.
	1.4 Achieve NCQA Health Equity Accreditation by January 2026.

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Quality & Value

Description	Organizational Goals
CalOptima Health is committed to providing the **highest quality of physical, behavioral and social health care** to our members and to ensuring **sound stewardship of public dollars** by achieving greater value.	2.1 Achieve NCQA rating of 4 stars for Medi-Cal. Achieve CMS rating of 3.5 stars for Medicare.
	2.2 Improve access to care by strengthening the delivery system through provider support and workforce initiatives.
	2.3 Increase provider engagement through improved provider tools, data exchange and collaboration.
	2.4 Expand the delivery of behavioral health services, invest in the workforce and drive quality improvement through innovation.

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Community Partnership & Investments

Description	Organizational Goals
CalOptima Health will continue to demonstrate our **partnership with Orange County members, providers, county agencies and community organizations** through Medi-Cal Transformation programs and robust community investments and partnerships to **advance health equity.**	3.1 Expand social health services through Medi-Cal Transformation programs and additional social needs.
	3.2 Launch a comprehensive framework for community collaboration to co-create equitable solutions.
	3.3 Prioritize community investments that advance health equity, drive prevention and improve access to care.

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Operational Excellence

Description	Organizational Goals
CalOptima Health's continued investment in our **performance** is vital to ensuring the **highest level of care and service** to our members across their lifespan.	4.1 Improve the turnaround time for treatment authorizations for direct and delegated networks.
	4.2 Improve the turnaround time for claims payment for direct and delegated networks.
	4.3 Launch and grow new programs that take care of our members and their families across their lifespan.
	4.4 Optimize the Medicare line of business to improve member retention rate and support growth.
	4.5 Implement the comprehensive Digital Transformation strategic roadmap.
	4.6 Optimize member engagement functions to improve member retention, satisfaction and outcomes.
	4.7 Achieve the Board-approved ALR target.

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Next Steps

- Review the discussion draft FY 2025-2027 Strategic Plan.
- Develop draft performance metrics and reporting dashboard.
- Bring the FY 2025-2027 Strategic Plan to the December Board of Directors meeting for review and approval.
- Publish an online brochure of the strategic plan.

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CalOptima Health

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Board of Directors Meeting
November 7, 2024

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

Report to the Board

The Member Advisory Committee (MAC), and the Provider Advisory Committee (PAC) held a regular joint meeting on October 10, 2024.

The MAC welcomed new member, Shirley Valencia, as the Orange County Social Services Representative.

Dianna Daly, Co-Lead, Family Support Task Force (FSTF), and Dr. Michele Cheung, Maternal Child Adolescent Health Medical Director, Orange County Health Care Agency (OCHCA), jointly presented on the Orange County Implementation of Family Wellness Plans. Ms. Daly discussed that in FY 2022-2023 the impact of perinatal substance use in Orange County was estimated to be approximately 2,280-5198 babies were born prematurely and had been exposed to substances out of the 30,000 babies born. This resulted in approximately 339 calls to child welfare and 285 families were investigated. 239 of those investigations were substantiated which resulted in 176 infants removed from their families and placed into foster care. Ms. Daly also reviewed the primary changes to the Child Abuse Prevention and Treatment Act (CAPTA) since 1974 and the best practices in prenatal plans for safe care. Dr. Cheung reviewed the provider resources available through the OCHCA and also reviewed the Family Wellness Plan. Both Ms. Daly and Dr. Cheung answered questions from members of both committees.

Marie Jeannis, Executive Director, Equity and Community Health, presented an update on the CalAIM Population Health Management (PHM) Program. She noted that CalOptima Health had implemented the CalAIM PHM program in January 2023 per the Department of Health Care Services (DHCS) requirements and reviewed the CalAIM PHM framework of the program as well as reviewing the new Public Health Needs Assessment requirements.

Janis Rizzuto, Director, Communications, and Geoff Patino, Associate Director, Communications, jointly presented an update on CalOptima Health's Website and Marketing Campaigns which provided an overview of the CalOptima Health website redesign, a brand awareness campaign refresh, PACE and OneCare marketing campaigns, and the cancer screening awareness campaign. The committees were able to see videos of the commercials that were being broadcast in the Orange County area. Both Ms. Rizzuto and Mr. Patino answered questions from both committees.

The members of the MAC and PAC appreciate the opportunity to update the Board on their current activities.

MINUTES
REGULAR MEETING
OF THE
CALOPTIMA HEALTH BOARD OF DIRECTORS

October 3, 2024

A Regular Meeting of the CalOptima Health Board of Directors (Board) was held on October 3, 2024, at CalOptima Health, 505 City Parkway West, Orange, California. The meeting was held in person and via Zoom webinar as allowed for under Assembly Bill 2449, which took effect after Governor Newsom ended the COVID-19 state of emergency on February 28, 2023. The meeting recording is available on CalOptima Health's website under Past Meeting Materials. Chair Becerra called the meeting to order at 2:03 p.m., and Director Norma Garcia Guillen led the Pledge of Allegiance.

ROLL CALL

Members Present: Isabel Becerra, Chair; Supervisor Vicente Sarmiento, Vice Chair; Maura Byron; Supervisor Doug Chaffee; Blair Contratto; Norma García Guillén; Catherine Green, R.N.; Brian Helleland; Veronica Kelley (non-voting) (left room at 2:50 p.m., returned at 3:17 p.m. and left the meeting at 3:50 p.m.); Jose Mayorga, M.D.

(All Board members in attendance participated in person)

Members Absent: None.

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

The Clerk noted that staff would like to pull Agenda Item 9 from the Consent Calendar for a separate vote and delete Item 12 from the Agenda.

PRESENTATIONS/INTRODUCTIONS

None

MANAGEMENT REPORTS

1. Chief Executive Officer (CEO) Report

Michael Hunn, CEO, started his report by presenting the Fast Facts for CalOptima Health. CalOptima Health currently serves about 915,950 individuals. CalOptima Health spends about 94% of every dollar on medical care, and 5.2% is the overhead cost to administer the program.

CalOptima Health's Board-designated reserves are a little over $1 billion; its capital assets are $104 million; its resources committed by the Board are $495.3 million; its Board approved provider rate increases are $491.1 million; and its unallocated and unassigned resources are $195.0 million. Mr. Hunn noted that CalOptima Health's total net assets are currently $2.4 billion.

Mr. Hunn also reviewed the CalOptima Health personnel data and noted that there are about 1,600 employees with a vacancy/turnover rate of about 5.12% as of the September 21, 2024, pay period. CalOptima Health's vacancy/turnover target is to be at less than 12.5% to 15% at any given time.

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Mr. Hunn reviewed the provider data, noting that CalOptima Health has about 8,064 providers, 1,297 primary care providers, and 6,770 specialists; 529 pharmacies; 40 acute and rehab hospitals; 52 community health centers; and 104 long term care facilities.

Mr. Hunn reviewed CalOptima Health's treatment authorizations, noting that the data is as of July 31, 2024. For urgent inpatient treatment authorizations, the average approval is within 35.32 hours; the state-mandated response is 72 hours. For urgent prior authorizations, the average approval is within 21.46 hours; the state-mandated response is 72 hours. And for routine prior authorizations, the average approval is 2.28 days; the state-mandated response is 5 days.

Mr. Hunn also highlighted the celebration of National Latino Physicians Day on October 1, recognizing partnerships with educational institutions to promote better representation in the healthcare workforce. Furthermore, Mr. Hunn recognized Dr. Mayorga as a leader in the healthcare industry and thanked him for his work and dedication in health care.

Director Mayorga thanked Mr. Hunn for the recognition, noting the importance of having Latino physicians serving the residents in Orange County. He added that in California, 40% of the population identifies as Latino and only 6% of physicians identify as Latino. Director Mayorga also noted that patients in the Latino community can be hard to reach, but when someone walks into a clinical exam room and recognizes a name or is greeted in the language they speak, it sets the tone for the rest of the visit and more than likely a better outcome.

Mr. Hunn updated the Board on a press conference that CalOptima Health held on September 26 to announce the launch of a Street Medicine Program in the City of Anaheim. Mr. Hunn noted that the event was well attended and included CalOptima Health Board members: Chair Becerra, Vice Chair Sarmiento, Supervisor Chaffee, and Directors Green and Kelley. He also noted that Mayor Ashleigh Aitken from the City of Anaheim was in attendance. Mr. Hunn added that Kelly Bruno-Nelson will be providing an update on CalOptima Health's Street Medicine Program in Garden Grove later in today's agenda. Mr. Hunn also added that there is a lot of work going on to address homelessness in Orange County, not only through the CalAIM program, but through many other organizations, including the County, which has several initiatives underway to assist and prevent homelessness.

Vice Chair Sarmiento congratulated Director Mayorga for the work he has done and noted the importance of Latino physicians delivering culturally competent care to Orange County residents. Vice Chair Sarmiento reported that CalOptima Health has opened Street Medicine Programs in Garden Grove, Costa Mesa, and now in Anaheim. He noted that a program like this is successful because there are other cities wanting to take part in the Street Medicine Program. Vice Chair Sarmiento noted that on October 7, the County is launching the Homeless Prevention and Stabilization Pilot Program. The program aims to support individuals at risk of homelessness before they lose their housing. By providing services and funding, the County's initiative seeks to prevent individuals from becoming unhoused. The program will also focus on workforce development and financial literacy support to help families stabilize. Furthermore, Supervisor Sarmiento stated that preventing homelessness was crucial, as the crisis is growing. He added that investing in a continuum of housing options, including transitional housing like tiny homes, could help address the bottleneck in shelters and support individuals in their pursuit of permanent housing.

Supervisor Chaffee thanked the Board for the opportunity to discuss the County's homeless prevention

program. He reported that within the first three days of announcing the program, 400 applications were received, funded in part by the Fourth District discretionary money. The program was streamlined in collaboration with the Friendly Center for Emergency Rental Assistance to handle the overwhelming number of applications. He stated that the program was based on the four pillars of prevention, street outreach services, shelter, and housing. It aims to provide 90 days of assistance to prevent homelessness by addressing various underlying issues such as medical, job loss, or budgeting challenges. The focus is on those facing eviction, families, and ensuring children remain in school while in housing. Statistics show that most participants stabilize sooner than the 90-day period, indicating program success. The cost comparison with other shelters reveals that around $5,000 is needed to prevent homelessness for a family, significantly lower than traditional shelter costs. The success of the program will be evaluated by tracking participants after 90 days, six months, and a year to ensure they do not return to homelessness.

Mr. Hunn also provided an update on CalOptima Health's sobering center services. He stated that sobering center services are transitioning from the Be Well Campus in Orange to the Phoenix House in Santa Ana starting September 18. The Orange County Healthcare Agency, led by Director Veronica Kelley, will continue to provide these services without disruption. This is a covered benefit under CalOptima Health.

Mr. Hunn recognized the PACE Program for celebrating its 11th anniversary. He stated that currently there are 171 PACE organizations across the Unites States, but CalOptima Health's PACE program is one of the largest in the country – currently serving more than 500 participants.

Lastly Mr. Hunn advised that Chief Operating Officer, Yunkyung Kim would provide updates on CalOptima Health's Star Rating and the National Committee for Quality Assurance (NCQA) ratings.

Ms. Kim reported that CalOptima Health has been proudly accredited by NCQA since 2012, far earlier than any Medi-Cal plan was required to be accredited in California, and it has enjoyed high star rankings for many years. She noted that CalOptima Health recently received its 2024 rating, which reflects services and performance in 2023 and saw a drop to 3.5-star rating. Ms. Kim noted that CalOptima Health is very competitive and losing half a star is not acceptable. She reviewed the areas where points were missed, which included: diabetes care, mental health care conditions, and immunizations for adolescents. Ms. Kim added that CalOptima Health has put together programs to address all these areas, while maintaining the performance in other domains of its quality program. She also noted that the Quality Assurance Committee, which meets next week, will be taking a deeper dive into the causes of the drop in performance as well as programs put in place to address the deficiencies.

Ms. Kim also reviewed two bills that were authorized by members of Orange County's own state legislative delegation that require public disclosure. Both bills have been signed into law by Governor Newsom. The first bill is Senate Bill (SB) 1111, which adds a new remote interest for a public officer, if that officer's child is an officer or director of or has an ownership interest of 10% or more in a party to a contract that is entered into by the body of which the public officer is a member. This new requirement is effective January 2026. The second bill is Assembly Bill (AB) 3130, which requires a member of the Board of Supervisors to disclose a known family relationship with an officer or employee of a nonprofit entity before the Board of Supervisors appropriates money to that nonprofit entity. Ms. Kim noted that in May 2024 the CalOptima Health Board approved the purchasing policy, which included some provisions in anticipation of AB 3130. Furthermore, CalOptima Health is continuing two policies on the Consent Calendar in order to align with the changes in these two legislative bills, to ensure consistency.

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Vice Chair Sarmiento noted that SB 1111 and AB 3130 were introduced as a result of what is occurring at the Orange County Board of Supervisors and a contract that was awarded by Supervisor Andrew Do to a nonprofit organization when Supervisor Do did not disclose his daughter's relationship with the nonprofit. Unfortunately, now it is not just the failure to disclose the relationship, but it is also whether the services have been delivered. Vice Chair Sarmiento recommended that CalOptima Health consider doing what the County CEO is doing, which is reviewing all the contracts that were either approved or directed by First District, Supervisor Andrew Do, including subcontracts. Vice Chair Sarmiento said it is something that he thinks that CalOptima Health should also look at any contracts that were sole source contracts or that maybe were not vetted as thoroughly as they should have been to ensure that it is not open to any risk.

Mr. Hunn responded that CalOptima Health has launched an investigation following the September Board meeting, which will be an independent investigation and thanked the Vice Chair for his comments.

2. Garden Grove Street Medicine Program Update

Kelly Bruno-Nelson, Executive Director, Medi-Cal & CalAIM, reported on the outcomes of the Street Medicine Program in Garden Grove over the past year. Ms. Bruno-Nelson reviewed the initial program goals and compared the outcomes for the four goals. Goal 1 was providing up to 200 participants with point-of-care medical services, and the outcome of Goal 1 was 338 participants served. Goal 2 was connecting 90% of participants with Enhanced Care Management (ECM) and/or housing navigation, and the outcome Goal 2 was 97% of participants connected. Goal 3 was connecting 80% of participants to an active primary care physician (PCP), and the outcome Goal 3 was 93% of participants connected. Goal 4 was connecting 25% of participants to permanent housing, and the outcome Goal 4 was 4% of participants transitioned to permanent housing. Ms. Bruno-Nelson shared the future vision, which includes the Care Traffic Control Center and dashboard, to monitor the population that is utilizing the Street Medicine Program and to be able to adapt the program as needed to better serve this population.

Ms. Bruno-Nelson responded to Board members' comments and questions.

PUBLIC COMMENTS

1. Jane Doe, Patient: Oral report regarding experience with Cal AIM and personal information.
2. Georgina Maldonado, Executive Director at Community Health Initiative of Orange County: Oral report regarding Agenda Item 15.
3. Becks Heyhoe-Khalil, Orange County United Way: Oral report regarding Agenda Item 16.

CONSENT CALENDAR

3. Minutes

a. Approve Minutes of the September 5, 2024, Regular Meeting of the CalOptima Health Board of Directors
b. Receive and File Minutes of the May 23, 2024, Special Meeting of the CalOptima Health Board of Directors' Finance and Audit Committee

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

5. Ratify Reappointment and Committee Chair Appointment to the CalOptima Health Board of Directors' Investment Advisory Committee

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6. Approve Reappointments to the CalOptima Health Board of Directors' Investment Advisory Committee

7. Approve Reappointment and Committee Chair Reappointment to the CalOptima Health Board of Directors' Investment Advisory Committee

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

9. Adopt Resolution No. 24-1003-01 Approving and Adopting Updated CalOptima Health Human Resources Policies
This item was pulled from the Consent Calendar for a separate vote.

10. Authorize Extension of Contracts Related to CalOptima Health's Key Operational Systems

11. Authorize an Extension of the Timeframe to Use Board-Approved Funding for an Expanded CalOptima Health OneCare Outreach and Engagement Strategy

12. Authorize Modification to and Extension of the Contract With Miller Geer & Associates for External Media Relations Support Services
This item was deleted from the Agenda.

13. Receive and File:
a. August 2024 Financial Summary
b. Compliance Report
c. Federal and State Legislative Advocates Reports
d. CalOptima Health Community Outreach and Program Summary

Action: ***On motion of Director Byron, seconded and carried, the Board of Directors approved the Consent Calendar Agenda Items 3 through 13, minus Agenda Items 9 and 12, as presented. (Motion carried; 9-0-0)***

9. Adopt Resolution No. 24-1003-01 Approving and Adopting Updated CalOptima Health Human Resources Policies
The Clerk noted for the record that staff was continuing two of policies from this Agenda Item: GA.8037: Leave of Absence and GA.8051: Hiring of Relatives. The Board approved the modified action below.

Action: ***On motion of Vice Chair Sarmiento, seconded and carried, the Board of Directors Adopted Resolution No. 24-1003-01 approving updated CalOptima Health policies: a.) GA.8018: Paid Time Off (PTO); b.) GA.8022: Performance and Behavior Standards; c.) GA.8025: Equal Employment Opportunity; d.) GA.8027: Harassment, Discrimination, and Retaliation Prevention, and Attachment A; e.) GA.8036: Education***

Reimbursement; ~~f.) GA.8037: Leave of Absence~~; g.) GA.8038: Personal Leave of Absence; h.) GA.8044: Telework Program; ~~i.) GA.8051: Hiring of Relatives~~; and j.) GA.8056: Paid Holidays. (Motion carried; 9-0-0)

REPORTS/DISCUSSION ITEMS

14. Accept, Receive, and File the Fiscal Year 2023-24 CalOptima Health Audited Financial Statements

Action: ***On motion of Director Green, seconded and carried, the Board of Directors Accepted, received, and filed the fiscal year 2023-24 CalOptima Health consolidated audited financial statements as submitted by independent auditors Moss Adams, LLP. (Motion carried; 9-0-0)***

Chair Becerra noted that she is recusing on Agenda Item 15 and passed the gavel to Vice Chair Sarmiento.

15. Approve Actions Related to the Community Enrollers for Medi-Cal Notice of Funding Opportunity

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

Public comment was received on this item as is noted under the Public Comments portion of the agenda.

Action: ***On motion of Director Green, seconded and carried, the Board of Directors: 1.) Appropriated up to $2.58 million in existing reserves to fund additional Community Enroller Grant Awards; and 2.) Authorized awarding additional grants under the Community Enrollers for Medi-Cal Notice of Funding Opportunity and authorized staff to administer grant agreements and award payments totaling $2,579,819 to the additional selected grant recipients (listed in Attachment 1). (Motion carried; 7-0-0; Chair Becerra and Director Mayorga recused)***

Vice Chair Sarmiento passed the gavel back to Chair Becerra.

16. Approve Actions Related to the Incentive Payment Program for Housing Supports

Public comment was received on this item as is noted under Public Comments portion of the agenda.

Action: ***On motion of Supervisor Chaffee, seconded and carried, the Board of Directors: 1.) Authorized the Chief Executive Officer, or designee, to execute a grant agreement amendment to extend the agreement term for an additional 17-months ending August 31, 2026, and adjust the award provisions with Orange County United Way for servicing the Whatever It Takes program and connecting CalOptima Health members to additional financial resources and landlord connections needed to secure permanent housing; and 2.) Authorized up to $4.58 million from***

CalAIM Incentive Payment Program, Program Year 1, for the Community Supports Provider Capacity Building priority area to provide support to housing-related community support providers. (Motion carried; 9-0-0)

17. Approve Actions Related to CalOptima Health's Potential Participation in Covered California

Vice Chair Sarmiento noted that this is exciting and said that he is grateful that staff is bringing this back to the Board again. He also noted that CalOptima Health has seen the consequences when individuals and families lose their health care coverage and how important it is to have continuity of care that is affordable.

Chair Becerra echoed Vice Chair Sarmiento adding that she thinks the Board missed the importance of this the first time and feels this is a second chance to fully vet through the Stakeholder Steering Committee, which includes elected officials, community clinics, and other community-based organizations with lived experience.

Action: ***On motion of Director Contratto, seconded and carried, the Board of Directors: 1.) Adopted CalOptima Health's Covered California Guiding Principles to inform the design and development of CalOptima Health's potential participation in Covered California; 2.) Authorized the continued regular convening of CalOptima Health's Covered California Stakeholder Steering Committee to inform ongoing operational and regulatory considerations for CalOptima Health's potential participation in Covered California; and 3.) Directed the Chief Executive Officer, or designee, to request the Orange County Board of Supervisors to amend Section 4-11-2 of the Codified Ordinances of the County of Orange to remove the prohibition on the participation of the Orange County Health Authority in the California Health Benefit Exchange. (Motion carried; 9-0-0)***

CLOSED SESSION

The Board adjourned to Closed Session at 3:49 p.m. Pursuant to Government Code section 54956.9(d)(2), CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION and Pursuant to Government Code section 54956.9(d)(1), CONFERENCE WITH LEGAL COUNSEL – EXISTING LITIGATION.

The Board returned to Open Session at 5:01 p.m. and the Clerk re-established a quorum.

ROLL CALL

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

Members Absent: Veronica Kelley (non-voting)

CLOSED SESSION

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Chair Becerra noted that the Board met in Closed Session and there were no reportable actions taken.

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

Director Contratto thanked staff for the immense amount of detail and reporting and the abundance of work.

Director Mayorga wished everyone a great evening and reminded the Board and the public to get their flu and COVID vaccinations.

ADJOURNMENT

Hearing no further business, Chair Becerra adjourned the meeting at 5:03 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: November 7, 2024

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MINUTES

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

CALOPTIMA HEALTH
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

June 12, 2024

A Regular Meeting of the CalOptima Health Board of Directors' Quality Assurance Committee (Committee) was held on June 12, 2024, at CalOptima Health, 505 City Parkway West, Orange, California. The meeting was held in person and via Zoom webinar as allowed for under Assembly Bill (AB) 2449, which took effect after Governor Newsom ended the COVID-19 state of emergency on February 28, 2023. The meeting recording is available on CalOptima Health's website under Past Meeting Materials.

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

CALL TO ORDER

Members Present: Trieu Tran, M.D., Chair; Maura Byron; José Mayorga, M.D.

(All Committee members in attendance participated in person except Director Mayorga, who participated remotely under Just Cause, using his first of two uses for calendar year 2024 as permitted by AB 2449.)

Members Absent: None.

Others Present: Michael Hunn, Chief Executive Officer; Yunkyung Kim, Chief Operating Officer; Richard Pitts, D.O., Ph.D., Chief Medical Officer; Troy Szabo, Outside General Counsel, Kennaday Leavitt; Linda Lee, Executive Director, Quality Improvement; Monica Macias, Director, PACE; Sharon Dwiers, Clerk of the Board

MANAGEMENT REPORTS

None.

PUBLIC COMMENTS

There were no public comments.

CONSENT CALENDAR

1. Approve the Minutes of the March 13, 2024, Regular Meeting of the CalOptima Health Board of Directors' Quality Assurance Committee

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

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REPORT/DISCUSSION ITEMS

2. Recommend that the Board of Directors Approve the Revised 2024 CalOptima Health Quality Improvement and Health Equity Transformation Program and Work Plan

Linda Lee, Executive Director, Quality Improvement, highlighted the revisions to CalOptima Health's 2024 Quality Improvement and Health Equity Program (QIHEP) and Work Plan. Ms. Lee noted that the program and annual work plan was previously approved by the Committee in March 2024, and noted that the revisions being brought before the Committee today are regulatory in nature and will help align CalOptima Health with contractual requirements as directed by the Department of Health Care Services (DHCS). Ms. Lee reviewed the changes to the agency's QIHEP and Work Plan, which included changing the name of the Population Health Management Program to the Equity and Community Health Program. She noted that CalOptima Health also changed its department name from Population Health Management Department to Equity and Community Health Department. Ms. Lee added that this highlights DHCS' priorities around identifying health disparities and working to ensure health equity amongst California members and the broader community that CalOptima Health serves in Orange County.

Ms. Lee reviewed other changes, which included adding a Cultural and Linguistic Appropriate Services (CLAS) Program to align cultural and linguistic services to quality improvement. Ms. Lee note that going forward, for Health Equity Accreditation, cultural and linguistic services are tightly integrated with quality improvement efforts. This is also a DHCS and National Committee for Quality Assurance (NCQA) requirement.

Ms. Lee reported that the revised documents are the Quality Improvement (QI) Program Description, the Work Plan, and the new CLAS Program. Ms. Lee noted that CalOptima Health has involved the community and members through its Member Advisory Committee (MAC). The MAC will review opportunities for CLAS. CalOptima Health has specified CLAS goals; one of the goals, which is new to CalOptima Health, is to implement a process to collect sexual orientation and gender identifying data. Ms. Lee added that collecting this data is an integral part of health equity accreditation, so staff is working towards ensuring that its systems can house this data and that there is a way for members to self-identify and report this information in the system.

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

Action: ***On motion of Director Mayorga, seconded and carried, the Committee recommended that the Board of Directors approve the revised 2024 CalOptima Health Quality Improvement and Health Equity Transformation Program and Work Plan. (Motion carried 3-0-0)***

3. Recommend that the Board of Directors Approve CalOptima Health's Calendar Year 2025 Member Health Rewards

Ms. Lee reviewed the proposal for the Calendar Year (CY) 2025 Member Health Rewards Program, which would start January 1, 2025, through December 31, 2025. The main change for CY 2025 Member Health Rewards is the alignment of the incentive amounts, so that all incentives have the same amount. Ms. Lee also noted that CalOptima Health is changing the blood lead testing from attestation-based rewards to passive rewarding and reducing the postpartum care amount from $50 to $25 to align it with the rest of the incentives. She added that the fiscal impact is estimated based on a

15% response rate. This is tracking with what the 2023-2024 experience has been so far. For Medi-Cal, the estimated cost for the CY 2025 Member Health Rewards Program is $4.87 million, which will be funded by the CalOptima Health Fiscal Year (FY) 2024-25 Operating Budget and unearned funds from the Measurement Year 2023 Medi-Cal Pay for Value Performance program. For OneCare, the estimated cost is $660,000, which will be funded by the proposed FY 2024-25 Operating Budget and expenses for the period of July 1, 2025, through December 31, 2025, will be included in the FY 2025-26 Operating Budget.

Ms. Lee and Yunkyung Kim, Chief Operating Officer, responded to Committee members' comments and questions.

Action: ***On motion of Director Byron, seconded and carried, the Committee recommended that the Board of Directors 1.) Approve CalOptima Health's Calendar Year 2025 Member Health Rewards for Medi-Cal and OneCare. (Motion carried 3-0-0)***

4. Recommend Appointments to the CalOptima Health Whole-Child Model Family Advisory Committee

Ms. Kim introduced this item noting that CalOptima Health is extremely fortunate to have a Whole-Child Model Family Advisory Committee (WCM FAC). She noted that as the former Chair, Director Byron is very familiar with the WCM FAC.

Director Byron asked for more information on the consumer advocate recommendation, Jennifer Heavner.

Cheryl Simmons, Staff to the Advisory Committees, responded to Director Byron's question noting that Jennifer Heavner is currently an authorized family member, but her son is aging out of the California Children's Services (CCS) program. Ms. Simmons noted that Ms. Heavner has been advocating for her son for 21 years and she would like to continue to advocate on behalf of other children that are in the program.

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

Director Byron emphasized how incredibly important the WCM FAC is, and noted that sometimes it gets overlooked. She also noted that the WCM FAC has gone through a lot of transitions, and now it is not under the Brown Act. She noted that the WCM FAC is a committee that meets virtually, which is very important because many of the members that sit on the committee do not have the ability to meet in person because they are taking care of their loved ones. Director Byron added that she appreciates the fact that CalOptima Health has a WCM FAC, and she is very proud of where the committee started and where it is going.

Action: ***On motion of Director Byron, seconded and carried, the Committee recommended that the Board of Directors approve the Whole-Child Model Family Advisory Committee's recommendations and in turn recommend that the Board of Directors approve those recommendations as follows: 1.) Reappoint the following individuals to each serve a two-year term on the Whole-Child Family Advisory Committee, effective upon Board of Directors***

approval: a.) Jessica Putterman as an Authorized Family Member Representative for a term ending June 30, 2026; b.) Kristen Rogers as an Authorized Family Member Representative for a term ending June 30, 2026; and c.) Erika Jewell as a Community Based Organization Representative for a term ending June 30, 2026. 2.) Newly appoint the following individuals to each serve a two-year term on the Whole-Child Model Family Advisory Committee, effective upon Board of Directors approval: a.) Jody Bullard as an Authorized Family Member Representative for a term ending June 30, 2026; and b.) Jennifer Heavener as a Consumer Advocate Representative for a term ending June 30, 2026. (Motion carried 3-0-0)

ADVISORY COMMITTEE UPDATES

5. Program of All-Inclusive Care for the Elderly Member Advisory Committee Update

Chair Tran noted that the update for the PACE Member Advisory Committee is in the meeting materials and the Committee accepted Agenda Item 5 as presented.

6. Whole-Child Model Family Advisory Committee Report

Kristen Rogers, Chair, WCM FAC, provided an update on the activities of the WCM FAC. Ms. Rogers thanked the Committee for recommending approval of the WCM FAC members, which included herself as one of the members. She added that the next WCM FAC is scheduled for June 18, 2024, at 9:30 a.m., at which the committee will be approving its quarterly schedule for the next fiscal year. Ms. Rogers reported that in addition to the Chief Executive Officer, Chief Operating Officer, and Chief Medical Officer updates, the committee will receive an update on the OneCare program, and a Quality Improvement Update from Linda Lee.

INFORMATION ITEMS

7. Update on Quality Improvement Programs

Ms. Lee provided an update on several key initiatives, which have been presented to the Committee in the past. She noted that she will provide updates on credentialing, CalOptima Health NCQA Health Plan Accreditation Survey, the NCQA Health Equity Accreditation Survey, and other key quality initiatives.

Credentialing Update

Ms. Lee noted that as she had previously reported to the Committee, there were opportunities for improvement of CalOptima Health's credentialing processes. Since the last update, staff contracted with a Credentialing Verification Organization (CVO) in March 2024 and held a kick-off meeting in April 2024. Ms. Lee noted that as part of the CVO implementation process, staff is attending weekly implementation meetings with the vendor, preparing documents, creating workflows and protocols for data exchange. Currently, staff expects to go live with the vendor by end of June 2024. Ms. Lee added that the vendor will assume most of CalOptima Health's credentialing services, which will improve credentialing turnaround times. CalOptima Health will monitor post go-live transmission for 30 days, after which time, internal auditor staff will continuously monitor to ensure the vendor is meeting contract requirements.

NCQA Health Plan Accreditation

Ms. Lee provided an update on CalOptima Health's Health Plan Accreditation, noting that it has been accredited by NCQA since 2012. The current Health Plan Accreditation is a re-survey for the agency

and is a 24-month look-back period, from April 30, 2022, to April 30, 2023, and from April 30, 2023, to April 30, 2024. Ms. Lee reported that staff has submitted all documents to NCQA. Ms. Lee also noted that CalOptima Health is prepared and added that the file review includes delegated network files for areas that CalOptima Health delegates to its health networks. She reported that the results will not be available until around August.

NCQA Health Equity Accreditation

Ms. Lee updated the Committee on the new DHCS requirement of NCQA Health Equity Accreditation. By way of background, DHCS will require all managed care plans to achieve Health Equity Accreditation by January 1, 2026. CalOptima Health's goal is to be accredited ahead of that date and is targeting quarter three of 2025. Ms. Lee noted that staff has engaged its NCQA consultant and completed a readiness assessment. The consultant has created a gap analysis and work plan, and staff is working towards remediating that work plan. Ms. Lee provided additional details on what Health Equity Accreditation standards cover, which included six areas: (1) organizational readiness, diverse staff, and promoting diversity among staff; (2) collection of race/ethnicity, gender identity, and sexual orientation data; (3) access and availability of language services; (4) practitioner network cultural responsiveness; (5) culturally and linguistically appropriate services program; and (6) reducing health care disparities. Ms. Lee added that CalOptima Health has already started including these requirements in the revised 2024 QIHEP and Work Plan. She also shared the project timeline for obtaining NCQA Health Equity Accreditation, noting that CalOptima Health's survey submission date is tentatively in June 2025.

Quality Initiatives

Ms. Lee provided an update on CalOptima Health's quality initiatives that are federally and state mandated Performance Improvement Projects (PIP). For Medi-Cal, the first DHCS mandated performance improvement initiative is on well infant visits for the first 15 months of life. This initiative addresses disparities for Black or African American members. Ms. Lee noted that CalOptima Health has a very low number of members that fit into this population, with only 153 members. Nevertheless, that population shows a disparity. In measurement year 2022, the baseline rate was about 35% for that population, compared to the 46% overall rate among all other members in the age cohort, which is an 11% difference. Ms. Lee noted that staff has conducted education campaigns, sent reminders, is coordinating appointments, and offering gifts cards. Ms. Lee also noted that staff has identified other racial populations that might have disparities, so CalOptima Health is reaching out to those populations as well.

The next PIP area falls under the Plan-Do-Study-Act (PDSA) Project for the age group of 15 to 30 months of life and similar initiatives. Ms. Lee noted that CalOptima Health has found that members who received two call attempts had similar rates of compliance as members who received three call attempts and a birthday card reminder, and as a result, staff can minimize the outreach and costs associated with this and conduct two call attempts and a post birthday card reminder. Ms. Lee reported that staff conducts rapid cycle studies to inform what initiatives CalOptima Health should undertake and whether the initiatives are having the desired impact.

Ms. Lee also reported that the agency has a behavioral health non-clinical PIP, which is mandated by DHCS. The purpose of the PIP is to increase enrollment of CalOptima Health Medi-Cal only members into care management, complex case management, or enhanced care management for members diagnosed with Specialty Mental Health/Substance Use Disorder to achieve better health

outcomes, reduce emergency visits, and reduced health care costs. Staff has collected baseline data and created the initial report. The first draft of the PIP was submitted to DHCS and they have reviewed and accepted the proposed PIP. Ms. Lee reported that the quality interventions due to this initiative include the following: text messaging campaigns; member health rewards; member outreach; member newsletter; automation via CalOptima Health provider portal; and provider communication, including tip sheets and best practice letters. Ms. Lee reminded the Committee that CalOptima Health has a Behavioral Health Pay for Value program, which is aligned with these efforts.

Ms. Lee reported on the blood lead screening initiative, which is an area that has hovered around the minimum performance level year after year. To date, staff has added an incentive for blood lead screening incentive, initiated text campaigns, and a live call campaign to address gaps for members who have not yet had a blood lead screen.

Ms. Lee reported on the OneCare Chronic Care Improvement Program (CCIP). This initiative focuses on members with diabetes on two fronts. The first is medication adherence for diabetes to ensure that members stay compliant and in control of their HbA1c levels. The second is identifying members who have an emerging risk for poor HbA1c control, this would be eligible members with diabetes whose HbA1c test result is below 8.0% but tested between 8.0% and 9.0% in their most recent test. Ms. Lee reported that CalOptima Health is tracking these results and when HbA1c levels rise it conducts outreach via telephone by a health coach to identify solutions, which could include general diabetes health education, blood sugar management, nutrition and exercise, and preventive care reminders.

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

Director Byron noted that currently, most people do not pick up the phone and said it may be advantageous to outreach to members via text and enlist providers and hospitals to help educate members on the importance of screenings for infants and children.

Ms. Lee thanked Director Byron for her comments and suggestions and noted that CalOptima Health will continue looking for avenues to reach members to ensure the best health outcomes for all CalOptima Health members.

Director Mayorga commented that he has read the PACE Member Advisory Committee update and the metrics within that report. He suggested that staff may want to consider connecting with other PACE providers within the county to exchange best practices on how to improve the care of this vulnerable population, from a performance perspective. He noted that staff could report out the results at a future Committee meeting.

Director Mayorga also requested a report on member grievances, particularly around access to care.

Ms. Kim responded to Director Mayorga's comments and suggestions regarding the PACE best practices and committed to bringing an update on the findings at a future Committee meeting. Ms. Kim also thanked Director Mayorga for requesting a report on member grievances, noting that this information is included in the meeting materials; but the Committee has not always had the opportunity to dig into the details. Ms. Kim noted that the Committee can expect a report on member

grievances for CalOptima Health's direct network, its delegated network, and the delivery system as a whole at the next Committee meeting.

The following items were accepted as presented.

8. Quarterly Reports to the Quality Assurance Committee
   a. Quality Improvement Health Equity 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 4:10 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: October 9, 2024

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CalOptima Health Board Action Agenda Referral

Action To Be Taken November 7, 2024
Regular Meetin of the CalOptima Health Board of Directors

Consent Calendar

6. Approve Modifications to CalOptima Policy AA.1207b and AA.1207c: Performance-based Heath Network and CalOptima Community Network Auto-Assignment Allocation Methodology and Performance-based Community Health Center Auto-Assignment Allocation Methodology

Contact

Linda Lee, Executive Director, Quality Improvement, (657) 900-1069

Recommended Actions

Approve recommended modifications to policy AA.1207b: Performance-based Heath Network and CalOptima Community Network Auto-Assignment Allocation Methodology and AA.1207c: Performance-based Community Health Center Auto-Assignment Allocation Methodology.

Background

Since 2006, CalOptima Health has utilized an auto assignment methodology to assign members to Health Networks and primary care providers when members do not choose a provider upon enrollment. The auto assignment methodology mimics selection criteria that members use when self-selecting, such as geography, previous provider assignment, member family link, and provider quality. CalOptima Health's auto assignment methodology and process are outlined in the following three policies:

- AA.1207a CalOptima Health Auto-Assignment.
- AA.1207b Performance-based Health Network and CalOptima Health Community Network Auto-Assignment Allocation Methodology.
- AA.1207c Performance-based Community Health Center Auto-Assignment Allocation Methodology.

Discussion

Staff regularly review agency policies and procedures to ensure that they are up-to-date and aligned with federal and state health care program requirements, contractual obligations, laws, and CalOptima Health operations.

CalOptima Health implements an auto-assignment process as a proxy for member selection when members do not actively choose a Health Network and primary care practitioner. The auto-assignment process utilizes factors that mimic selection criteria that a member may use when self-selecting. These factors include geographic distance between the member's location and provider's office, previous affiliation with a provider, linkage between a provider and other eligible family members, and provider quality performance.

Staff has reviewed the auto assignment methodology and recommends changes to align CalOptima Health's auto assignment quality score with the California Department of Health Care Services auto assignment quality score, update the quality measures based on CalOptima Health priorities, and create a method for new providers to participate in auto assignment before a quality score can be calculated.

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

Policy AA.1207b revisions update the quality metrics and scoring used to allocate auto-assignment for Health Networks. These changes were shared and discussed with the health networks at Health Network Forums, Community Clinic Forum, Quality Forum, and the Quality Improvement and Health Equity Committee.

Policy Section	**Changes to Policy AA.1207b: Performance based Heath Network and CalOptima Community Network Auto-Assignment Allocation Methodology**
Page: 1 Policy Section: II.B.1.a Lines: 28-32	Added new language defining an updated auto assignment quality score.
Page: 2 Policy Section: II.F.1 Lines: 31-37	Updated language that describes new methodology for assigning an auto assignment quality score to new Health Networks.
Page: 3-4 Procedure Sections: III.C-I Lines: 11-28, 1-17	Added new language defining the procedure for calculating the auto assignment quality score, including the quality measures that will be used.

Policy AA.1207c revisions update the quality metrics and scoring used to allocate auto-assignment for Community Health Centers. These changes were shared and discussed with the health networks at Health Network Forums, Community Clinic Forum, Quality Forum, and the Quality Improvement and Health Equity Committee.

Policy Section	**Changes to Policy AA.1207c: Performance-based Community Health Center Auto-Assignment Allocation Methodology**
Pages: 1-3 Policy Sections: II.B-D.1.2. E-F Lines: 12-41	Added new language defining an updated auto assignment quality score.
Page: 3 Policy Sections: II.G-K. Lines: 15-26	Updated language that describes new methodology for assigning an auto assignment quality score to new Health Networks.

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Pages: 3-4 Procedure Sections: III.A-I Lines: 30-37, 1-34	Added new language defining the procedure for calculating the auto assignment quality score, including the quality measures that will be used.

Fiscal Impact

The recommended action to approve changes to policies AA.1207b and AA.1207c is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Fiscal Year 2024-25 Operating Budget.

Rationale for Recommendation

To ensure CalOptima Health's continuing commitment to conducting its operations in compliance with all applicable laws, regulations, rules, and accreditation standards, CalOptima Health staff recommends that the Quality Assurance Committee recommend that the Board of Directors approve and adopt the revised policies. The updated policies will supersede prior versions.

Concurrence

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

Attachments

1. AA.1207b Performance based Heath Network and CalOptima Community Network Auto-Assignment Allocation Methodology
2. AA.1207c Performance-based Community Health Center Auto-Assignment Allocation Methodology
3. Presentation: Changes to Auto-Assignment Quality Metrics and Scoring

/s/ Michael Hunn *10/31/2024*
Authorized Signature **Date**

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Policy:	AA.1207b
Title:	**Performance-based Health Network and CalOptima Health Community Network Auto-Assignment Allocation Methodology**
Department:	Provider Network Operations
Section:	Provider Data Management Services
CEO Approval:	*/s/*
Effective Date:	01/01/2007
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy establishes CalOptima Health's methodology for determining a Health Network and CalOptima Health's Community Network's (CHCN) Assignment allocations according to performance-based indicators.

II. POLICY

A. ~~CalOptima Health shall Auto-Assign a Health Network Eligible Member who has not selected a Health Network, or CHCN, to a Health Network, or CHCN, in accordance with CalOptima Health Policy AA.1207a: CalOptima Health Auto-Assignment.~~CalOptima Health shall Auto-Assign a Health Network Eligible Member who has not selected a Health Network, or CHCN, to a Health Network, or CHCN, utilizing performance-based indicators and in accordance with CalOptima Health Policy AA.1207a: CalOptima Health Auto-Assignment.

~~B. CalOptima Health shall assign eligible Members not Auto-Assigned under CalOptima Health Policy AA.1207a: CalOptima Health Auto-Assignment based on a Health Network's, or CHCN's, performance-based Auto-Assignment allocation.~~

~~C.~~B. CalOptima Health shall determine a Health Network's, or CHCN's, performance-based Auto-Assignment allocation according to indicators listed in the Health Network/CHCN Performance-based Auto-Assignment Allocation Table.

~~1.~~ CalOptima Health shall calculate a Health Network's, (including CHCN's), performance-based Auto-Assignment allocation as follows:

~~2.~~1.

a. CalOptima Health shall calculate an ~~Health Network Quality Rating~~ Auto Assignment Quality Score (~~HNQR~~AAQS) (scored between zero (~~1~~0) ~~–~~and ten (~~5~~10)) for each Health Network. A higher score indicates better performance. ~~-~~The scores are ranked to determine the order of the Auto-Assignment allocation run.~~The HNQR utilizes industry standard scoring developed by the National Committee for Quality Assurance to derive health plan~~

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~~quality performance scores. This methodology also aligns with CalOptima Health's Board of Directors approved Pay for Value program scoring methodology.~~

~~2. Health networks that do not achieve a HNQR of at least 2.5 will be suspended from Auto-Assignment until the next measurement period. Health Networks that do not achieve a HNQR of at least 2.5 will be notified and required to complete an improvement plan that details their plans to raise their performance to expected minimum performance levels.~~

b. Annually, each Health Network will be provided with documentation of how their ~~HNQR~~ AAQS score was derived which includes their performance on each quality metric, comparison to national benchmarks which are used in the scoring, as well as assigned measure weights and calculations used to derive the ~~HNQR~~AAQS.

~~D.~~C. CHCN, and each individual Health Network, shall be given a ~~HNQR~~ AAQS score from zero (~~1.0~~0) to ten (~~5.0~~10) based on their performance during the measurement period. CalOptima Health shall utilize the Health Network, or CHCN, ~~HNQR~~AAQS, in numerical sequence, (highest to lowest) as the processing order for Auto-Assignment~~s~~.

~~E.~~D. In the event that CHCN's, or a Health Network's, Auto-Assignment is suspended for any reason, CalOptima Health shall distribute that Health Network's, or CHCN's, allocation of Auto-Assigned Members amongst the remaining eligible Health Networks, or CHCN, in a manner that is proportional to each individual Health Network's, or CHCN's, Performance-based Auto-Assignment allocation.

~~F.~~E. CalOptima Health shall score a Health Network for an indicator as long as the Health Network maintains a Contract for Health Care Services for the entire measurement year and is contracted with CalOptima Health at the time of measurement calculation.

~~G.~~F. Performance-based Auto-Assignment allocation for a new Health Network, or CHCN:

1. A new Health Network, for purposes of Auto-Assignment, is considered a Health Network with less than one (1) full measurement year of data during the measurement period. Prior to one (1) full measurement year, a new Health Network will receive three (3.0) points per measure used in the AAQS. ~~New health networks will not be eligible for Auto-Assignment until the following year w~~When a full year of data is available and ~~and~~ an ~~HNQR~~ AAQS can be calculated, ~~with evidence of minimum performance level~~ then the new Health Network shall receive an AAQS based on performance. ~~achievement calculated by CalOptima Health staff.~~

2. In the event of a declaration of a "extreme and uncontrollable event" declared by DHCS (such as the previous declarations for regional wild-fires and flooding which adversely impacted ability to collect data and calculate quality scores), there will be no penalties to scores and each HN will ~~achieve at least a 2.5 HNQR~~ receive the better of the current or prior year AAQS.

~~H.~~G. CalOptima Health shall evaluate the performance-based Auto-Assignment allocation methodology for Health Networks and CHCN annually, or upon:

1. Addition, or termination, of a Health Network;

2. A material change; or

3. Change in indicators.

~~I.~~H. CalOptima Health shall notify Health Networks of any changes in the performance-based Auto-Assignment allocation methodology~~,~~ or ~~indicators~~measures prior to the measurement period.

III. PROCEDURE

A. CalOptima Health shall ~~measure~~ calculate each ~~indicator~~ measure annually using the most current data available for the preceding year.

B. The measurement results shall take effect the year following ~~the~~ measurement.

C. The AAQS shall be based on the following eleven (11) measures weighted equally:

Measure	Category
Adult Access to Preventive and Ambulatory Care Visits	HEDIS
Child and Adolescent Well-Care Visits	HEDIS
Childhood Immunization Status- Combination 10	HEDIS
Immunizations for Adolescents- Combination 2	HEDIS
Well-Child Visits in the First 30 Months of Life- 0 to 15 Months- Six or More Well-Child Visits	HEDIS
Well-Child Visits in the First 30 Months of Life- 15 to 30 Months- Six or More Well-Child Visits	HEDIS
Prenatal and Postpartum Care: Postpartum Care	HEDIS
Prenatal and Postpartum Care: Timeliness of Prenatal Care	HEDIS
Cervical Cancer Screening	HEDIS
Getting Care Quickly	CAHPS
Getting Needed Care	CAHPS

D. Healthcare Effectiveness Data and Information Set (HEDIS) performance rates shall be calculated for each Health Network, including CHCN, using administrative data (claims and encounter data). The minimum denominator to report a performance rate shall be thirty (30) M~~m~~embers.

E. Consumer Assessment of Healthcare Providers and Systems (CAHPS) performance rates will be calculated based on M~~m~~ember satisfaction surveys fielded by CalOptima Health for each Health Network, including CHCN, according to CalOptima Health P~~p~~olicy GG.1637: Assessing Member Experience.

F. Points will be allocated for each measure based on comparison to the most recent National Committee for Quality Assurance (NCQA) National Medicaid percentiles available at the time of measurement. Point allocation shall be as follows:

Points Earned for Individual Measures	
NCQA Percentile	**Points**
At or above the 75th percentile	10
At or above the 66.67th percentile, below the 75th percentile	8
At or above the 50th percentile, below the 66.67th percentile	6
At or above the 33.33rd percentile, below the 50th percentile	4
At or above the 25th percentile, below the 33.33rd percentile	2
Below the 25th percentile	0

G. A new Health Network, prior to the ability to report performance rates as described in Section II.G.1. ~~above~~of this Policy, shall receive three (3) points per measure.

H. The AAQS is calculated based on the sum of points for each measure divided by the number of reportable measures. The maximum possible AAQS is ten (10) points. Health Networks must report a minimum of three (3) HEDIS measures to generate an AAQS and to participate in Auto Assignment.

I. CalOptima shall calculate eligible and participating Health Network's (including CHCN's) performance-based Auto-Assignment allocation as follows:

1. For each Health Network, derive a score relative to the sum of all AAQS scores for all eligible and participating Health Networks;

2. For each Health Network, calculate the final allocation percentage by multiplying the relative score with the percent of the total Health Network Auto-Assignment in accordance with CalOptima Health Policy AA.1207a: CalOptima Health Auto-Assignment.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Policy AA.1207a: CalOptima Health Auto-Assignment
C. CalOptima Health Policy GG.1637: Assessing Member Experience

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
11/14/1995	Regular Meeting of the CalOptima Board of Directors
01/23/1996	Regular Meeting of the CalOptima Board of Directors
12/04/2008	Regular Meeting of the CalOptima Board of Directors
10/07/2010	Regular Meeting of the CalOptima Board of Directors
03/03/2011	Regular Meeting of the CalOptima Board of Directors
03/07/2013	Regular Meeting of the CalOptima Board of Directors
03/06/2014	Regular Meeting of the CalOptima Board of Directors
10/06/2022	Regular Meeting of the CalOptima Health Board of Directors
TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2007	AA.1207b	Performance-based Auto Assignment Allocation Methodology	Medi-Cal

Action	Date	Policy	Policy Title	Program(s)
Revised	01/01/2009	AA.1207b	Performance-based Auto Assignment Allocation Methodology	Medi-Cal
Revised	01/01/2011	AA.1207b	Performance-based Auto Assignment Allocation Methodology	Medi-Cal
Revised	07/01/2013	AA.1207b	Performance-based Health Network Auto Assignment Allocation Methodology	Medi-Cal
Revised	12/01/2014	AA.1207b	Performance-based Health Network Auto Assignment Allocation Methodology	Medi-Cal
Revised	02/01/2016	AA.1207b	Performance-based Health Network and CalOptima Community Network Auto Assignment Allocation Methodology	Medi-Cal
Revised	02/01/2017	AA.1207b	Performance-based Health Network and CalOptima Community Network Auto Assignment Allocation Methodology	Medi-Cal
Revised	11/01/2017	AA.1207b	Performance-Based Health Network and CalOptima Community Network Auto Assignment Allocation Methodology	Medi-Cal
Revised	10/06/2022	AA.1207b	Performance-based Health Network and CalOptima Health Community Network Auto-Assignment Allocation Methodology	Medi-Cal
Revised	01/01/2024	AA.1207b	Performance-based Health Network and CalOptima Health Community Network Auto-Assignment Allocation Methodology	Medi-Cal
Revised	05/01/2024	AA.1207b	Performance-based Health Network and CalOptima Health Community Network Auto-Assignment Allocation Methodology	Medi-Cal
Revised	TBD	AA.1207b	Performance-based Health Network and CalOptima Health Community Network Auto-Assignment Allocation Methodology	Medi-Cal

IX. GLOSSARY

Term	Definition
Auto-Assignment	The process by which a CalOptima Health Member who does not select a Primary Care Provider (PCP) and/or Health Network is assigned to a participating CalOptima Health Provider and/or Health Network.
CalOptima Health Community Network (CHCN)	A managed care network operated by CalOptima Health that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the Members.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Health Network Eligible Member	A member who is eligible to choose a CalOptima Health, Health Network or CalOptima Health Community Network (CHCN).
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Health program.

Policy:	AA.1207b
Title:	**Performance-based Health Network and CalOptima Health Community Network Auto-Assignment Allocation Methodology**
Department:	Provider Network Operations
Section:	Provider Data Management Services
CEO Approval:	*/s/*
Effective Date:	01/01/2007
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy establishes CalOptima Health's methodology for determining a Health Network and CalOptima Health's Community Network's (CHCN) Assignment allocations according to performance-based indicators.

II. POLICY

A. CalOptima Health shall Auto-Assign a Health Network Eligible Member who has not selected a Health Network, or CHCN, to a Health Network, or CHCN, utilizing performance-based indicators and in accordance with CalOptima Health Policy AA.1207a: CalOptima Health Auto-Assignment.

B. CalOptima Health shall determine a Health Network's, or CHCN's, performance-based Auto-Assignment allocation according to indicators listed in the Health Network/CHCN Performance-based Auto-Assignment Allocation Table.

1. CalOptima Health shall calculate a Health Network's, (including CHCN's), performance-based Auto-Assignment allocation as follows:

a. CalOptima Health shall calculate an Auto Assignment Quality Score (AAQS) (scored between zero (0) and ten (10)) for each Health Network. A higher score indicates better performance. The scores are ranked to determine the order of the Auto-Assignment allocation run.

b. Annually, each Health Network will be provided with documentation of how their AAQS score was derived which includes their performance on each quality metric, comparison to national benchmarks which are used in the scoring, as well as assigned measure weights and calculations used to derive the AAQS.

C. CHCN, and each individual Health Network, shall be given a AAQS score from zero (0) to ten (10) based on their performance during the measurement period. CalOptima Health shall utilize the Health Network, or CHCN, AAQS, in numerical sequence, (highest to lowest) as the processing order for Auto-Assignment.

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D. In the event that CHCN's, or a Health Network's, Auto-Assignment is suspended for any reason, CalOptima Health shall distribute that Health Network's, or CHCN's, allocation of Auto-Assigned Members amongst the remaining eligible Health Networks, or CHCN, in a manner that is proportional to each individual Health Network's, or CHCN's, Performance-based Auto-Assignment allocation.

E. CalOptima Health shall score a Health Network for an indicator as long as the Health Network maintains a Contract for Health Care Services for the entire measurement year and is contracted with CalOptima Health at the time of measurement calculation.

F. Performance-based Auto-Assignment allocation for a new Health Network, or CHCN:

1. A new Health Network, for purposes of Auto-Assignment, is considered a Health Network with less than one (1) full measurement year of data during the measurement period. Prior to one (1) full measurement year, a new Health Network will receive three (3.0) points per measure used in the AAQS. When a full year of data is available and an AAQS can be calculated, then the new Health Network shall receive an AAQS based on performance.

2. In the event of a declaration of a "extreme and uncontrollable event" declared by DHCS (such as the previous declarations for regional wild-fires and flooding which adversely impacted ability to collect data and calculate quality scores), there will be no penalties to scores and each HN will receive the better of the current or prior year AAQS.

G. CalOptima Health shall evaluate the performance-based Auto-Assignment allocation methodology for Health Networks and CHCN annually, or upon:

1. Addition, or termination, of a Health Network;

2. A material change; or

3. Change in indicators.

H. CalOptima Health shall notify Health Networks of any changes in the performance-based Auto-Assignment allocation methodology or measures prior to the measurement period.

III. PROCEDURE

A. CalOptima Health shall calculate each measure annually using the most current data available for the preceding year.

B. The measurement results shall take effect the year following measurement.

C. The AAQS shall be based on the following eleven (11) measures weighted equally:

Measure	Category
Adult Access to Preventive and Ambulatory Care Visits	HEDIS
Child and Adolescent Well-Care Visits	HEDIS
Childhood Immunization Status- Combination 10	HEDIS
Immunizations for Adolescents- Combination 2	HEDIS
Well-Child Visits in the First 30 Months of Life- 0 to 15 Months- Six or More Well-Child Visits	HEDIS

Measure	Category
Well-Child Visits in the First 30 Months of Life- 15 to 30 Months- Six or More Well-Child Visits	HEDIS
Prenatal and Postpartum Care: Postpartum Care	HEDIS
Prenatal and Postpartum Care: Timeliness of Prenatal Care	HEDIS
Cervical Cancer Screening	HEDIS
Getting Care Quickly	CAHPS
Getting Needed Care	CAHPS

D. Healthcare Effectiveness Data and Information Set (HEDIS) performance rates shall be calculated for each Health Network, including CHCN, using administrative data (claims and encounter data). The minimum denominator to report a performance rate shall be thirty (30) Members.

E. Consumer Assessment of Healthcare Providers and Systems (CAHPS) performance rates will be calculated based on Member satisfaction surveys fielded by CalOptima Health for each Health Network, including CHCN, according to CalOptima Health Policy GG.1637: Assessing Member Experience.

F. Points will be allocated for each measure based on comparison to the most recent National Committee for Quality Assurance (NCQA) National Medicaid percentiles available at the time of measurement. Point allocation shall be as follows:

Points Earned for Individual Measures	
NCQA Percentile	**Points**
At or above the 75th percentile	10
At or above the 66.67th percentile, below the 75th percentile	8
At or above the 50th percentile, below the 66.67th percentile	6
At or above the 33.33rd percentile, below the 50th percentile	4
At or above the 25th percentile, below the 33.33rd percentile	2
Below the 25th percentile	0

G. A new Health Network, prior to the ability to report performance rates as described in Section II.G.1. of this Policy, shall receive three (3) points per measure.

H. The AAQS is calculated based on the sum of points for each measure divided by the number of reportable measures. The maximum possible AAQS is ten (10) points. Health Networks must report a minimum of three (3) HEDIS measures to generate an AAQS and to participate in Auto Assignment.

I. CalOptima shall calculate eligible and participating Health Network's (including CHCN's) performance-based Auto-Assignment allocation as follows:

1. For each Health Network, derive a score relative to the sum of all AAQS scores for all eligible and participating Health Networks;

2. For each Health Network, calculate the final allocation percentage by multiplying the relative score with the percent of the total Health Network Auto-Assignment in accordance with CalOptima Health Policy AA.1207a: CalOptima Health Auto-Assignment.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Policy AA.1207a: CalOptima Health Auto-Assignment
C. CalOptima Health Policy GG.1637: Assessing Member Experience

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
11/14/1995	Regular Meeting of the CalOptima Board of Directors
01/23/1996	Regular Meeting of the CalOptima Board of Directors
12/04/2008	Regular Meeting of the CalOptima Board of Directors
10/07/2010	Regular Meeting of the CalOptima Board of Directors
03/03/2011	Regular Meeting of the CalOptima Board of Directors
03/07/2013	Regular Meeting of the CalOptima Board of Directors
03/06/2014	Regular Meeting of the CalOptima Board of Directors
10/06/2022	Regular Meeting of the CalOptima Health Board of Directors
TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2007	AA.1207b	Performance-based Auto Assignment Allocation Methodology	Medi-Cal
Revised	01/01/2009	AA.1207b	Performance-based Auto Assignment Allocation Methodology	Medi-Cal
Revised	01/01/2011	AA.1207b	Performance-based Auto Assignment Allocation Methodology	Medi-Cal
Revised	07/01/2013	AA.1207b	Performance-based Health Network Auto Assignment Allocation Methodology	Medi-Cal
Revised	12/01/2014	AA.1207b	Performance-based Health Network Auto Assignment Allocation Methodology	Medi-Cal
Revised	02/01/2016	AA.1207b	Performance-based Health Network and CalOptima Community Network Auto Assignment Allocation Methodology	Medi-Cal
Revised	02/01/2017	AA.1207b	Performance-based Health Network and CalOptima Community Network Auto Assignment Allocation Methodology	Medi-Cal
Revised	11/01/2017	AA.1207b	Performance-Based Health Network and CalOptima Community Network Auto Assignment Allocation Methodology	Medi-Cal

Action	Date	Policy	Policy Title	Program(s)
Revised	10/06/2022	AA.1207b	Performance-based Health Network and CalOptima Health Community Network Auto-Assignment Allocation Methodology	Medi-Cal
Revised	01/01/2024	AA.1207b	Performance-based Health Network and CalOptima Health Community Network Auto-Assignment Allocation Methodology	Medi-Cal
Revised	05/01/2024	AA.1207b	Performance-based Health Network and CalOptima Health Community Network Auto-Assignment Allocation Methodology	Medi-Cal
Revised	TBD	AA.1207b	Performance-based Health Network and CalOptima Health Community Network Auto-Assignment Allocation Methodology	Medi-Cal

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IX. GLOSSARY

Term	Definition
Auto-Assignment	The process by which a CalOptima Health Member who does not select a Primary Care Provider (PCP) and/or Health Network is assigned to a participating CalOptima Health Provider and/or Health Network.
CalOptima Health Community Network (CHCN)	A managed care network operated by CalOptima Health that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the Members.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Health Network Eligible Member	A member who is eligible to choose a CalOptima Health, Health Network or CalOptima Health Community Network (CHCN).
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Health program.

Policy:	AA.1207c
Title:	**Performance-based Community Health Center Auto-Assignment Allocation Methodology**
Department:	Provider Network Operations
Section:	Provider Data Management Services
CEO Approval:	*/s/*
Effective Date:	07/01/2013
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy establishes CalOptima Health's methodology for determining a Community Health Center's Auto-Assignment allocation according to performance-based indicators.

II. POLICY

A. CalOptima Health shall auto-assign a Health Network Eligible Member who has not selected a Health Network, or CalOptima Health Community Network, to a Health Network, or CHCN, in accordance with CalOptima Health Policy AA.1207a: CalOptima Health Auto-Assignment.

~~B. CalOptima Health shall auto-assign no less than thirty-seven percent (37%) of eligible Members, not otherwise assigned, and up to forty-five (45%) in accordance with under CalOpt~~CalOptima Health Policy AA.1207a: CalOptima Health Auto-Assignment, to a Health Network, or CHCN, based on the Members' assignment to a Community Health Center as a Primary Care Physician (PCP).

~~C.~~B. CalOptima Health shall auto-assign Members to a Community Health Center based on performance metrics established herein and indicators for population served by each Community Health Center.~~.~~

~~D. CalOptima Health shall determine a Community Health Center's performance-based Auto-Assignment allocation, in accordance with indicators listed in the Community Clinic Performance-based Auto-Assignment Allocation Table.~~

~~Indicators listed in the Community Clinic Performance-based Auto-Assignment Allocation Table shall measure the following:~~

~~a. Quality of clinical service; and~~

~~b. Member Experience.~~

~~E. The Community Clinic performance-based Auto-Assignment Allocation Table shall be generated every year~~annually ~~by the CalOptima Health Provider Data Management Services Department. The Allocation Table will include Community Clinic performance on all HEDIS clinical~~auto-assignment

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~~quality measures, provided by Quality Analytics Department, as well as the Member experience survey results that are the part of the P4V program for each measurement year.~~

C. CalOptima Health shall calculate a Community Health Center's performance-based Auto-Assignment allocation as follows:

~~F. For the Auto Assignment program, staff shall maintain Quality Rating methodology approved by the CalOptima Health Board of Directors for Health Networks, consistent with NCQA's validated methodology. Standard quality rating methodology has provided CalOptima Health with one reliable methodology to establish an overall quality rating score for each Health Network and community clinic.~~

~~1.~~ 1. CalOptima Health shall calculate an Auto Assignment Quality Score (AAQS) (scored between zero (0) ~~—~~and ten (10)) for each Community Health Center. A higher score indicates better performance. ~~CalOptima Health shall assign each indicator a weight percent and score based on performance. Each clinic will be assigned a clinic quality rating from 1.0–5.0 (a higher score is better) based on their performance on of the clinical quality measures.~~

1.

2. Annually, each Community Health Center will be provided with documentation of how their AAQS score was derived which includes their performance on each quality metric, comparison to national benchmarks which are used in the scoring, as well as assigned measure weights and calculations used to derive the AAQS.

~~G. CalOptima Health shall increase the Community Health Center Auto-Assignment allocation from thirty-seven percent (37%) to a maximum of forty-five percent (45%) of eligible Members based on individual clinic performance and Federally Qualified Health Center (FQHC) participation.~~

~~1. The base Community Health Center Auto-Assignment allocation shall increase by one percent (1%) for each new FQHC, or FQHC-Look-Alike, that enters the CalOptima Health program. If a FQHC, or FQHC-Look-Alike, terminates from the CalOptima Health program, the base Community Health Center Auto-Assignment allocation shall decrease by one percent (1%), not to fall below thirty-seven percent (37%).~~

~~H.~~D. Each individual Community Health Center shall be given a Clinic rank. The Clinic rank is determined by the Community Health Center's achieved ~~Clinic quality rating~~AAQS which is calculated annually. The Clinic ranking determines the order of the auto-assignment allocation run.

E. The aggregate Community Health Center allocation of auto-assigned Members shall be distributed amongst all eligible Community Health Centers to reflect AAQS score ranking and ~~in such a manner as to ensure that~~ensure Federally Qualified Health Centers (-FQHCs) and FQHC-Look-Alikes receive twice the allocation of other Community Health Centers.

~~1.~~

~~2. The total allocation of Community Health Center Members shall be initially divided into two (2) groups in order to establish the appropriate distribution of membership to the Community Health Centers so that FQHC's and FQHC-Look-Alikes receive twice the allocation as all other Community Health Centers.~~

~~3. The allocation of auto-assigned Members for the FQHCs and FQHC-Look-Alikes shall be evenly distributed amongst all eligible FQHCs and FQHC-Look-Alikes.~~

~~4. The allocation of auto-assigned Members for all other Community Health Centers shall be evenly distributed amongst all eligible Community Health Centers.~~

~~I.~~F. CalOptima Health shall evaluate the performance-based Auto-Assignment allocation methodology annually, or upon:

1. Addition, or termination, of a Community Health Center~~linic~~;

2. A material change of a Community Health Center~~linic~~; or

3. Change in indicators.

~~J.~~G. The Community Health Center Auto-Assignment allocation distribution shall be recalculated upon the addition of any new Community Health Centers to the CalOptima Health program. A new Community Health Center, for purposes of Auto-Assignment, is considered a Community Health Center with less than one (1) full measurement year of data during the measurement period. Prior to one full measurement year, a new Community Health Center will receive 3.0 points per measure used in the AAQS. When a full year of data is available and an AAQS can be calculated, then the new Community Health Center shall receive an AAQS based on performance. The established aggregate Auto-Assignment allocation for that calendar year shall be redistributed amongst all eligible Community Health Centers, in accordance with Section III.G. of this policy.

~~K.~~H. CalOptima Health shall notify Health Networks and Community Health Centers of any changes in the performance-based Auto-Assignment allocation methodology~~,~~ or ~~indicators~~measures prior to the measurement period.

III. PROCEDURE

A. CalOptima Health shall calculate each measure annually using the most current data available for the preceding year.

B. The measurement results shall take effect the year following measurement.

C. The AAQS shall be based on the following eleven (11) measures weighted equally:

Measure	Category
Adult Access to Preventive and Ambulatory Care Visits	HEDIS
Child and Adolescent Well-Care Visits	HEDIS
Childhood Immunization Status- Combination 10	HEDIS
Immunizations for Adolescents- Combination 2	HEDIS
Well-Child Visits in the First 30 Months of Life- 0 to 15 Months- Six or More Well-Child Visits	HEDIS
Well-Child Visits in the First 30 Months of Life- 15 to 30 Months- Six or More Well-Child Visits	HEDIS
Prenatal and Postpartum Care: Postpartum Care	HEDIS
Prenatal and Postpartum Care: Timeliness of Prenatal Care	HEDIS
Cervical Cancer Screening	HEDIS
Getting Care Quickly	CAHPS
Getting Needed Care	CAHPS

D. Healthcare Effectiveness and Data Information Set (HEDIS) performance rates shall be calculated for each Community Health Center using administrative data (claims and encounter data). The minimum denominator to report a performance rate shall be thirty (30) M~~m~~embers.

E. Consumer Assessment of Healthcare Providers and Systems (CAHPS) performance rates will be calculated based on M~~m~~ember satisfaction surveys fielded by CalOptima Health according to CalOptima Health P~~p~~olicy GG.1637: Assessing Member Experience. A Community Health Center shall receive the CAHPS score achieved by their affiliated Health Network.

F. Points will be allocated for each measure based on comparison to the most recent National Committee for Quality Assurance (NCQA) National Medicaid percentiles available at the time of measurement. Point allocation shall be as follows:

Points Earned for Individual Measures	
NCQA Percentile	**Points**
At or above the 75th~~th~~ percentile	10
At or above the 66.67th~~th~~ percentile, below the 75th~~th~~ percentile	8
At or above the 50th~~th~~ percentile, below the 66.67th~~th~~ percentile	6
At or above the 33.33rd~~rd~~ percentile, below the 50th~~th~~ percentile	4
At or above the 25th~~th~~ percentile, below the 33.33rd~~rd~~ percentile	2
Below the 25th~~th~~ percentile	0

G. A new Community Health Center, prior to the ability to report performance rates as described in S~~s~~ection ~~K~~II.H. above, shall receive three (3) points per measure.

H. The AAQS is calculated based on the sum of points for each measure divided by the number of reportable measures. The maximum possible AAQS is ten (10) points. Community Health Centers must report a minimum of three (3) HEDIS measures to generate an AAQS and to participate in Auto Assignment.

I. CalOptima Health shall calculate eligible and participating Community Health Center's performance-based Auto-Assignment Allocation as follows:

a. For each Community Health Center, AAQS score is adjusted for FHQC status by applying an FQHC factor – two (2) for FQHC and FHQC-look-alike and one (1) for all others;

b. A relative score to the sum of all Community Health Center adjusted scores is calculated for each Community Health Center;

c. The Adjusted Relative Score is multiplied by the percent of the total Community Health Center Auto-Assignment allocation in accordance with CalOptima Health Policy AA.1207a: CalOptima Health Auto-Assignment.

~~A. CalOptima Health shall measure each indicator annually using the most current data available for the preceding year.~~

~~B. The measurement results shall take effect the year following the measurement.~~

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Policy AA.1207a: CalOptima Health Auto-Assignment
~~B.~~C. CalOptima Health Policy GG.1637: Assessing Member Experience

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
03/03/2011	Regular Meeting of the CalOptima Board of Directors
11/01/2012	Regular Meeting of the CalOptima Board of Directors
12/06/2012	Regular Meeting of the CalOptima Board of Directors
03/07/2013	Regular Meeting of the CalOptima Board of Directors
03/06/2014	Regular Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	07/01/2013	AA.1207c	Performance-based Community Health Center Auto Assignment Allocation Methodology	Medi-Cal
Revised	02/01/2016	AA.1207c	Performance-based Community Health Center Auto Assignment Allocation Methodology	Medi-Cal
Revised	02/01/2017	AA.1207c	Performance-based Community Health Center Auto Assignment Allocation Methodology	Medi-Cal
Revised	11/01/2017	AA.1207c	Performance-based Community Health Center Auto-Assignment Allocation Methodology	Medi-Cal
Revised	02/01/2023	AA.1207c	Performance-based Community Health Center Auto-Assignment Allocation Methodology	Medi-Cal
Revised	01/01/2024	AA.1207c	Performance-based Community Health Center Auto-Assignment Allocation Methodology	Medi-Cal
Revised	06/01/2024	AA.1207c	Performance-based Community Health Center Auto-Assignment Allocation Methodology	Medi-Cal
Revised	TBD	AA.1207c	Performance-based Community Health Center Auto-Assignment Allocation Methodology	Medi-Cal

IX. GLOSSARY

Term	Definition
Auto-Assignment	The process by which a CalOptima Health Member who does not select a PCP and/or Health Network is assigned to a participating CalOptima Health Provider and/or to a Health Network or CalOptima Health Community Network.
Community Health Center	Also known as Community Clinic—a health center that meets all of the following criteria: 1. Recognized by the Department of Public Health as a licensed Community Clinic or is a Federally Qualified Health Center (FQHC) or FQHC Look-Alike; 2. Affiliated with a Health Network or CalOptima Health Community Network; and 3. Ability to function as a Primary Care Provider (PCP).
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima Health, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima Health departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima Health and its regulators.
Healthcare Effectiveness Data and Information Set (HEDIS)	The set of standardized performance measures sponsored and maintained by the National Committee for Quality Assurance (NCQA).
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Health program.

Policy:	AA.1207c
Title:	**Performance-based Community Health Center Auto-Assignment Allocation Methodology**
Department:	Provider Network Operations
Section:	Provider Data Management Services
CEO Approval:	*/s/*
Effective Date:	07/01/2013
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy establishes CalOptima Health's methodology for determining a Community Health Center's Auto-Assignment allocation according to performance-based indicators.

II. POLICY

A. CalOptima Health shall auto-assign a Health Network Eligible Member who has not selected a Health Network, or CalOptima Health Community Network, to a Health Network, or CHCN, in accordance with CalOptima Health Policy AA.1207a: CalOptima Health Auto-Assignment.

B. CalOptima Health shall auto-assign Members to a Community Health Center based on performance metrics established herein and indicators for population served by each Community Health Center.

C. CalOptima Health shall calculate a Community Health Center's performance-based Auto-Assignment allocation as follows:

1. CalOptima Health shall calculate an Auto Assignment Quality Score (AAQS) (scored between zero (0) and ten (10)) for each Community Health Center. A higher score indicates better performance.

2. Annually, each Community Health Center will be provided with documentation of how their AAQS score was derived which includes their performance on each quality metric, comparison to national benchmarks which are used in the scoring, as well as assigned measure weights and calculations used to derive the AAQS.

D. Each individual Community Health Center shall be given a Clinic rank. The Clinic rank is determined by the Community Health Center's achieved AAQS which is calculated annually. The Clinic ranking determines the order of the auto-assignment allocation run.

E. The aggregate Community Health Center allocation of auto-assigned Members shall be distributed amongst all eligible Community Health Centers to reflect AAQS score ranking and ensure Federally Qualified Health Centers (FQHCs) and FQHC-Look-Alikes receive twice the allocation of other Community Health Centers.

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F. CalOptima Health shall evaluate the performance-based Auto-Assignment allocation methodology annually, or upon:

1. Addition, or termination, of a Community Health Center;

2. A material change of a Community Health Center; or

3. Change in indicators.

G. The Community Health Center Auto-Assignment allocation distribution shall be recalculated upon the addition of any new Community Health Centers to the CalOptima Health program. A new Community Health Center, for purposes of Auto-Assignment, is considered a Community Health Center with less than one (1) full measurement year of data during the measurement period. Prior to one full measurement year, a new Community Health Center will receive 3.0 points per measure used in the AAQS. When a full year of data is available and an AAQS can be calculated, then the new Community Health Center shall receive an AAQS based on performance. The established aggregate Auto-Assignment allocation for that calendar year shall be redistributed amongst all eligible Community Health Centers, in accordance with Section III.G. of this policy.

H. CalOptima Health shall notify Health Networks and Community Health Centers of any changes in the performance-based Auto-Assignment allocation methodology or measures prior to the measurement period.

III. PROCEDURE

A. CalOptima Health shall calculate each measure annually using the most current data available for the preceding year.

B. The measurement results shall take effect the year following measurement.

C. The AAQS shall be based on the following eleven (11) measures weighted equally:

Measure	Category
Adult Access to Preventive and Ambulatory Care Visits	HEDIS
Child and Adolescent Well-Care Visits	HEDIS
Childhood Immunization Status- Combination 10	HEDIS
Immunizations for Adolescents- Combination 2	HEDIS
Well-Child Visits in the First 30 Months of Life- 0 to 15 Months- Six or More Well-Child Visits	HEDIS
Well-Child Visits in the First 30 Months of Life- 15 to 30 Months- Six or More Well-Child Visits	HEDIS
Prenatal and Postpartum Care: Postpartum Care	HEDIS
Prenatal and Postpartum Care: Timeliness of Prenatal Care	HEDIS
Cervical Cancer Screening	HEDIS
Getting Care Quickly	CAHPS
Getting Needed Care	CAHPS

D. Healthcare Effectiveness and Data Information Set (HEDIS) performance rates shall be calculated for each Community Health Center using administrative data (claims and encounter data). The minimum denominator to report a performance rate shall be thirty (30) Members.

E. Consumer Assessment of Healthcare Providers and Systems (CAHPS) performance rates will be calculated based on Member satisfaction surveys fielded by CalOptima Health according to CalOptima Health Policy GG.1637: Assessing Member Experience. A Community Health Center shall receive the CAHPS score achieved by their affiliated Health Network.

F. Points will be allocated for each measure based on comparison to the most recent National Committee for Quality Assurance (NCQA) National Medicaid percentiles available at the time of measurement. Point allocation shall be as follows:

Points Earned for Individual Measures	
NCQA Percentile	**Points**
At or above the 75th percentile	10
At or above the 66.67th percentile, below the 75th percentile	8
At or above the 50th percentile, below the 66.67th percentile	6
At or above the 33.33rd percentile, below the 50th percentile	4
At or above the 25th percentile, below the 33.33rd percentile	2
Below the 25th percentile	0

G. A new Community Health Center, prior to the ability to report performance rates as described in Section II.H. above, shall receive three (3) points per measure.

H. The AAQS is calculated based on the sum of points for each measure divided by the number of reportable measures. The maximum possible AAQS is ten (10) points. Community Health Centers must report a minimum of three (3) HEDIS measures to generate an AAQS and to participate in Auto Assignment.

I. CalOptima Health shall calculate eligible and participating Community Health Center's performance-based Auto-Assignment Allocation as follows:

a. For each Community Health Center, AAQS score is adjusted for FHQC status by applying an FQHC factor – two (2) for FQHC and FHQC-look-alike and one (1) for all others;

b. A relative score to the sum of all Community Health Center adjusted scores is calculated for each Community Health Center;

c. The Adjusted Relative Score is multiplied by the percent of the total Community Health Center Auto-Assignment allocation in accordance with CalOptima Health Policy AA.1207a: CalOptima Health Auto-Assignment.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Policy AA.1207a: CalOptima Health Auto-Assignment
C. CalOptima Health Policy GG.1637: Assessing Member Experience

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
03/03/2011	Regular Meeting of the CalOptima Board of Directors
11/01/2012	Regular Meeting of the CalOptima Board of Directors
12/06/2012	Regular Meeting of the CalOptima Board of Directors
03/07/2013	Regular Meeting of the CalOptima Board of Directors
03/06/2014	Regular Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	07/01/2013	AA.1207c	Performance-based Community Health Center Auto Assignment Allocation Methodology	Medi-Cal
Revised	02/01/2016	AA.1207c	Performance-based Community Health Center Auto Assignment Allocation Methodology	Medi-Cal
Revised	02/01/2017	AA.1207c	Performance-based Community Health Center Auto Assignment Allocation Methodology	Medi-Cal
Revised	11/01/2017	AA.1207c	Performance-based Community Health Center Auto-Assignment Allocation Methodology	Medi-Cal
Revised	02/01/2023	AA.1207c	Performance-based Community Health Center Auto-Assignment Allocation Methodology	Medi-Cal
Revised	01/01/2024	AA.1207c	Performance-based Community Health Center Auto-Assignment Allocation Methodology	Medi-Cal
Revised	06/01/2024	AA.1207c	Performance-based Community Health Center Auto-Assignment Allocation Methodology	Medi-Cal
Revised	TBD	AA.1207c	Performance-based Community Health Center Auto-Assignment Allocation Methodology	Medi-Cal

IX. GLOSSARY

Term	Definition
Auto-Assignment	The process by which a CalOptima Health Member who does not select a PCP and/or Health Network is assigned to a participating CalOptima Health Provider and/or to a Health Network or CalOptima Health Community Network.
Community Health Center	Also known as Community Clinic—a health center that meets all of the following criteria: 1. Recognized by the Department of Public Health as a licensed Community Clinic or is a Federally Qualified Health Center (FQHC) or FQHC Look-Alike; 2. Affiliated with a Health Network or CalOptima Health Community Network; and 3. Ability to function as a Primary Care Provider (PCP).
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima Health, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima Health departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima Health and its regulators.
Healthcare Effectiveness Data and Information Set (HEDIS)	The set of standardized performance measures sponsored and maintained by the National Committee for Quality Assurance (NCQA).
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Health program.

MY2025/RY2026/CY2027 Auto Assignment Policy Update

Quality Assurance Committee Meeting

October 9, 2024

Linda Lee, Executive Director, Quality Improvement

Our Mission

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

Our Vision

By 2027, remove barriers to health care access for our members, implement same-day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.

Auto Assignment Background

- CalOptima Health implements an auto-assignment process as a proxy for member selection when members do not actively choose a Health Network and primary care practitioner.
- The auto-assignment process utilizes factors that mimic selection criteria that a member may use when self-selecting.
- These factors include:
  - Geography
  - Previous member affiliation (prior Health Network, community clinic, or provider assignment) if available
  - Member family link (other eligible family members)
  - FQHC status
  - Quality scores

Auto-Assignment Policy Overview

- A process to assign new members who have not voluntarily selected a delegated HN or CCN and who have no other family members in a CalOptima Health Network.
- CalOptima's AA Policy was structured to ensure:
  - Members are assigned to a contracted Health Network to coordinate their care
  - Support Community Health Centers (Community Clinics, FQHCs and FQHC look-alikes)
  - Members have access to providers near their residence
- Community Health Centers (CHCs) receive no less than 37% of the AA allocations. Each new clinic increases the allocation by 1%, not to exceed 45%. If a clinic terminates with CalOptima Health, this decreases the total allocation by 1%, not to fall below 37%.

Quality Scores in Auto Assignment

- Quality scores are used in state Medicaid auto assignment programs in several states including the California Department of Health Care Services (DHCS) in local initiative and geographic managed care counties.
- CalOptima Health has utilized quality scores in its auto assignment program since 2006
- Auto assignment is one of several quality-based incentive programs implemented by CalOptima Health. The other quality-based incentive programs include the Health Network Pay for Value program and Hospital Quality Initiative.

Auto Assignment Quality Score Proposal

- Staff proposes a modified auto assignment quality score based on the following criteria:
  - Establish performance thresholds based on industry standards
  - Select measures based on alignment with DHCS priorities including MCAS MPL, quality withhold, and auto assignment measures
  - Utilize administrative data collection as designated by NCQA
  - Determine minimum eligible population with adequate volume to calculate meaningful rates
  - Include method for new providers to participate before quality scores can be calculated
- Proposed changes apply to providers participating in the auto assignment process including Health Networks and community clinics

MCAS MPL (Managed Care Accountability Set Minimum Performance Level)

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MY2025 Auto Assignment Quality Measurement Set

Measure
Adult Access to Preventive and Ambulatory Care Visits
Child and Adolescent Well-Care Visits
Childhood Immunization Status- Combination 10
Immunizations for Adolescents- Combination 2
Well-Child Visits in the First 30 Months of Life- 0 to 15 Months- Six or More Well-Child Visits
Well-Child Visits in the First 30 Months of Life- 15 to 30 Months- Six or More Well-Child Visits
Prenatal and Postpartum Care: Postpartum Care
Prenatal and Postpartum Care: Timeliness of Prenatal Care
Cervical Cancer Screening
CAHPS- Getting Care Quickly
CAHPS- Getting Needed Care

Auto Assignment Quality Score Methodology

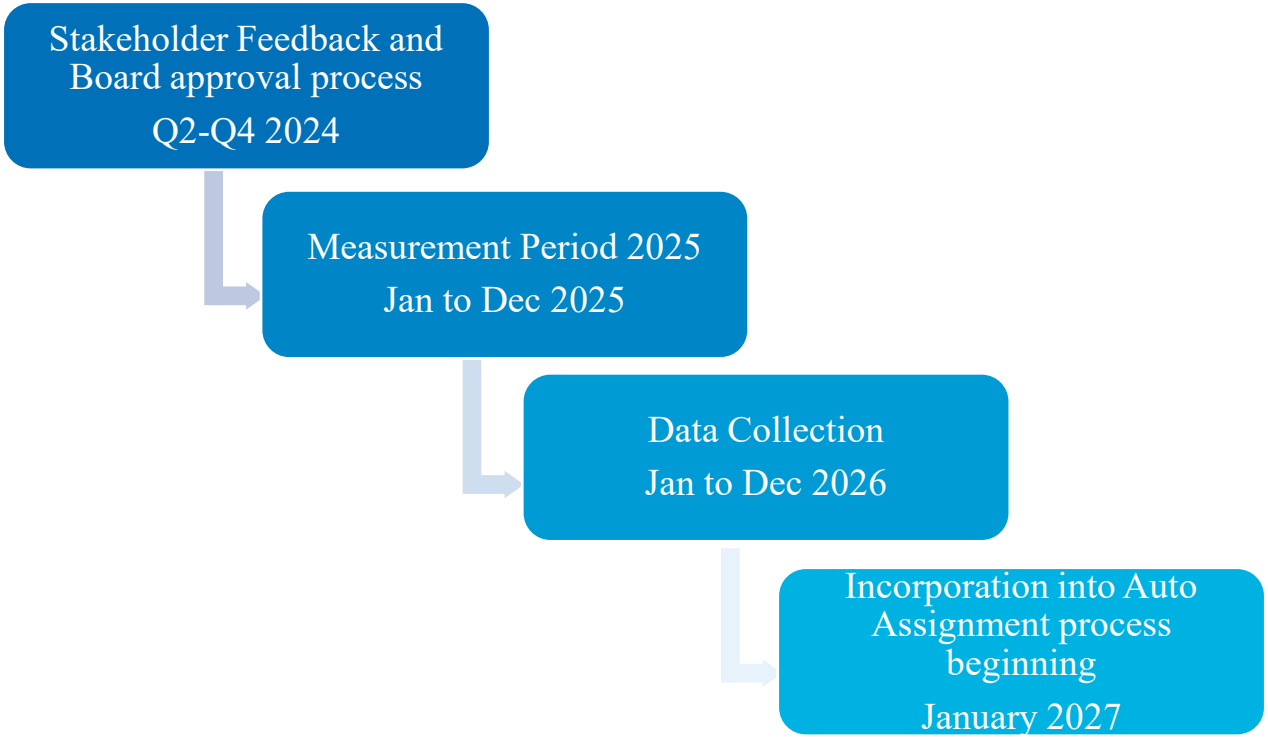
- Measure rates are based on administrative data only, using claims and encounter data
- Minimum denominator of 30 eligible members required to report a rate
- Points will be allocated per reportable auto assignment measure compared to the NCQA National Medicaid percentiles
- Each provider must qualify to report three of the nine HEDIS measures to calculate a quality score for auto assignment.
- Each provider earns an auto assignment quality score based on aggregate scores
- New providers attributed a baseline score of 3.0 points per measure for the first contract year, at a minimum

Points Earned for Individual Measures	
NCQA Percentile	**Points**
At or above the 75th percentile	10
At or above the 66.67th percentile, below the 75th percentile	8
At or above the 50th percentile, below the 66.67th percentile	6
At or above the 33.33rd percentile, below the 50th percentile	4
At or above the 25th percentile, below the 33.33rd percentile	2
Below the 25th percentile	0

The Auto Assignment Quality Score equals sum of points for each measure divided by the total number of reported measures.

Maximum possible score is 10.0

Proposed Implementation Timeline



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CalOptima Health Board Action Agenda Referral

Action To Be Taken November 7, 2024
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

7. Approve CalOptima Health Measurement Year 2025 Medi-Cal and OneCare Pay-for-Value Programs

Contacts

Richard Pitts, D.O., Ph.D., Chief Medical Officer, (714) 246-8491
Linda Lee, Executive Director, Quality Improvement, (657) 900-1069

Recommended Actions

1. Approve Measurement Year 2025 Medi-Cal Pay for Value Performance Program for the period effective January 1, 2025, through December 31, 2025.
2. Approve Measurement Year 2025 OneCare Pay for Value Performance Program for the period effective January 1, 2025, through December 31, 2025.
3. Approve the use of unearned Measurement Year 2025 Pay for Value Performance Program funds for quality initiatives and grants.

Background

CalOptima Health's Pay for Value Performance Program (P4V Program) recognizes outstanding performance and supports ongoing improvement to strengthen CalOptima Health's mission of serving members with excellence and providing quality health care. Health Networks (HNs), including CalOptima Health Community Network (CCN) and HNs' primary care physicians (PCPs) are eligible to participate in the P4V Programs.

The purpose of CalOptima Health's P4V Program is to:

1. Recognize and reward HNs and their PCPs for demonstrating quality performance;
2. Promote adherence to evidence-based practice and improve performance;
3. Provide comparative performance information for members, providers, and the public on CalOptima Health's HN and PCP performance; and
4. Provide industry benchmarks and data-driven feedback to HNs and their PCPs on their quality improvement efforts.

CalOptima Health has aligned P4V Program measures with regulatory requirements and priorities. The Medi-Cal P4V Program incentivizes performance on all Healthcare Effectiveness Data and Information Set (HEDIS®) measures that are included in the Department of Health Care Services (DHCS) Managed Care Accountability Set (MCAS) measures required to achieve a minimum performance level (MPL) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) member satisfaction measures. The OneCare P4V Program utilizes Centers for Medicare & Medicaid Services (CMS) Star HEDIS and CAHPS measures and focuses on measures with the greatest opportunity for improvement.

CalOptima Health staff have obtained feedback from HNs on recommendations to refine and improve the P4V Program by aligning with industry-based programs and by rewarding year-over-year improvements. These recommendations are incorporated into the Calendar Year 2025 program elements

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discussed below.

Discussion

Medi-Cal Pay for Value Program

Staff recommends implementing Measurement Year (MY) 2025 Medi-Cal P4V Program with the following program components:

1. Maintain Integrated Healthcare Association (IHA) pay for performance methodology to assess performance.
    - The methodology uses both attainment and improvement to assess performance and is based on the CMS hospital value-based purchasing model.
    - The greater of either the attainment or improvement score is used to calculate incentive payments.

2. Utilize the MY 2025 DHCS MCAS measures held to MPL for the HEDIS measurement set. Based on preliminary notice from DHCS, MY 2025 Medi-Cal P4V Program will have a total of 25 HEDIS measures. CalOptima Health's P4V Program will adopt the final MY 2025 MCAS MPL measure set upon availability by DHCS.

3. Continue to include CAHPS composites and overall ratings as member experience measures. Utilize both the child and adult CAHPS results, proportional to the age distribution of the assigned member population. For example, if a HN's membership is 30% children ages 0 to 18 and 70% adults, the CAHPS rate would be 30% from the child CAHPS score and 70% from the adult CAHPS score.

4. Continue to use the National Committee for Quality Assurance (NCQA) Quality Compass National Medicaid percentiles as benchmarks.

5. Maintain program funding methodology at ten percent (10%) of professional capitation (base rate only).

6. Corrective Action:
   HNs that score below the 50th percentile will be required to submit an improvement plan for that measure to CalOptima Health.

7. Application of DHCS Quality Withhold:
   For calendar year 2025, DHCS will apply a quality withhold percent on capitation payments for each Medi-Cal managed care plan. Based on the DHCS quality measures, CalOptima Health will be assessed the amount of withhold payments that may be earned back.

   CalOptima Health will apply the unearned quality withhold percentage in the P4V Program calculation across all HNs and will continue to deduct the percent of unearned DHCS withhold from each HN's earned P4V Program payment.

8. Utilize unearned incentive dollars for quality improvement initiatives in the form of grants to HNs or for CalOptima Health-led initiatives.

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OneCare Pay for Value Program
Staff recommends implementing MY 2025 OneCare P4V Program with the following program components:

1. Adopt the IHA pay for performance methodology as described in the Medi-Cal section above to assess performance.

2. Utilize select CMS Part C and D measures for the P4V Program measurement set. Selected measures are those that have the greatest opportunity for improvement.

3. Continue to use the NCQA Quality Compass National Medicare percentiles as benchmarks.

4. Maintain program funding at $20 per member per month (PMPM).

5. HNs that score below the 50th percentile will be required to submit an improvement plan for that measure to CalOptima Health.

6. Utilize unearned incentive dollars for quality improvement initiatives in the form of grants to HN or for CalOptima Health-led initiatives.

Measurement Process
CalOptima Health staff calculates the quality rating score for each HN and CCN PCP annually. CCN PCPs must have a minimum of 30 eligible members to report a measure for calculation of the quality rating score. For MY 2025, staff will use the IHA methodology for both Medi-Cal and OneCare. This will enable CalOptima Health to use an industry standard methodology and improve efficiencies by using one standard quality rating methodology. The performance score is derived from the most recently available audited HEDIS, CAHPs, and CMS Star measure data.

MY 2025 Unearned Incentive Dollars
MY 2025 P4V Program funds that remain unused – due to HNs failing to earn the maximum incentive possible or due to forfeitures based on CalOptima Health's failure to achieve the MPL – may be used for quality improvement initiatives. Grants will be available from unearned funds for both Medi-Cal and OneCare.

HNs may apply for grants to utilize incentive dollars for quality improvement initiatives. Grants may be awarded for individual measures or groups of measures targeting similar member populations, for example, well-child visits and childhood immunizations. Grant amounts may range from $50,000 to $500,000 per measure/measure group. Total grant funds to an individual HN shall not exceed the HN's maximum pool funding incentive for each MY, including deduction for DHCS quality withhold application. Grants may not be used to fund administrative staffing nor for capital investments but may be used for staff for direct implementation of quality initiatives.

Staff will provide oversight of grants pursuant to CalOptima Health Policy AA.1400p: Grants Management and will return to the Board of Directors to provide updates on the status of these grants at future meetings.

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Eligibility for Incentive Payments
Performance incentive payments are distributed upon final calculation and validation of each measurement rate. To qualify for payments, a HN or their PCPs must be contracted with CalOptima Health during the entire measurement period (January 1, 2025, through December 31, 2025) and the calculation period (January 1, 2026, through June 30, 2026) and in good standing with CalOptima Health, as determined by the Audit and Oversight Department, at the time of disbursement of payment. HNs must distribute a minimum of 85% of their incentive payment to their contracted physicians.

Fiscal Impact
Medi-Cal P4V Program
Staff estimates that the fiscal impact for the MY 2025 P4V Program will be no more than ten percent (10%) of the professional capitation (base rate only) or approximately $97.2 million. Staff will include estimated pool funding for the MY 2025 P4V Program initiatives and grant activities in the Fiscal Year (FY) 2025-26 Operating Budget.

OneCare P4V Program
Staff estimates that the fiscal impact for the MY 2025 OneCare P4V Program will be no more than $20 PMPM or approximately $4.2 million. Staff will include estimated pool funding for the MY 2025 P4V Program initiatives and grant activities in the FY 2025-26 Operating Budget.

Rationale for Recommendation
CalOptima Health strives to continuously improve the quality of care and outcomes for all members. By aligning with industry methodologies for assessing performance and for measurement sets, CalOptima Health aims to minimize HN and provider burden and confusion. CalOptima Health is committed to demonstrating breakthrough improvement in all quality measures, achieving high performing managed care plan status and achieving 5-star rating status. Issuing unearned incentive dollars in the form of grants for quality improvement initiatives will support improvement goals.

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

Attachments
1. CalOptima Health's Measurement Year 2025 Medi-Cal and OneCare Pay for Value Programs
2. Measurement Year 2025 Pay for Value Program Proposal

/s/ Michael Hunn *10/31/2024*
Authorized Signature **Date**

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CalOptima Health Measurement Year (MY) 2025
Medi-Cal and OneCare Pay for Value Programs

MY2025 Medi-Cal Pay for Value (P4V)

The Medi-Cal P4V program incentivizes performance on all Healthcare Effectiveness Data and Information Set (HEDIS®) that are included in the Department of Health Care Services (DHCS) Managed Care Accountability Set (MCAS) measures required to achieve a minimum performance level (MPL). The Medi-Cal P4V programs also incentives for Consumer Assessment of Healthcare Providers and Systems (CAHPS) member satisfaction measures. Health networks (HNs) and CalOptima Health Community Network (CCN) primary care physicians (PCPs) are eligible to participate in the Medi-Cal P4V program.

Recommended for MY2025 Medi-Cal P4V

1. Include measures held to an MPL in the MY2025 MCAS measure set.

MY 2025 Medi-Cal Pay for Value Program Measurement Set	
Measure Category	**Measure**
HEDIS	Follow-up After ED Visit for Mental Illness- 30 days
	Follow-Up After ED Visit for Substance Abuse- 30 days
	Child and Adolescent Well-Care Visits
	Childhood Immunization Status- Combination 10
	Development Screening in the First Three Years of Life
	Immunizations for Adolescents- Combination 2
	Lead Screening in Children
	Topical Fluoride in Children
	Well-Child Visits in the First 30 Months of Life- 0 to 15 Months- Six or More Well-Child Visits
	Well-Child Visits in the First 30 Months of Life- 15 to 30 Months- Six or More Well-Child Visits
	Asthma Medication Ratio
	Controlling High Blood Pressure*
	Glycemic Status Assessment for Patients with Diabetes (>9%) lower is better*
	Chlamydia Screening in Women
	Prenatal and Postpartum Care: Postpartum Care
	Prenatal and Postpartum Care: Timeliness of Prenatal Care
	Breast Cancer Screening
	Cervical Cancer Screening
	Colorectal Cancer Screening
	Depression Remission or Response for Adolescents and Adults
	Depression Screening and Follow-Up for * Adolescents and Adults
	Pharmacotherapy for Opioid Use Disorder
	Postpartum Depression Screening and Follow Up
	Prenatal Depression Screening and Follow Up
	Prenatal Immunization Status
CAHPS	CAHPS- Rating of Health Plan: Adult and Child

	CAHPS- Rating of Health Care: Adult and Child
	CAHPS- Rating of Personal Doctor: Adult and Child
	CAHPS- Rating of Specialist Seen Most Often: Adult and Child
	CAHPS- Getting Needed Care: Adult and Child
	CAHPS- Getting Care Quickly: Adult and Child
	CAHPS- Coordination of Care: Adult and Child

- Utilize both the child and adult CAHPS results, proportional to the age distribution of the assigned member population. For example, if a HN's membership is 30% children ages 0 to 18 and 70% adults, the CAHPS rate would be 30% from the child CAHPS score and 70% from the adult CAHPS score.

2. Maintain program funding at ten percent (10%) of professional capitation (base rate only).
3. Adopt IHA scoring methodology to assess overall quality rating score based on performance for each HN.
   - Attainment and Improvement score calculated for each measure. The better of the two scores is used.
   - Scoring
     - Attainment Points
       - Scale of 0-10 points
       - Points based on performance between 50th percentile and 95th percentile.
       - $1 + \left(\frac{(MY2022\ Rate - 50th\ Percentile)}{((MY2022\ Rate - MY2021\ Rate)/9)} \right)$
     - Improvement Points
       - Scale of 0-10 points
       - Points reflect performance in the prior year compared to the current year.
       - $\left(\frac{(MY2022\ Rate - MY2021\ Rate)}{((95th\ Percentile - MY2021\ Rate)/10)} \right)$
   - National Committee for Quality Assurance (NCQA) Quality Compass National Medicaid percentiles used as benchmarks.
   - Measure weighting
     - HEDIS measures weighted 1.0
     - CAHPS measures weighted 1.5
   - Performance incentive allocations will be distributed upon final calculation and validation of and each provider's performance.

CalOptima Health Measurement Year (MY) 2025
Medi-Cal and OneCare Pay for Value Programs

OneCare Pay for Value Program (P4V)

The OneCare P4V program focuses on areas with the greatest opportunity for improvement and incentivizes performance on select Centers for Medicare and Medicaid Services (CMS) Star Part C and Part D measures. Measures are developed from industry standards including HEDIS, CAHPS member experience, and Pharmacy Quality Alliance. Health networks (HNs) and CalOptima Health Community Network (CCN) primary care physicians (PCPs) are eligible to participate in the OneCare P4V program.

Recommended for MY 2024 OneCare P4V

Alignment with the CMS Star program and the following components:

1. Utilize the following CMS Star Part C and Part D measures and measure weights:

MY 2025 OneCare Pay for Value Program Measurement Set	
Measure Category	**Measure**
Part C HEDIS	Breast Cancer Screening
	Colorectal Cancer Screening
	Controlling Blood Pressure*
	Comprehensive Diabetes Care – Eye Exam
	Comprehensive Diabetes Care – HbA1c Poor Control
	Kidney Health Evaluation for Patients with Diabetes
	Statin Therapy for Patients with Cardiovascular Disease
	Transitions of Care*
	Follow-Up After ED Visit for Patients with Multiple Chronic Conditions
	Plan All-Cause Readmission
Part C Member Experience	Care Coordination
	Getting Care Quickly
	Getting Needed Care
	Customer Service
	Rating of Health Plan Quality
	Rating of Health Plan
Part D HEDIS	Medication Adherence for Diabetes
	Medication Adherence for Hypertension
	Medication Adherence for Cholesterol
	Statin Use in Persons with Diabetes
	Polypharmacy Use of Multiple Anticholinergic Medications in Older Adults
	Polypharmacy Use of Multiple Central Nervous System Active Medications in Older Adults
Part D Member Experience	Rating of Drug Plan
	Getting Needed Prescription Drugs

2. Adopt IHA scoring methodology to assess overall quality rating score based on performance for each HN
   - Attainment and Improvement score calculated for each measure. The better of the two scores is used.
   - Scoring
     - Attainment Points
       - Scale of 0-10 points
       - Points based on performance between 50th percentile and 95th percentile.
       - $1 + \left(\frac{(MY2022\ Rate - 50th\ Percentile)}{((MY2022\ Rate - MY2021\ Rate)/9)} \right)$
     - Improvement Points
       - Scale of 0-10 points
       - Points reflect performance in the prior year compared to the current year.
       - $\left(\frac{(MY2022\ Rate - MY2021\ Rate)}{((95th\ Percentile - MY2021\ Rate)/10)} \right)$
   - National Committee for Quality Assurance (NCQA) Quality Compass National Medicare percentiles used as benchmarks.
   - Measure weighting
     - HEDIS process measures weighted 1.0
     - CAHPS measures weighted 2.0
     - Outcome measures weighted 3.0
   - Performance incentive allocations will be distributed upon final calculation and validation of and each provider's performance.

3. Program funding of $20 PMPM

CalOptima Health

MY2025 Pay for Value Program Proposal

Quality Assurance Committee Meeting

October 9, 2024

Linda Lee, Executive Director, Quality Improvement

Our Mission

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

Our Vision

By 2027, remove barriers to health care access for our members, implement same-day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.

CalOptima Health
P4V Program Principles

CalOptima Health P4V Program Principles

- Use industry standard measures aligned with product regulatory requirements i.e. DHCS MCAS and CMS Star measurement sets
- Align with DHCS Minimum Performance Levels (MPL)
  - Set minimum benchmark at 50th percentile
  - CalOptima Health may issue financial sanctions to health networks (HN) if CalOptima Health is issued a sanction
  - Align with DHCS Quality Withhold
- Align with CMS Star measurement set
- Assess performance on HN improvement and achieving benchmarks
- Require HNs to implement physician-level incentives
- Encourage continuous quality improvement by providing grant funding for lower performing measures

MY2025 P4V Program Components

MY2025 Incentive Pool

- Medi-Cal:
  - Ten percent of professional capitation (base rate only)
  - Estimated at $73.9 million

- OneCare:
  - $20pmpm
  - Estimated at $4.3 million

MY2025 P4V Program Elements

- Measure Sets
  - Medi-Cal: Align with DHCS MCAS MPL and Quality Withhold measures
    - Utilize NCQA National Medicaid percentiles
    - Utilize both Child and Adult CAHPS rates
  - OneCare: Align with CMS Star measures
    - Utilize NCQA National Medicare percentiles
- Measure Weights
  - Align with industry measure weights, where applicable
  - Clinical measures = 1.0
  - Medi-Cal Member experience measures = 1.5
  - OneCare Member experience measures = 2.0*
- Data Collection Methodology
  - To promote adoption of electronic clinical data sets, utilize administrative data

*CMS has proposed dropping the member experience weight for 2026 stars

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Performance Methodology and Benchmarks

- Adopt Integrated Healthcare Association (IHA) scoring method
  1. Performance points are calculated by comparing HN score to benchmarks, starting at the 50th percentile
  2. Performance points are also calculated by comparing a HN's prior year score to current score
- Use option 1 or 2, selecting option with higher number of points
- Medi-Cal
  - Based on NCQA National Medicaid Percentiles
- OneCare
  - Based on NCQA National Medicare Percentiles

Health Network Corrective Action

- Corrective action: HN scoring below the MPL must submit a corrective action plan

Unearned Incentive Dollars

- Issue quality grants using unearned dollars
- Grants will be used to improve individual or groups of measures
- Funds used for quality improvement efforts including staff directly involved with quality initiatives
- Health Networks submit a plan, subject to quarterly monitoring
  - Must meet implementation requirements to continue to access improvement funds
- CalOptima Health will implement delivery system-wide interventions with remaining incentive dollars

Appendix

MY2025 Medi-Cal Measurement Set

Measure	DHCS MPL	DHCS Quality Withhold	PV4 Program
Follow-up After ED Visit for Mental Illness- 30 days	X		X
Follow-Up After ED Visit for Substance Abuse- 30 days	X		X
Child and Adolescent Well-Care Visits	X	X	X
Childhood Immunization Status- Combination 10	X	X	X
Development Screening in the First Three Years of Life	X		X
Immunizations for Adolescents- Combination 2	X	X	X
Lead Screening in Children	X		X
Topical Fluoride in Children	X		X
Well-Child Visits in the First 30 Months of Life- 0 to 15 Months- Six or More Well-Child Visits	X	X	X
Well-Child Visits in the First 30 Months of Life- 15 to 30 Months- Two or More Well-Child Visits	X	X	X
Asthma Medication Ratio	X		X
Controlling High Blood Pressure*	X	X	X
Hemoglobin A1c Control for Patients with Diabetes- HbA1c Poor Control (>9%) lower is better*	X	X	X

Measure rate may include findings from medical record review

*Measure set subject to change until DHCS issues final MY25 MCAS MPL set

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MY2025 Medi-Cal Measurement Set

Measure	DHCS MPL	DHCS Quality Withhold	PV4 Program
Chlamydia Screening in Women	X		X
Prenatal and Postpartum Care: Postpartum Care	X	X	X
Prenatal and Postpartum Care: Timeliness of Prenatal Care	X	X	X
Breast Cancer Screening	X		X
Cervical Cancer Screening	X		X
Colorectal Cancer Screening	X		X
Depression Remission or Response for Adolescents and Adults	X		X
Depression Screening and Follow-Up for Adolescents and Adults	X		X
Pharmacotherapy for Opioid Use Disorder	X		X
Postpartum Depression Screening and Follow Up	X		X
Prenatal Depression Screening and Follow Up	X		X
Prenatal Immunization Status	X		X

Measure rate may include findings from medical record review

Measure set subject to change until DHCS issues final MY25 MCAS MPL set

*

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MY2025 Medi-Cal Measurement Set

Measure	DHCS MPL	DHCS Quality Withhold	PV4 Program
CAHPS- Rating of Health Plan: Adult and Child		X	X
CAHPS- Getting Needed Care: Adult and Child		X	X
CAHPS- Getting Care Quickly: Adult and Child			X
CAHPS- Coordination of Care: Adult and Child			X
CAHPS- Rating of Personal Doctor: Adult and Child			X
CAHPS- Rating of Specialist Seen Most Often: Adult and Child			X
CAHPS- Rating of Health Care: Adult and Child			X

Measure rate may include findings from medical record review

* Measure set subject to change until DHCS issues final MY25 MCAS MPL set

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MY2025 OneCare Measurement Set

Measure Category	Measure
Part C HEDIS	Breast Cancer Screening
	Colorectal Cancer Screening
	Controlling Blood Pressure*
	Comprehensive Diabetes Care – Eye Exam
	Comprehensive Diabetes Care – HbA1c Poor Control
	Kidney Health Evaluation for Patients with Diabetes
	Statin Therapy for Patients with Cardiovascular Disease
	Transitions of Care*
	Follow-Up After ED Visit for Patients with Multiple Chronic Conditions
	Plan All-Cause Readmission
Part C Member Experience	Care Coordination
	Getting Care Quickly
	Getting Needed Care
	Customer Service
	Rating of Health Plan Quality
	Rating of Health Plan

* Measure rate may include findings from medical record review

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MY2025 OneCare Measurement Set

Measure Category	Measure
Part D	Medication Adherence for Diabetes
	Medication Adherence for Hypertension
	Medication Adherence for Cholesterol
	Statin Use in Persons with Diabetes
	Polypharmacy Use of Multiple Anticholinergic Medications in Older Adults
	Polypharmacy Use of Multiple Central Nervous System Active Medications in Older Adults
	Rating of Drug Plan
	Getting Needed Prescription Drugs

Performance Scoring Methodology

- Adopt Integrated Healthcare Association (IHA) scoring method
- Attainment and Improvement score calculated for each measure
  - The better of the two scores is used.
- Scoring
  - Attainment Points
    - Scale of 0-10 points
    - Points based on performance between 50th percentile and 95th percentile
    - $1 + \left(\frac{(MY2022\ Rate - 50th\ Percentile)}{((MY2022\ Rate - MY2021\ Rate)/9)} \right)$
  - Improvement Points
    - Scale of 0-10 points
    - Points reflect performance in the prior year compared to the current year.
    - $\left(\frac{(MY2022\ Rate - MY2021\ Rate)}{((95th\ Percentile - MY2021\ Rate)/10)} \right)$

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 7, 2024
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

8. Approve Recommendations for the Chair and Vice Chair Appointments to the Whole-Child Model Family Advisory Committee

Contact

Yunkyung Kim, Chief Operating Officer, (714) 923-8834

Recommended Actions

1. Approve appointment of Lori Sato as Chair and Erika Jewell as the Vice-Chair of the Whole-Child Model Family Advisory Committee to each serve a two-year term through November 5, 2026.

Background

The CalOptima Health Board of Directors established the Whole-Child Model Family Advisory Committee (WCM FAC) by Resolution No. 17-1102-01 on November 2, 2017, to serve solely in an advisory capacity, providing input and recommendations concerning the Whole-Child Model program. The WCM FAC is comprised of 11 voting members, seven of whom are designated as family representatives and four of whom are designated as community seats representing the interests of children receiving services from California Children's Services (CCS).

Pursuant to Resolution No. 20-0806, the CalOptima Health Board of Directors is responsible for the appointment of the WCM FAC Chair and Vice Chair biennially from among appointed members. The Chair and Vice Chair may serve a two-year term.

Discussion

WCM FAC members were asked to submit a letter of interest in the open Chair and Vice-Chair positions. WCM FAC Authorized Family member Lori Sato and Community-Based Organization member Erika Jewell each submitted a letter of interest for these positions. At the September 24, 2024, WCM FAC meeting, the committee voted to recommend that the Board of Director's Quality Assurance Committee recommend that the Board of Directors approve Ms. Sato as the Chair and Ms. Jewell as Vice-Chair of the committee.

WCM FAC Chair Candidate

Lori Sato

Ms. Sato is the mother of a special needs child who currently receives CCS and Medi-Cal services. Ms. Sato has learned to navigate new systems to better advocate for children with special needs. She is familiar with medical therapy units for various therapies (physical and occupational) and for special equipment needs by CCS children. Ms. Sato has been a member on the committee since July 2022.

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WCM FAC Vice Chair Candidate
Erika Jewell

Ms. Jewell currently holds a Community-Based Organization seat on the WCM FAC and has been on the committee since 2022. She is the Manager for Case Management at Children's Hospital Orange County and has a good working knowledge of the needs of the WCM FAC.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
Open nominations were held at the September 24, 2024, WCM FAC meeting based on the letters of interest received. There were no additional nominations from the floor. The WCM FAC forwards the recommended Chair and Vice Chair candidates to the Board of Directors' Quality Assurance Committee for consideration and recommended appointment by the Board of Directors.

Concurrence
Whole-Child Model Family Advisory Committee
Troy R. Szabo, Outside General Counsel, Kennaday Leavitt
Board of Directors' Quality Assurance Committee

Attachments
None

/s/ Michael Hunn *10/31/2024*
Authorized Signature **Date**

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 7, 2024
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

9. Ratify Amendment to CalOptima Health's Primary Agreement with the California Department of Health Care Services

Contact

John Tanner, Chief Compliance Officer, (657) 235-6997

Recommended Actions

1. Ratify Contract Amendment 03 to the Primary Agreement between the California Department of Health Care Services and CalOptima Health.

Background

As a County Organized Health System, CalOptima Health contracts with the California Department of Health Care Services (DHCS) to provide health care services to Medi-Cal members in Orange County. In January 2024, CalOptima Health entered into new Primary and Secondary Agreements with DHCS. The new Primary Agreement is numbered Agreement 23-30235, and the new Secondary Agreement is numbered Agreement 23-30267. Amendments to these new agreements are summarized in Attachment 1. The Primary Agreement contains, among other terms and conditions, the payment rates CalOptima Health receives from DHCS to provide health care services. The Secondary Agreement is a companion agreement to CalOptima Health's Primary Agreement and covers specific Medi-Cal state-supported services for CalOptima Health's members enrolled under the Primary Agreement.

Discussion

Contract Amendment 03 (A – 03) to CalOptima Health's Primary Agreement (January 1, 2025, through December 31, 2025)

On September 17, 2024, DHCS provided CalOptima Health with Amendment 03 (A-03) for signature, which extends the term of CalOptima Health's Primary Agreement with DHCS to December 31, 2025. DHCS subsequently confirmed that Amendment 03 (A-03) extends the term of the Secondary Agreement by default to December 31, 2025, based on a provision within the Secondary Agreement stating that the agreement will continue in full force and effect through the term of the Primary Agreement.

DHCS requested that CalOptima Health sign and return the amendment no later than October 1, 2024. In order to meet DHCS's deadline, CalOptima Health procured the Chair's signature on September 19, 2024, and returned the signed amendment to DHCS. As such, staff requests the CalOptima Health Board of Directors ratify the Chair's execution of the amendment with DHCS. The amendment does not contain any language or benefit changes, nor does the amendment contain any rate changes or otherwise set new rates.

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Fiscal Impact
The recommended action has no additional fiscal impact in the current fiscal year. Staff will include funding for the contract period of July 1, 2025, through December 31, 2025, in the Fiscal Year 2025-26 Operating Budget.

Rationale for Recommendation
CalOptima Health's execution of Amendment 03 (A-03) to its Primary Agreement with the DHCS is necessary for the continued operation of CalOptima Health's Medi-Cal program.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Attachment 1_Appendix Summary of Agreement Amendments with DHCS

/s/ Michael Hunn *10/31/2024*
Authorized Signature **Date**

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APPENDIX TO AGENDA ITEM 9

The following is a summary of amendments to the Primary Agreement (23-30235) approved by the CalOptima Health Board of Directors (Board) to date:

Amendments to Primary Agreement	Board Approval
Primary Agreement 23-30235 provides language and benefit changes effective January 1, 2024.	December 7, 2023
A-01 incorporates Calendar Year (CY) 2024 capitation rates.	March 7, 2024
A-02 incorporates language and benefit changes effective January 1, 2024.	August 1, 2024
A-03 extends the term of the Primary Agreement and Secondary Agreement (23 – 30267) (by default) to December 31, 2025.	November 7, 2024

The following is a summary of amendments to the Primary Agreement (08-85214) approved by the CalOptima Health Board of Directors (Board) to date:

Amendments to Primary Agreement	Board Approval
A-01 provided language changes related to Indian Health Services, home and community-based services, and addition of aid codes effective January 1, 2009.	October 26, 2009
A-02 provided rate changes that reflected implementation of the gross premiums tax authorized by AB 1422 (2009) for the period January 1, 2009, through June 30, 2009.	October 26, 2009
A-03 provided revised capitation rates for the period July 1, 2009, through June 30, 2010; and rate increases to reflect the gross premiums tax authorized by AB 1422 (2009) for the period July 1, 2009, through June 30, 2010.	January 7, 2010
A-04 included the necessary contract language to conform to AB X3 (2009), to eliminate nine (9) Medi-Cal optional benefits.	July 8, 2010
A-05 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, including rate increases to reflect the gross premium tax authorized by AB 1422 (2009), the hospital quality assurance fee (QAF) authorized by AB 1653 (2010), and adjustments for maximum allowable cost pharmacy pricing.	November 4, 2010
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

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Amendments to Primary Agreement	Board Approval
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

Amendments to Primary Agreement	Board Approval
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

Amendments to Primary Agreement	Board Approval
A-42 incorporated revised base rates for July 2017 to June 2018, directed payments language and mental health parity documentation requirements.	August 1, 2019
A–43 incorporates revises Hospital Quality Assurance Fee (HQAF) rates for January 1, 2017 to June 30, 2017.	August 1, 2019
A-44 incorporates full dual rates for Calendar Year (CY) 2017.	August 1, 2019
A–45 incorporates the new requirements of the 2018 Final Rule Amendment, Behavioral Health Treatment (BHT) and State Fiscal Year (SFY) 2018 – 19 capitation rates	June 7, 2018 August 1, 2019 August 6, 2020
A-46 incorporates full dual rates for Calendar Year (CY) 2018.	August 1, 2019
A-47 incorporates full dual rates for Calendar Year (CY) 2019.	October 1, 2020
A-48 incorporates new Bridge Period, Health Homes Program (HHP) and Whole Child Model (WCM) language and adds 2019 – 2020 capitation rates	June 7, 2018 October 1, 2020 February 4, 2021
A-49 extends the Primary Agreement with DHCS to December 31, 2021	November 5, 2020
A-50 incorporates full dual rates for Calendar Year (CY) 2020.	February 4, 2021
A-51 incorporates full dual rates for Calendar Year (CY) 2021.	February 4, 2021
A-52 incorporates Calendar Year (CY) 2021 base amendment contract language.	October 7, 2021
A-53 incorporates Calendar Year (CY) 2021 fall amendment contract language.	October 7, 2021
A-54 extends the Primary Agreement with DHCS to December 31, 2022.	October 7, 2021
A-55 incorporates full dual rates for Calendar Year (CY) 2022.	March 3, 2022
A-56 incorporates updated Bridge Period (July 1, 2019 – December 31, 2020) capitation payment rates that are now split into rates for Satisfactory Immigration Status (SIS) and Unsatisfactory Immigration Status (UIS) members, and includes new corresponding rate tables that split each existing category into a SIS and UIS version.	October 1, 2020
A-57 incorporates Calendar Year (CY) 2022 risk mitigation language.	March 3, 2022
A-58 incorporates the COVID Vaccination Incentive Program.	March 3, 2022
A-59 incorporates new Calendar Year (CY) 2022 capitation rates and benefit changes implemented in CY 2022	August 5, 2021 March 3, 2022 August 4, 2022
A-60 incorporates new benefits changes for Calendar Year (CY) 2022.	August 4, 2022
A-61 incorporates new benefit changes for Calendar Year (CY) 2022.	May 4, 2023
A-62 extends the Primary Agreement with DHCS to December 31, 2023.	May 5, 2022
A-63 incorporates new benefits changes for Calendar Year (CY) 2023.	February 2, 2023
A-64 incorporates updated Calendar Year (CY) 2021 capitation payment rates that are now split into rates for Satisfactory Immigration Status (SIS) members and Unsatisfactory Immigration Status (UIS) members.	Not applicable due to non – substantive changes.
A-65 incorporates updated Calendar Year (CY) 2022 Public Health Emergency (PHE) capitation rates.	November 2, 2023

Amendments to Primary Agreement	Board Approval
A-66 incorporates updated Calendar Year 2022 Capitation Payment rates that are now split into rates for Satisfactory Immigration Status (SIS) members and Unsatisfactory Immigration Status (UIS) members and includes new corresponding rate tables that split each existing category into a SIS version and UIS version.	Not applicable due to non – substantive changes.
A-67 incorporates Calendar Year (CY) 2023 capitation rates and new benefits for CY 2023.	December 7, 2023
A-68 incorporates revised Calendar Year (CY) 2022 CCI Full Dual capitation rates.	June 1, 2023
A-69 incorporates updated Calendar Year (CY) 2023 capitation rates.	October 3, 2024

The following is a summary of amendments to the Secondary Agreement (23-30267) approved by the CalOptima Health Board of Directors (Board) to date:

Amendments to Secondary Agreement	Board Approval
Agreement 23 – 30267 covers specific state – supported services to CalOptima Health's members enrolled under CalOptima Health's Primary Agreement (23 – 30235).	December 7, 2023
A-01 incorporates Calendar Year (CY) 2024 capitation rates.	March 7, 2024

The following is a summary of amendments to the Secondary Agreement (08-85221) approved by the CalOptima Health Board of Directors (Board) to date:

Amendments to Secondary Agreement	Board Approval
A-01 implemented rate amendments to conform to rate amendments contained in the Primary Agreement with DHCS (08-85214).	July 8, 2010
A-02 implemented rate adjustments to reflect a decrease in the statewide average cost for Sensitive Services for the rate period July 1, 2010 through June 30, 2011.	August 4, 2011
A-03 extended the term of the Secondary Agreement to December 31, 2014.	June 6, 2013
A-04 incorporates rates for the periods July 1, 2011 through June 30, 2012, and July 1, 2012 through June 30, 2013 as well as extends the current term of the Secondary Agreement to December 31, 2015	January 5, 2012 (FY 11-12 and FY 12-13 rates) May 1, 2014 (term extension)
A-05 incorporates rates for the periods July 1, 2013 through June 30, 2014, and July 1, 2014 through June 30, 2015. For the period July 1, 2014 through June 30, 2015, Amendment A-05 also adds funding for the Medi-Cal expansion population for services provided through the Secondary Agreement.	December 4, 2014
A-06 incorporates rates for the period July 1, 2015 onward. A-06 also extends the term of the Secondary Agreement to December 31, 2016.	May 7, 2015 (term extension)

	Ratification of rates requested April 7, 2016
A-07 extends the Secondary Agreement with the DHCS to December 31, 2020.	December 1, 2016
A–08 incorporates Adult & Family/Optional Targeted Low–Income Child and Adult Expansion rates for July 2016 to June 2017 and July 2017 to June 2018.	December 6, 2018
A-09 incorporates updated Calendar Year (CY) 2022 Public Health Emergency (PHE) capitation rates.	November 2, 2023
A-10 extends the Secondary Agreement with DHCS to December 31, 2021	November 5, 2020
A-12 extends the Secondary Agreement with DHCS to December 31, 2022.	October 7, 2021

The following is a summary of amendments to the Secondary Agreement (22-20494) approved by the CalOptima Health Board of Directors (Board) to date:

Agreement 22-20494 incorporates both Hyde services ("Private Services") and the new Unsatisfactory Immigration Status members from January 1, 2023 to December 31, 2023.	December 1, 2022
A-01 incorporates rates for CY 2023 for Hyde services (now referred to as "Private Services") and the new Unsatisfactory Immigration Status (UIS) members.	December 1, 2022
A-02 incorporates updated Calendar Year (CY) 2023 capitation rates.	October 3, 2024

The following is a summary of amendments to Agreement 16-93274 approved by the CalOptima Health Board of Directors (Board) to date:

Amendments to Agreement 16-93274	**Board Approval**
A-01 extends the Agreement 16-93274 with DHCS to December 31, 2018.	August 3, 2017
A–02 extends the Agreement 16–93274 with DHCS to December 31, 2019	June 7, 2018
A–03 extends the Agreement 16–93274 with DHCS to December 31, 2020	May 2, 2019
A–04 extends the Agreement 16–93274 with DHCS to December 31, 2021	June 4, 2020
A–05 extends the Agreement 16–93274 with DHCS to December 31, 2022.	June 3, 2021
A-06 extends Agreement 16 – 93274 with DHCS to December 31, 2023.	May 5, 2022
A-07 extends Agreement 16 – 93274 with DHCS to December 31, 2023.	October 6, 2022
A-08 extends Agreement 16 – 93274 with DHCS to December 31, 2023.	Not applicable due to non – substantive changes.
A-09 extends Agreement 16 – 93274 with DHCS to December 31, 2024.	May 4, 2023

A-10 extends Agreement 16 – 93274 with DHCS to December 31, 2025.	May 2, 2024

The following is a summary of amendments to Agreement 17–94488 approved by the CalOptima Health Board of Directors (Board) to date:

Amendments to Agreement 17-94488	Board Approval
A-01 enables DHCS to fund the development of palliative care policies and procedures (P&Ps) to implement California Senate Bill (SB) 1004.	December 7, 2017

The following is a summary of amendments to CalOptima Health's Agreement for Disclosure and Use of DHCS Data (2023 Post – Expiration Data Use Agreement (DUA)) and 2024 Operational Readiness (OR) DUA.

Amendments to Data Use Agreement	Board Approval
CY 2023 Data Use Agreement (DUA) allows for the exchange of information between DHCS and CalOptima Health after the current contract expires on December 31, 2023.	November 2, 2023
CY 2024 Operational Readiness (OR) DUA allows DHCS to initiate and execute the necessary data releases ahead of January 1, 2024 for DHCS to share necessary data with CalOptima Health.	November 2, 2023

CalOptima Health Board Action Agenda Referral

Action To Be Taken November 7, 2024
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

10. Adopt Resolution No. 24-1107-02 Approving and Adopting Updated CalOptima Health Human Resources Policy

Contacts

Michael Hunn, Chief Executive Officer, (657) 900-1481
Steve Eckberg, Chief Human Resources Officer (657) 328-9053

Recommended Actions

Adopt Resolution No. 24-1107-02 approving updated CalOptima Health Policy GA.8019: Promotions and Transfers

Background

Near CalOptima Health's inception, the Board of Directors (Board) delegated authority to the Chief Executive Officer to develop and implement employee policies and procedures and to amend them as appropriate from time to time, subject to bi-annual updates to the Board. CalOptima Health's Bylaws require that the Board adopt by resolution, and from time to time amend, procedures, practices, and policies for, among other things, hiring employees and managing personnel.

Discussion

Staff includes the revised policy for Board approval and a summary of changes for the updated policy below.

GA.8019: Promotions and Transfers: This policy establishes a consistent method of considering current employees for internal promotions and transfers.

Policy Section	Proposed Change	Rationale	Impact
II.C.	Change length of open positions from 5 business days to 14 calendar days, and change reference to when "job offer can me made" to when "the selection can begin".	To align with policy GA.8060: Recruitment, Selection, and Hiring.	Provides consistency with other related policies.
II.E.1	Remove reference to Good Standing and specific performance rating and replace with "achieved an overall satisfactory or higher rating on the annual performance review for the most recent performance review period".	Aligns with Compensation Program merit eligibility.	Provides consistency with Compensation Program.

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II.E.3	Remove general reference to corrective action and instead refer to CalOptima Health policy GA.8022: Performance and Behavior Standards.	Provides consistency by referring to the policy that governs corrective action and reduces possibility of conflict between policies.	Provides clarity by referencing source policy.
II.F	Add "selection" to clarify which process must to be followed.	Provides clarity and aligns with practice.	Provides process clarity.
II.H	Clarify language related to the timing of the start date of a new position resulting from promotion or transfer.	Provides clarity and aligns with practice.	Provides clarity for all parties.
III.Table.Employee.2	Add language regarding notification to current manager regarding application for promotion or transfer: "If an interview is scheduled with the employee, the employee must notify their current manager at that time."	Promotes clear communication between internal applicant and current supervisor if application status reaches the point of interview and impacts the employee's work schedule.	Provides clarity on employee responsibility to communicate with their current manager and minimum timing on when the communication should occur.
III.Table.Hiring Manager.2	Add statement that "The Hiring Manager may not have any discussions with the direct supervisor outside of this process regarding the performance of the employee."	Protects integrity of the selection process in a fair manner for all applicants regardless of whether they are internal or external to the organization.	Ensures a fair and consistent selection process for all applicants.
III.Table.Hiring Manager.3	Remove responsibility of Hiring Manager to coordinate with the current supervisor regarding start date.	Provides clarity and aligns policy with practice.	Provides clarity that Human Resources is responsible for coordinating the start date.
IX. Glossary	Clarify that a performance improvement plan is a type of formal corrective action for purposes of good standing eligibility for promotions and transfers.	Aligns to policy GA.8022 Performance and Behavior Standards.	Provides policy alignment.

Fiscal Impact

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

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Adopt Resolution No. 24-1107-02 Approving and Adopting Updated CalOptima Health Human Resources Policy
2. GA.8019: Promotions and Transfers

/s/ Michael Hunn *11/01/2024*
Authorized Signature **Date**

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RESOLUTION NO. 24-1107-02

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

APPROVE UPDATED CALOPTIMA HEALTH POLICY

WHEREAS, Section 13.1 of the CalOptima Health Bylaws provides that the Board of Directors shall adopt by resolution, and may from time to time amend, procedures, practices, and policies for, inter alia, hiring employees, and managing personnel;

WHEREAS, in 1994, the Board of Directors designated the Chief Executive Officer as the Appointing Authority with full power to hire and terminate CalOptima Health employees at will, to set compensation within the boundaries of the budget limits set by the Board of Directors, to promulgate employee policies and procedures, and to amend said policies and procedures from time to time, subject to annual review by the Board of Directors, or a committee appointed by the Board of Directors for that purpose; and

WHEREAS, staff has revised certain policies and now presents those revised policies to the Board of Directors for approval.

NOW, THEREFORE, BE IT RESOLVED:

Section 1. That the Board of Directors hereby approves and adopts the following updated CalOptima Health policy:

- GA.8019: Promotions and Transfers

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima Health this 7th day of November 2024.

AYES:
NOES:
ABSENT:
ABSTAIN:

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Isabel Becerra, Chair, CalOptima Health Board of Directors

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

Policy:	GA.8019
Title:	**Promotions and Transfers**
Department:	CalOptima Health Administrative
Section:	Human Resources
CEO Approval:	*/s/*
Effective Date:	01/05/2012
Revised Date:	11/07/2024
Applicable to:	☐ Medi-Cal ☐ OneCare ~~☐ OneCare Connect~~ ☐ PACE ☒ Administrative

I. PURPOSE

This policy establishes a consistent method of considering current employees for internal Promotions and Transfers.

II. POLICY

A. CalOptima Health supports the development and advancement of its employees from within the organization.

B. CalOptima Health encourages employees to apply for Promotions or Transfers to open positions for which they meet the qualifications and minimum job requirements.

C. CalOptima Health posts open positions for ~~five (5) business~~ fourteen (14) calendar days before ~~a job offer~~the selection ~~process~~ can ~~be made~~begin.

D. To express interest in an open position, current employees must submit a job application with an updated resume and any other supporting documents described in the job positing to CalOptima Health's Applicant Tracking System. An employee may also attach a cover letter.

E. An employee may be considered for any position for which they apply only if the following conditions are met:

1. The ~~employee's work~~employee achieved an overall satisfactory or higher rating on their annual performance ~~is in Good Standing with a minimum of "Fully Meets Expectations"~~ review for the most ~~current~~recent performance review period.

2. The employee meets the qualifications and minimum requirements for the position to which the Transfer or Promotion is sought.

3. The employee is not on a ~~formal~~ Performance Improvement Plan and/or has not received ~~a~~formal corrective action as described in CalOptima Health Policy GA.8022: Performance ~~Improvement Plan or a written or final warning~~and Behavior Standards within the last six (6) months.

4. The employee has been employed in their current position for a minimum of three (3) months.

F. Qualified internal applicants will be considered using the same selection process followed with external candidates, including, but not limited to, interview questions, bilingual screening, and/or other skills tests, as appropriate.

G. On rare occasions, there may be situations where: (1) a position is not posted; or (2) a Transfer or Promotion is granted due to a sensitive business need, necessitated by other requirements, or implemented prior to the employee being in the position for three (3) months. Exceptions to the standard recruitment process may only be made if there is: (1) a substantiated and documented need to Transfer or Promote an employee; and (2) sufficient facts to establish that if CalOptima Health followed the standard procedure, it would result in a demonstrated impairment to the organization or a specific time sensitive project. Without such substantiated business need, the exception should not be made. The Chief Executive Officer (CEO) must approve the exception.

H. If a job offer is extended and accepted by a current employee, the employee may be subject to a background check in accordance with CalOptima Health Policy GA.8030: Background Check and/or any other required medical examinations, prior to the effective date of the new position. The effective start date will be coordinated between Human Resources (HR), the new supervisor, and the current supervisor. which is typically the start of the pay period following two (2) weeks' notice of the pending action. The employee may need to be available to orient and participate in training a replacement following the promotion or transfer.

III. PROCEDURE

Responsible Party	Action
Employee	1. Review the job description and/or job posting and ensure that they meet the qualifications and minimum requirements before submitting an application. 2. In order to express interest in an open position, employees must apply for the opening through CalOptima Health's Applicant Tracking System and attach an updated resume. As a courtesy, it is recommended that employees notify their managers upon applying. If an interview is scheduled with the employee, the employee must notify their current manager at that time. 3. Participate in the same process followed with external candidates, including an interview, bilingual screening, if applicable, and/or other skills tests applicable to the selection process. 4. Cooperate with any background check and/or any other required medical examinations.
Hiring Manager	1. Review all job applications received from HR and notify HR of those candidates who best meet the qualifications to move them forward in the selection process, which may include, but is not limited to, interview questions, bilingual screening, and/or other skills tests. 2. Once a qualified internal applicant has been identified and the Hiring Manager is interested in selecting that applicant to fill an open position, coordinate with HR to complete the hiring process, including but not limited to, reference check, compensation review, offer letter creation, background check, educational verification, licensure verification, etc. The Hiring Manager may not have any discussions with the direct

Responsible Party	Action
	supervisor outside of this process regarding the performance of the employee. 3. Coordinate with HR ~~and the current supervisor~~ to agree upon a start date. 4. Complete the new hire/internal transfer form for HR to initiate the internal transfer eTicket.
HR	1. Review applications and resumes for minimum and preferred qualifications. 2. Determine Good Standing status of internal applicants. 3. If the internal applicant meets the qualifications and minimum requirements, send the application and/or resume to the Hiring Manager. At the request of the Hiring Manager, move the internal candidate forward in the selection process. If the internal applicant is not selected, notify the internal applicant of the decision. 4. If an internal applicant is selected to fill an open position, extend an offer, based on application of CalOptima Health's Compensation Program, Compensation Administration Guidelines, and Salary Schedule. 5. Initiate the background check in accordance with CalOptima Health Policy GA.8030: Background Check. Coordinate the employee's start date with the current and new supervisors. 6. Submit the internal transfer eTicket and process a Personnel Action Form to document the action taking place

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Policy GA.8022: Performance and Behavior Standards
~~A. Personnel Action Form (Sample)~~
B. CalOptima Health Policy GA.8030: Background Check
C. CalOptima Health Policy GA.8060: Recruitment, Selection, and Hiring
D. Personnel Action Form (Sample)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
01/05/2012	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors

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Date	Meeting
12/01/2022	Regular Meeting of the CalOptima Health Board of Directors
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/05/2012	GA.8019	Promotions and Transfers	Administrative
Revised	08/07/2014	GA.8019	Promotions and Transfers	Administrative
Revised	12/01/2016	GA.8019	Promotions and Transfers	Administrative
Revised	12/03/2020	GA.8019	Promotions and Transfers	Administrative
Revised	12/01/2022	GA.8019	Promotions and Transfers	Administrative
Revised	11/07/2024	GA.8019	Promotions and Transfers	Administrative

IX. GLOSSARY

Term	Definition
Good Standing	The employee has at least a satisfactory level of performance on their most recent evaluation and has not received written corrective action within the last six (6) months.
Hiring Manager	The supervisor or manager responsible for making final hiring decision.
Performance Improvement Plan	~~A developmental coaching tool~~A formal action used to document performance and behavioral deficiencies or issues and create an action plan with goals and due dates to help employees correct and/or improve performance and behavior while still holding them accountable for past performance.
Promotion	Occurs when an employee is selected for a job with a higher pay grade.
Transfer	Occurs when an employee moves to a different job title having the same pay grade.

Policy:	GA.8019
Title:	**Promotions and Transfers**
Department:	CalOptima Health Administrative
Section:	Human Resources
CEO Approval:	*/s/*
Effective Date:	01/05/2012
Revised Date:	11/07/2024
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ PACE ☒ Administrative

I. PURPOSE

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B. CalOptima Health encourages employees to apply for Promotions or Transfers to open positions for which they meet the qualifications and minimum job requirements.

C. CalOptima Health posts open positions for fourteen (14) calendar days before the selection can begin.

D. To express interest in an open position, current employees must submit a job application with an updated resume and any other supporting documents described in the job positing to CalOptima Health's Applicant Tracking System. An employee may also attach a cover letter.

E. An employee may be considered for any position for which they apply only if the following conditions are met:

1. The employee achieved an overall satisfactory or higher rating on their annual performance review for the most recent performance review period.

2. The employee meets the qualifications and minimum requirements for the position to which the Transfer or Promotion is sought.

3. The employee is not on a Performance Improvement Plan and/or has not received formal corrective action as described in CalOptima Health Policy GA.8022: Performance and Behavior Standards within the last six (6) months.

4. The employee has been employed in their current position for a minimum of three (3) months.

F. Qualified internal applicants will be considered using the same selection process followed with external candidates, including, but not limited to, interview questions, bilingual screening, and/or other skills tests, as appropriate.

G. On rare occasions, there may be situations where: (1) a position is not posted; or (2) a Transfer or Promotion is granted due to a sensitive business need, necessitated by other requirements, or implemented prior to the employee being in the position for three (3) months. Exceptions to the standard recruitment process may only be made if there is: (1) a substantiated and documented need to Transfer or Promote an employee; and (2) sufficient facts to establish that if CalOptima Health followed the standard procedure, it would result in a demonstrated impairment to the organization or a specific time sensitive project. Without such substantiated business need, the exception should not be made. The Chief Executive Officer (CEO) must approve the exception.

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Responsible Party	Action
	supervisor outside of this process regarding the performance of the employee. 3. Coordinate with HR to agree upon a start date. 4. Complete the new hire/internal transfer form for HR to initiate the internal transfer eTicket.
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IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Policy GA.8022: Performance and Behavior Standards
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C. CalOptima Health Policy GA.8060: Recruitment, Selection, and Hiring
D. Personnel Action Form (Sample)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

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Promotion	Occurs when an employee is selected for a job with a higher pay grade.
Transfer	Occurs when an employee moves to a different job title having the same pay grade.

CalOptima Health Board Action Agenda Referral

Action To Be Taken November 7, 2024
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

11. Authorize Amendments to Extend the Term of Contracts with Translation and Interpreter Services Vendors

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 923-8834
Ladan Khamseh, Executive Director, Operations, (714) 246-8866

Recommended Actions

Make an exception to CalOptima Health Policy GA.5002: Purchasing Policy and authorize the Chief Executive Officer to execute amendments to extend contracts for additional three-year terms under the current terms and conditions, effective March 1, 2025, with two one-year extension options, each exercisable at CalOptima Health's discretion, with the following translation and interpreter services vendors:

- AvantPage;
- Hanna Interpreting Services LLC;
- Interpreting Services International LLC;
- Language Line Services Inc.; and
- Voiance Language Services LLC.

Background

Federal and state regulations require CalOptima Health to provide interpreter and translation services to members with limited English proficiency (LEP). LEP members include those who have a limited ability to read, speak, write, or understand English.

CalOptima Health contracts with various vendors to provide the following services for members with LEP and members that are visually and hearing impaired for the OneCare, Medi-Cal, and PACE lines of business.

Primary support and services include:

AvantPage

- Written translations.
- Alternative format services (braille, audio, and data files).

Hanna Interpreting Services LLC

- Face-to-face interpreting.
- Telephonic interpreting.

Interpreting Services International LLC

- Written translations.
- Telephonic interpreting.

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- Video and face-to-face interpreting.

Language Line Services Inc.

- Written translations.
- Telephonic interpreting.
- Video interpreting.
- Face-to-face interpreting.

Voiance Language Services, LLC

- Telephonic interpreting.
- Face-to-face interpreting.

Discussion

Staff recommends that the CalOptima Health Board of Directors (Board) authorize an exception to CalOptima Health Policy GA.5002: Purchasing to bypass a process for competitive bidding and extend the contract term. The extension would be for an additional three-year term with two additional one-year extension options, each exercisable at CalOptima Health's. The contracted vendors have provided services well and have ensured CalOptima Health members have access to health care related interpreter services in any language and translated materials in CalOptima Health's threshold languages.

The contracted vendors have performed well during external audits. There have been no interpreter or translation services findings in recent annual Department of Health Care Services (DHCS) audits.

In addition, CalOptima Health's Audit & Oversight (A&O) Department conducts an annual audit on all contracted vendors. The purpose of the annual audit is to monitor and ensure that CalOptima Health functions are performed satisfactorily for OneCare, Medi-Cal, and PACE lines of business. The vendors are evaluated based upon CalOptima Health's requirements, as well as Centers for Medicare & Medicaid Services and DHCS regulatory requirements. The five contracted vendors performed well in the annual audits and worked cooperatively with the A&O Department to remediate any minor deficiencies identified.

A RFP and selection of vendors would take approximately 3-5 months to complete. The RFP would require participation from several departments within CalOptima Health at a time when there are multiple competing resource-intensive initiatives. Some of these initiatives include implementation of the new phone system and a Customer Relations Management (CRM) system, and preparation for the OneCare Plus and OneCare Complete plans.

The interpreter and translation services vendors are following current CalOptima Health contract requirements, are not on any exclusion lists (System for Award Management, Office of the Inspector General, Medi-Cal Suspended and Ineligible), are not on the Medicare Preclusion List, and are actively listed with the California Secretary of State.

Fiscal Impact

Funding for the recommended action through June 30, 2025, is a budgeted item under the CalOptima Health Fiscal Year 2024-25 Operating Budget approved by the Board on June 6, 2024. Management

will include expenses for the contracts with translation and interpreter services vendors for the period beginning July 1, 2025, and after in future operating budgets.

Rationale for Recommendation

Extending the contracts for the above vendors ensures continuation of important and regulatorily required services for CalOptima Health members, while allowing staff to work on other regulatory deliverables and critical projects.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachment

1. Entities Covered by this Recommended Action

/s/ Michael Hunn *10/31/2024*
Authorized Signature **Date**

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AvantPage	523 G Street	Davis	CA	95616
Hanna Interpreting Services LLC	3322 Sweetwater Springs Blvd	Spring Valley	CA	91977
Interpreting Services International LLC	700 N. Brand Blvd.	Glendale	CA	91203
Language Line Services Inc	1 Lower Ragsdale Drive	Monterey	CA	93940
Voiance Language Services LLC	2650 E. Elvira Road	Tucson	AZ	85756

Financial Summary

September 30, 2024

Board of Directors Meeting

November 7, 2024

Nancy Huang, Chief Financial Officer

Our Mission

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

Our Vision

By 2027, remove barriers to health care access for our members, implement same-day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.

Financial Highlights: September 2024

September 2024 Actual	September 2024 Budget	September 2024 $ Variance	September 2024 % Variance		July - September 2024 Actual	July - September 2024 Budget	July - September 2024 $ Variance	July - September 2024 % Variance
913,501	897,705	15,796	1.8%	Member Months	2,740,379	2,706,605	33,774	1.2%
525,566,111	354,582,592	170,983,519	48.2%	Revenues	1,255,951,660	1,068,106,279	187,845,381	17.6%
499,406,773	347,815,431	(151,591,342)	(43.6%)	Medical Expenses	1,236,461,011	1,059,866,014	(176,594,997)	(16.7%)
18,465,473	23,436,647	4,971,174	21.2%	Administrative Expenses	56,486,311	71,765,553	15,279,242	21.3%
7,693,866	**(16,669,486)**	**24,363,352**	**146.2%**	**Operating Margin**	**(36,995,662)**	**(63,525,288)**	**26,529,626**	**41.8%**
				Non-Operating Income (Loss)				
22,461,830	6,666,660	15,795,170	236.9%	Net Investment Income/Expense	72,703,867	19,999,980	52,703,887	263.5%
(128,088)	(117,280)	(10,808)	(9.2%)	Net Rental Income/Expense	(92,199)	(351,840)	259,641	73.8%
2,614	-	2,614	100.0%	Net MCO Tax	6,753	-	6,753	100.0%
(16,700)	(1,178,825)	1,162,125	98.6%	Grant Expense	(2,495,859)	(3,445,566)	949,707	27.6%
490	-	490	100.0%	Other Income/Expense	55,712	-	55,712	100.0%
22,320,146	**5,370,555**	**16,949,591**	**315.6%**	**Total Non-Operating Income (Loss)**	**70,178,274**	**16,202,574**	**53,975,700**	**333.1%**
30,014,012	**(11,298,931)**	**41,312,943**	**365.6%**	**Change in Net Assets**	**33,182,612**	**(47,322,714)**	**80,505,326**	**170.1%**
95.0%	*98.1%*	*(3.1%)*		*Medical Loss Ratio*	*98.4%*	*99.2%*	*(0.8%)*	
3.5%	*6.6%*	*3.1%*		*Administrative Loss Ratio*	*4.5%*	*6.7%*	*2.2%*	
1.5%	*(4.7%)*	*6.2%*		*Operating Margin Ratio*	*(2.9%)*	*(5.9%)*	*3.0%*	
100.0%	*100.0%*			*Total Operating*	*100.0%*	*100.0%*		
88.2%	*93.2%*	*(5.0%)*		**Adjusted MLR*	*93.3%*	*94.3%*	*(1.0%)*	
4.8%	*6.6%*	*1.8%*		**Adjusted ALR*	*5.1%*	*6.7%*	*1.6%*	

*Adjusted MLR /ALR excludes estimated provider rate increases funded by reserves, Community Reinvestment accruals and Directed Payments

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Financial Highlights Notes: September 2024

- Notable events/items in September 2024
  - $142.4 million of Hospital Directed Payment (DP) was received and $145.3 million was paid in the month
    - For dates of service from July 1, 2022, through December 31, 2022
    - Approximately $3.4 million of prior period recoupment was included in September 2024
  - $19.7 million net change in revenue related to Calendar Year (CY) 2024 Department of Health Care Services (DHCS) capitation rate true-up

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FY 2024-25: Management Summary

- Change in Net Assets Surplus or (Deficit)
  - Month To Date (MTD) September 2024: $30.0 million, favorable to budget $41.3 million or 365.6% driven primarily by:
    - Favorable net investment income; and
    - Release of accruals due to updated CY 2024 premium capitation rates received from DHCS
  - Year To Date (YTD) July - September 2024: $33.2 million, favorable to budget $80.5 million or 170.1% driven primarily by favorable net investment income and enrollment
    - Offset by increased utilization

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FY 2024-25: Management Summary (cont.)

- Enrollment
  - MTD: 913,501 members, favorable to budget 15,796 or 1.8%
  - YTD: 2,740,379 member months, favorable to budget 33,774 or 1.2%

- Revenue
  - MTD: $525.6 million, favorable to budget $171.0 million or 48.2% driven by Medi-Cal (MC) Line of Business (LOB) due primarily to CY 2022 DP, updated CY 2024 rates and enrollment
  - YTD: $1,256.0 million, favorable to budget $187.8 million or 17.6% driven by MC LOB due to CY 2022 DP and enrollment

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FY 2024-25: Management Summary (cont.)

- Medical Expenses
  - MTD: $499.4 million, unfavorable to budget $151.6 million or 43.6% driven by MC LOB
    - Due primarily to $145 million for CY 2022 DP and incentive payments expenses
  - YTD: $1,236.5 million, unfavorable to budget $176.6 million or 16.7% driven by MC LOB:
    - Due primarily to CY 2022 DP and Board-approved provider rate increases

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FY 2024-25: Management Summary (cont.)

- Administrative Expenses
  - MTD: $18.5 million, favorable to budget $5.0 million or 21.2%
  - YTD: $56.5 million, favorable to budget $15.3 million or 21.3%

- Non-Operating Income (Loss)
  - MTD: $22.3 million, favorable to budget $16.9 million or 315.6% due primarily to favorable net investment income
  - YTD: $70.2 million, favorable to budget $54.0 million or 333.1% due primarily to favorable net investment income

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FY 2024-25: Key Financial Ratios

- Medical Loss Ratio (MLR)

		Actual	Budget	Variance (%)
MTD	MLR	95.0%	98.1%	-3.1%
	Adjusted MLR*	88.2%	93.2%	-5.0%
YTD	MLR	98.4%	99.2%	-0.8%
	Adjusted MLR*	93.3%	94.3%	-1.0%

- Administrative Loss Ratio (ALR)

		Actual	Budget	Variance (%)
MTD	ALR	3.5%	6.6%	3.1%
	Adjusted ALR*	4.8%	6.6%	1.8%
YTD	ALR	4.5%	6.7%	2.2%
	Adjusted ALR*	5.1%	6.7%	1.6%

* Adjusted MLR/ALR excludes estimated Board-approved Provider Rate Increases, Community Reinvestment Accruals and Directed Payments

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FY 2024-25: Key Financial Ratios (cont.)

- Balance Sheet Ratios
  - Current ratio*: 1.8
  - Board Designated Reserve level: 2.78
  - Statutory Designated Reserve level: 1.03
  - Net-position: $2.5 billion, including required Tangible Net Equity (TNE) of $131.9 million

*Current ratio compares current assets to current liabilities. It measures CalOptima Health's ability to pay short-term obligations

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CalOptima Health

Enrollment Summary: September 2024

September 2024					July - September 2024			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
144,652	136,567	8,085	5.9%	SPD	433,367	408,570	24,797	6.1%
269,485	271,892	(2,407)	(0.9%)	TANF Child	812,510	819,103	(6,593)	(0.8%)
131,865	137,428	(5,563)	(4.0%)	TANF Adult	391,996	413,794	(21,798)	(5.3%)
2,480	2,598	(118)	(4.5%)	LTC	7,395	7,838	(443)	(5.7%)
337,385	321,770	15,615	4.9%	MCE	1,011,686	974,979	36,707	3.8%
9,849	9,549	300	3.1%	WCM	30,008	28,734	1,274	4.4%
895,716	**879,804**	**15,912**	**1.8%**	**Medi-Cal Total**	**2,686,962**	**2,653,018**	**33,944**	**1.3%**
17,282	**17,428**	**(146)**	**(0.8%)**	**OneCare**	**51,900**	**52,176**	**(276)**	**(0.5%)**
503	**473**	**30**	**6.3%**	**PACE**	**1,517**	**1,411**	**106**	**7.5%**
487	**568**	**(81)**	**(14.3%)**	**MSSP**	**1,440**	**1,704**	**(264)**	**(15.5%)**
913,501	**897,705**	**15,796**	**1.8%**	**CalOptima Health Total**	**2,740,379**	**2,706,605**	**33,774**	**1.2%**

*CalOptima Health Total does not include MSSP

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Consolidated Revenue & Expenses: September 2024 MTD

	Total Medi-Cal	OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS	895,716	17,282	503	487	913,501
REVENUES					
Capitation Revenue	$ 489,892,830	$ 31,163,127	$ 4,288,061	$ 222,093	$ 525,566,111
Total Operating Revenue	**489,892,830**	**31,163,127**	**4,288,061**	**222,093**	**525,566,111**
MEDICAL EXPENSES					
Provider Capitation	116,680,117	14,436,141			131,116,257
Claims	135,698,572	5,151,276	1,274,443		142,124,291
MLTSS	48,601,129		4,657	35,516	48,641,303
Prescription Drugs		5,204,434	563,421		5,767,855
Case Mgmt & Other Medical	168,455,604	1,882,449	1,232,966	186,047	171,757,066
Total Medical Expenses	**469,435,421**	**26,674,300**	**3,075,488**	**221,563**	**499,406,773**
Medical Loss Ratio	*95.8%*	*85.6%*	*71.7%*	*99.8%*	*95.0%*
GROSS MARGIN	**20,457,408**	**4,488,827**	**1,212,573**	**530**	**26,159,339**
ADMINISTRATIVE EXPENSES					
Salaries & Benefits	10,459,674	1,043,179	147,712	92,500	11,743,065
Non-Salary Operating Expenses	2,667,365	640,693	49,684	1,430	3,359,173
Depreciation & Amortization	719,097		939		720,036
Other Operating Expenses	2,346,172	60,738	5,207	7,579	2,419,695
Indirect Cost Allocation, Occupancy	(711,998)	910,908	20,195	4,397	223,503
Total Administrative Expenses	**15,480,311**	**2,655,518**	**223,737**	**105,907**	**18,465,473**
Administrative Loss Ratio	*3.2%*	*8.5%*	*5.2%*	*47.7%*	*3.5%*
Operating Income/(Loss)	**4,977,098**	**1,833,309**	**988,836**	**(105,377)**	**7,693,866**
Investments and Other Non-Operating	3,104				22,320,146
CHANGE IN NET ASSETS	**$ 4,980,202**	**$ 1,833,309**	**$ 988,836**	**$ (105,377)**	**$ 30,014,012**
BUDGETED CHANGE IN NET ASSETS	(15,837,963)	(690,765)	(31,579)	(109,179)	(11,298,931)
Variance to Budget - Fav/(Unfav)	$ 20,818,165	$ 2,524,074	$ 1,020,415	$ 3,802	$ 41,312,943

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Consolidated Revenue & Expenses: September 2024 YTD

	Total Medi-Cal	OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS	2,686,962	51,900	1,517	1,440	2,740,379
REVENUES					
Capitation Revenue	$1,141,371,322	$ 100,894,082	$ 13,034,875	$ 651,380	$ 1,255,951,660
Total Operating Revenue	**1,141,371,322**	**100,894,082**	**13,034,875**	**651,380**	**1,255,951,660**
MEDICAL EXPENSES					
Provider Capitation	336,463,033	44,580,487			381,043,520
Claims	435,883,479	17,005,793	4,126,602		457,015,873
MLTSS	149,488,843		19,645	99,657	149,608,145
Prescription Drugs		24,485,409	1,857,464		26,342,872
Case Mgmt & Other Medical	213,933,329	4,276,910	3,701,085	539,276	222,450,600
Total Medical Expenses	**1,135,768,684**	**90,348,599**	**9,704,795**	**638,933**	**1,236,461,011**
Medical Loss Ratio	*99.5%*	*89.5%*	*74.5%*	*98.1%*	*98.4%*
GROSS MARGIN	**5,602,639**	**10,545,484**	**3,330,080**	**12,446**	**19,490,649**
ADMINISTRATIVE EXPENSES					
Salaries & Benefits	33,157,048	3,276,991	469,325	272,476	37,175,840
Non-Salary Operating Expenses	7,829,000	1,097,736	159,031	4,264	9,090,031
Depreciation & Amortization	2,153,380		2,817		2,156,196
Other Operating Expenses	6,816,955	81,288	17,808	21,420	6,937,471
Indirect Cost Allocation, Occupancy	(1,893,116)	2,951,868	48,962	19,057	1,126,772
Total Administrative Expenses	**48,063,267**	**7,407,883**	**697,943**	**317,217**	**56,486,311**
Administrative Loss Ratio	*4.2%*	*7.3%*	*5.4%*	*48.7%*	*4.5%*
Operating Income/(Loss)	**(42,460,628)**	**3,137,601**	**2,632,136**	**(304,771)**	**(36,995,662)**
Investments and Other Non-Operating	62,465				70,178,274
CHANGE IN NET ASSETS	**$ (42,398,163)**	**$ 3,137,601**	**$ 2,632,136**	**$ (304,771)**	**$ 33,182,612**
BUDGETED CHANGE IN NET ASSETS	(59,790,520)	(3,049,319)	(347,032)	(338,417)	(47,322,714)
Variance to Budget - Fav/(Unfav)	$ 17,392,357	$ 6,186,920	$ 2,979,168	$ 33,646	$ 80,505,326

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Balance Sheet: As of September 2024

ASSETS	
Current Assets	
Operating Cash	$594,419,494
Short-term Investments	1,746,560,045
Receivables & Other Current Assets	691,308,229
Total Current Assets	**3,032,287,768**
Capital Assets	
Capital Assets	189,645,456
Less Accumulated Depreciation	(85,758,376)
Capital Assets, Net of Depreciation	103,887,079
Other Assets	
Restricted Deposits	300,000
Board Designated Reserves	1,036,123,723
Statutory Designated Reserves	136,448,560
Total Other Assets	**1,172,872,283**
TOTAL ASSETS	**4,309,047,131**
Deferred Outflows	**75,899,007**
TOTAL ASSETS & DEFERRED OUTFLOWS	**4,384,946,138**

LIABILITIES & NET POSITION	
Current Liabilities	
Accounts Payable	$336,158,208
Medical Claims Liability	1,154,153,968
Capitation and Withholds	175,031,470
Other Current Liabilities	41,880,330
Total Current Liabilities	**1,707,223,977**
Other Liabilities	
GASB 96 Subscription Liabilities	21,616,375
Community Reinvestment	105,737,300
Postemployment Health Care Plan	17,475,895
Net Pension Liabilities	45,981,359
Total Other Liabilities	**190,810,929**
TOTAL LIABILITIES	**1,898,034,906**
Deferred Inflows	**8,646,445**
Net Position	
Required TNE	131,917,008
Funds in Excess of TNE	2,346,347,779
TOTAL NET POSITION	**2,478,264,787**
TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION	**4,384,946,138**

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Board Designated Reserve and TNE Analysis: As of September 2024

Board Designated Reserves

Investment Account Name	Market Value	Benchmark		Variance	
		Low	High	Mkt - Low	Mkt - High
Payden & Rygel Tier One	518,158,442				
MetLife Tier One	517,965,281				
Board Designated Reserves	1,036,123,723	932,399,027	1,118,878,833	103,724,696	(82,755,110)
Current Reserve Level (X months of average monthly revenue) [1]	*2.78*	*2.50*	*3.00*		

Statutory Designated Reserves

Investment Account Name	Market Value	Benchmark		Variance	
		Low	High	Mkt - Low	Mkt - High
Payden & Rygel Tier Two	68,365,839				
MetLife Tier Two	68,082,721				
Statutory Designated Reserves	136,448,560	131,917,008	145,108,709	4,531,552	(8,660,149)
Current Reserve Level (X min. TNE) [1]	*1.03*	*1.00*	*1.10*		

[1] *See CalOptima Health policy GA.3001 Statutory and Board-Designasted Reserve Funds for more information*

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Spending Plan: As of September 2024

Category	Item Description	Amount (millions)	Approved Initiative	Expense to Date	%
	Total Net Position @ 9/30/2024	**$2,478.3**			**100.0%**
Resources Assigned	Board Designated Reserve[1]	**$1,036.1**			**41.8%**
	Statutory Designated Reserve[1]	**$136.4**			**5.5%**
	Capital Assets, net of Depreciation[2]	**$103.9**			**4.2%**
Resources Allocated[3]	Homeless Health Initiative[4]	$17.1	$61.7	44.6	0.7%
	Housing and Homelessness Incentive Program[4]	22.3	87.4	65.1	0.9%
	Intergovernmental Transfers (IGT)	55.0	111.7	56.7	2.2%
	Digital Transformation and Workplace Modernization[5]	53.3	100.0	46.7	2.2%
	CalFresh Outreach Strategy	0.1	2.0	1.9	0.0%
	CalFresh and Redetermination Outreach Strategy	2.0	6.0	4.0	0.1%
	Coalition of Orange County Community Health Centers Grant	30.0	50.0	20.0	1.2%
	OneCare Member Health Rewards and Incentives	0.2	0.5	0.3	0.0%
	General Awareness Campaign	1.3	4.7	3.4	0.1%
	Member Health Needs Assessment	1.1	1.3	0.2	0.0%
	Five-Year Hospital Quality Program Beginning MY 2023	132.9	153.5	20.6	5.4%
	Medi-Cal Annual Wellness Initiative	2.5	3.8	1.3	0.1%
	Skilled Nursing Facility Access Program	10.0	10.0	0.0	0.4%
	In-Home Care Pilot Program with the UCI Family Health Center	2.0	2.0	0.0	0.1%
	National Alliance for Mental Illness Orange County Peer Support Program Grant	3.5	5.0	1.5	0.1%
	Community Living and PACE center (previously approved for project located in Tustin)	17.6	18.0	0.4	0.7%
	Wellness & Prevention Program Grant	2.1	2.7	0.6	0.1%
	CalOptima Health Provider Workforce Development Fund Grant	45.6	50.0	4.4	1.8%
	Distribution Event- Naloxone Grant	2.3	15.0	12.7	0.1%
	Garden Grove Bldg. Improvement	10.0	10.5	0.5	0.4%
	Post-Pandemic Supplemental	7.6	107.5	99.9	0.3%
	CalOptima Health Community Reinvestment Program	38.0	38.0	0.0	1.5%
	Dyadic Services Program Academy	1.0	1.9	0.9	0.0%
	Outreach Strategy for newly eligible Adult Expansion members	4.2	5.0	0.8	0.2%
	Quality Initiatives from unearned Pay for Value Program	23.3	23.3	0.0	0.9%
	Expansion of CalOptima Health OC Outreach and Engagement Strategy	0.7	1.0	0.3	0.0%
	Medi-Cal Provider Rate Increases	473.6	526.2	52.6	19.1%
	Subtotal:	**$959.3**	**$1,398.7**	**$439.4**	**38.7%**
Resources Available for New Initiatives	Unallocated/Unassigned[1]	**$242.5**			**9.8%**

[1] Total Designated Reserves and unallocated reserve amount can support approximately 119 days of CalOptima Health's current operations
[2] Increase due to the adoption of GASB 96 Subscription-Based Information Technology Arrangements
[3] Initiatives that have been paid in full in the previous year are omitted from the list of Resources Allocated
[4] See HHI and HHIP summaries and Allocated Funds for list of Board approved initiatives. Amount reported includes only portion funded by reserves
[5] On June 6, 2024, the Board of Directors approved an update to the Digital Transformation Strategy which will impact these figures beginning July 2024

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Homeless Health Initiative and Allocated Funds: As of September 2024

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000	11,400,000	-
Recuperative Care	6,194,190	6,194,190	-
Medical Respite	250,000	250,000	-
Day Habilitation (County for HomeKey)	2,500,000	2,500,000	-
Clinical Field Team Start-up & Federally Qualified Health Center (FQHC)	1,600,000	1,600,000	-
CalOptima Health Homeless Response Team	1,681,734	1,681,734	-
Homeless Coordination at Hospitals	10,000,000	9,956,478	43,522
			145,343
CalOptima Health Days, Homeless Clinical Access Program (HCAP) and FQHC Administrative Support	963,261	817,918	
FQHC (Community Health Center) Expansion	21,902	21,902	-
HCAP and CalOptima Health Days	9,888,914	3,446,240	6,442,675
Vaccination Intervention and Member Incentive Strategy	123,348	54,649	68,699
Street Medicine[1]	10,076,652	6,666,229	3,410,423
Outreach and Engagement	7,000,000	-	7,000,000
Housing and Homelessness Incentive Program (HHIP)[2]	40,100,000	-	40,100,000
Subtotal of Approved Initiatives	**$101,800,000**	**$44,589,340**	**$57,210,661**
Transfer of funds to HHIP[2]	(40,100,000)	-	(40,100,000)
Program Total	**$61,700,000**	**$44,589,340**	**$17,110,661**

Notes:

[1]On March 7, 2024, CalOptima Health's Board of Directors approved $5M. $3.2 million remaining from Street Medicine Initiative (from the HHI reserve) and $1.8 million from existing reserves to fund 2-year agreements to Healthcare in Action and Celebrating Life Community Health Center

[2]On September 1, 2022, CalOptima Health's Board of Directors approved reallocation of $40.1M from HHI to HHIP

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Housing and Homelessness Incentive Program
As of September 2024

Summary by Funding Source:	Total Funds	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funds Available for New Initiatives
DHCS HHIP Funds	72,931,189	35,200,994	28,812,256	6,388,739	37,730,195[1]
Existing Reserves & HHI Transfer	87,384,530	87,384,530	65,127,247	22,257,283	-
Total	**160,315,719**	**122,585,524**	**93,939,503**	**28,646,022**	**37,730,195**

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funding Source(s)
Office of Care Coordination	2,200,000	2,200,000	-	HHI
Pulse For Good	800,000	684,600	115,400	HHI
Consultant	600,000	-	600,000	HHI
Equity Grants for Programs Serving Underrepresented Populations	4,021,311	3,271,805	749,507	HHI & DHCS
Infrastructure Projects	5,832,314	5,391,731	440,583	HHI
Capital Projects	98,247,369	77,195,575	21,051,794	HHI, DHCS & Existing Reserves
System Change Projects	10,184,530	4,863,856	5,320,674	DHCS
Non-Profit Healthcare Academy	700,000	331,935	368,065	DHCS
Total of Approved Initiatives	**$122,585,524[1]**	**$93,939,502**	**$28,646,022**	

Notes:

[1]Total funding $160.3 million: $40.1 million Board-approved reallocation from HHI, $47.2 million from CalOptima Health existing reserves and $73.0 million from DHCS HHIP incentive payments

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UNAUDITED FINANCIAL STATEMENTS

September 30, 2024

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CalOptima Health - Consolidated
Financial Highlights
For the Three Months Ending September 30, 2024

September 2024					July - September 2024			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
913,501	897,705	15,796	1.8%	Member Months	2,740,379	2,706,605	33,774	1.2%
525,566,111	354,582,592	170,983,519	48.2%	Revenues	1,255,951,660	1,068,106,279	187,845,381	17.6%
499,406,773	347,815,431	(151,591,342)	(43.6%)	Medical Expenses	1,236,461,011	1,059,866,014	(176,594,997)	(16.7%)
18,465,473	23,436,647	4,971,174	21.2%	Administrative Expenses	56,486,311	71,765,553	15,279,242	21.3%
7,693,866	**(16,669,486)**	**24,363,352**	**146.2%**	**Operating Margin**	**(36,995,662)**	**(63,525,288)**	**26,529,626**	**41.8%**
				Non-Operating Income (Loss)				
22,461,830	6,666,660	15,795,170	236.9%	Net Investment Income/Expense	72,703,867	19,999,980	52,703,887	263.5%
(128,088)	(117,280)	(10,808)	(9.2%)	Net Rental Income/Expense	(92,199)	(351,840)	259,641	73.8%
2,614	-	2,614	100.0%	Net MCO Tax	6,753	-	6,753	100.0%
(16,700)	(1,178,825)	1,162,125	98.6%	Grant Expense	(2,495,859)	(3,445,566)	949,707	27.6%
490	-	490	100.0%	Other Income/Expense	55,712	-	55,712	100.0%
22,320,146	**5,370,555**	**16,949,591**	**315.6%**	**Total Non-Operating Income (Loss)**	**70,178,274**	**16,202,574**	**53,975,700**	**333.1%**
30,014,012	**(11,298,931)**	**41,312,943**	**365.6%**	**Change in Net Assets**	**33,182,612**	**(47,322,714)**	**80,505,326**	**170.1%**
95.0%	*98.1%*	*(3.1%)*		*Medical Loss Ratio*	*98.4%*	*99.2%*	*(0.8%)*	
3.5%	*6.6%*	*3.1%*		*Administrative Loss Ratio*	*4.5%*	*6.7%*	*2.2%*	
1.5%	*(4.7%)*	*6.2%*		*Operating Margin Ratio*	*(2.9%)*	*(5.9%)*	*3.0%*	
100.0%	*100.0%*			*Total Operating*	*100.0%*	*100.0%*		
88.2%	*93.2%*	*(5.0%)*		**Adjusted MLR*	*93.3%*	*94.3%*	*(1.0%)*	
4.8%	*6.6%*	*1.8%*		**Adjusted ALR*	*5.1%*	*6.7%*	*1.6%*	

*Adjusted MLR /ALR excludes estimated provider rate increases funded by reserves, Community Reinvestment accruals and Directed Payments

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CalOptima Health - Consolidated
Full Time Employee Data
For the Three Months Ending September 30, 2024

Total FTE's MTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	1,287	1,361	74
OneCare	174	186	12
PACE	105	113	8
MSSP	20	25	5
Total	1,587	1,685	98

Total FTE's YTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	3,849	4,082	233
OneCare	520	558	38
PACE	319	339	20
MSSP	60	75	15
Total	4,748	5,055	307

MM per FTE MTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	696	647	(49)
OneCare	99	94	(5)
PACE	5	4	(1)
MSSP	24	23	(1)
Consolidated	576	533	(43)

MM per FTE YTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	698	650	(48)
OneCare	100	93	(7)
PACE	5	4	(1)
MSSP	24	23	(1)
Consolidated	577	535	(42)

Open FTE			
	Total	Medical	Admin
Medi-Cal	66	24	42
OneCare	11	9	2
PACE	7	5	2
MSSP	1	1	0
Total	85	39	46

CalOptima Health - Consolidated - Month to Date
Statement of Revenues and Expenses
For the One Month Ending September 30, 2024

MEMBER MONTHS		913,501		897,705		15,796
	Actual		**Budget**		**Variance**	
REVENUE	**$**	**PMPM**	**$**	**PMPM**	**$**	**PMPM**
Medi-Cal	$489,892,830	$546.93	$315,447,769	$358.54	$174,445,061	$188.39
OneCare	31,163,127	1,803.21	34,958,393	2,005.88	(3,795,266)	(202.67)
OneCare Connect	-		-		-	-
PACE	4,288,061	8,524.97	3,922,913	8,293.68	365,148	231.29
MSSP	222,093	456.04	253,517	446.33	(31,424)	9.71
Total Operating Revenue	525,566,111	575.33	354,582,592	394.99	170,983,519	180.34
MEDICAL EXPENSES						
Medi-Cal	469,435,421	524.09	311,376,764	353.92	(158,058,657)	(170.17)
OneCare	26,674,300	1,543.47	32,533,661	1,866.75	5,859,361	323.28
OneCare Connect					-	-
PACE	3,075,488	6,114.29	3,664,265	7,746.86	588,777	1,632.57
MSSP	221,563	454.96	240,741	423.84	19,178	(31.12)
Total Medical Expenses	499,406,773	546.70	347,815,431	387.45	(151,591,342)	(159.25)
GROSS MARGIN	26,159,339	28.63	6,767,161	7.54	19,392,178	21.09
ADMINISTRATIVE EXPENSES						
Salaries and Benefits	11,743,065	12.86	13,016,384	14.50	1,273,319	1.64
Professional Fees	1,178,152	1.29	1,566,026	1.74	387,874	0.45
Purchased Services	1,447,676	1.58	2,733,743	3.05	1,286,067	1.47
Printing & Postage	733,345	0.80	793,816	0.88	60,471	0.08
Depreciation & Amortization	720,036	0.79	1,027,958	1.15	307,922	0.36
Other Expenses	2,419,695	2.65	3,855,167	4.29	1,435,472	1.64
Indirect Cost Allocation, Occupancy	223,503	0.24	443,553	0.49	220,050	0.25
Total Administrative Expenses	18,465,473	20.21	23,436,647	26.11	4,971,174	5.90
NET INCOME (LOSS) FROM OPERATIONS	7,693,866	8.42	(16,669,486)	(18.57)	24,363,352	26.99
INVESTMENT INCOME						
Interest Income	15,163,125	16.60	6,666,660	7.43	8,496,465	9.17
Realized Gain/(Loss) on Investments	291,333	0.32	-	-	291,333	0.32
Unrealized Gain/(Loss) on Investments	7,007,372	7.67	-	-	7,007,372	7.67
Total Investment Income	22,461,830	24.59	6,666,660	7.43	15,795,170	17.16
NET RENTAL INCOME/EXPENSE	(128,088)	(0.14)	(117,280)	(0.13)	(10,808)	(0.01)
NET MCO TAX	2,614	-	-	-	2,614	-
GRANT EXPENSE	(16,700)	(0.02)	(1,178,825)	(1.31)	1,162,125	1.29
OTHER INCOME/EXPENSE	490	-	-	-	490	-
CHANGE IN NET ASSETS	**30,014,012**	**32.86**	**(11,298,931)**	**(12.59)**	**41,312,943**	**45.45**
MEDICAL LOSS RATIO	**95.0%**		**98.1%**		**(3.1%)**	
ADMINISTRATIVE LOSS RATIO	**3.5%**		**6.6%**		**3.1%**	

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CalOptima Health- Consolidated - Year to Date
Statement of Revenues and Expenses
For the Three Months Ending September 30, 2024

MEMBER MONTHS		2,740,379		2,706,605		33,774
	Actual		**Budget**		**Variance**	
REVENUE	**$**	**PMPM**	**$**	**PMPM**	**$**	**PMPM**
Medi-Cal	$1,141,371,322	$424.78	$950,458,623	$358.26	$190,912,699	$66.52
OneCare	100,894,082	1,944.01	105,161,755	2,015.52	(4,267,673)	(71.51)
OneCare Connect	-		-		-	0.00
PACE	13,034,875	8,592.53	11,725,350	8,309.96	1,309,525	282.57
MSSP	651,380	452.35	760,551	446.33	(109,171)	6.02
Total Operating Revenue	1,255,951,660	458.31	1,068,106,279	394.63	187,845,381	63.68
MEDICAL EXPENSES						
Medi-Cal	1,135,768,684	422.70	949,213,373	357.79	(186,555,311)	(64.91)
OneCare	90,348,599	1,740.82	98,746,881	1,892.57	8,398,282	151.75
OneCare Connect					-	0.00
PACE	9,704,795	6,397.36	11,183,537	7,925.97	1,478,742	1,528.61
MSSP	638,933	443.70	722,223	423.84	83,290	(19.86)
Total Medical Expenses	1,236,461,011	451.20	1,059,866,014	391.59	(176,594,997)	(59.61)
GROSS MARGIN	19,490,649	7.11	8,240,265	3.04	11,250,384	4.07
ADMINISTRATIVE EXPENSES						
Salaries and Benefits	37,175,840	13.57	40,411,419	14.93	3,235,579	1.36
Professional Fees	2,667,938	0.97	4,539,578	1.68	1,871,640	0.71
Purchased Services	5,126,319	1.87	8,236,544	3.04	3,110,225	1.17
Printing & Postage	1,295,774	0.47	2,481,629	0.92	1,185,855	0.45
Depreciation & Amortization	2,156,196	0.79	3,083,874	1.14	927,678	0.35
Other Expenses	6,937,471	2.53	11,682,020	4.32	4,744,549	1.79
Indirect Cost Allocation, Occupancy	1,126,772	0.41	1,330,489	0.49	203,717	0.08
Total Administrative Expenses	56,486,311	20.61	71,765,553	26.51	15,279,242	5.90
NET INCOME (LOSS) FROM OPERATIONS	(36,995,662)	(13.50)	(63,525,288)	(23.47)	26,529,626	9.97
INVESTMENT INCOME						
Interest Income	45,923,015	16.76	19,999,980	7.39	25,923,035	9.37
Realized Gain/(Loss) on Investments	404,334	0.15	-	0.00	404,334	0.15
Unrealized Gain/(Loss) on Investments	26,376,518	9.63	-	0.00	26,376,518	9.63
Total Investment Income	72,703,867	26.53	19,999,980	7.39	52,703,887	19.14
NET RENTAL INCOME/EXPENSE	(92,199)	(0.03)	(351,840)	(0.13)	259,641	0.10
NET MCO TAX	6,753	0.00	-	0.00	6,753	0.00
GRANT EXPENSE	(2,495,859)	(0.91)	(3,445,566)	(1.27)	949,707	0.36
OTHER INCOME/EXPENSE	55,712	0.02	-	0.00	55,712	0.02
CHANGE IN NET ASSETS	**33,182,612**	**12.11**	**(47,322,714)**	**(17.48)**	**80,505,326**	**29.59**
MEDICAL LOSS RATIO	**98.4%**		**99.2%**		**(0.8%)**	
ADMINISTRATIVE LOSS RATIO	**4.5%**		**6.7%**		**2.2%**	

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CalOptima Health - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ending September 30, 2024

	Total Medi-Cal	OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS	895,716	17,282	503	487	913,501
REVENUES					
Capitation Revenue	$ 489,892,830	$ 31,163,127	$ 4,288,061	$ 222,093	$ 525,566,111
Total Operating Revenue	**489,892,830**	**31,163,127**	**4,288,061**	**222,093**	**525,566,111**
MEDICAL EXPENSES					
Provider Capitation	116,680,117	14,436,141			131,116,257
Claims	135,698,572	5,151,276	1,274,443		142,124,291
MLTSS	48,601,129		4,657	35,516	48,641,303
Prescription Drugs		5,204,434	563,421		5,767,855
Case Mgmt & Other Medical	168,455,604	1,882,449	1,232,966	186,047	171,757,066
Total Medical Expenses	**469,435,421**	**26,674,300**	**3,075,488**	**221,563**	**499,406,773**
Medical Loss Ratio	*95.8%*	*85.6%*	*71.7%*	*99.8%*	*95.0%*
GROSS MARGIN	**20,457,408**	**4,488,827**	**1,212,573**	**530**	**26,159,339**
ADMINISTRATIVE EXPENSES					
Salaries & Benefits	10,459,674	1,043,179	147,712	92,500	11,743,065
Non-Salary Operating Expenses	2,667,365	640,693	49,684	1,430	3,359,173
Depreciation & Amortization	719,097		939		720,036
Other Operating Expenses	2,346,172	60,738	5,207	7,579	2,419,695
Indirect Cost Allocation, Occupancy	(711,998)	910,908	20,195	4,397	223,503
Total Administrative Expenses	**15,480,311**	**2,655,518**	**223,737**	**105,907**	**18,465,473**
Administrative Loss Ratio	*3.2%*	*8.5%*	*5.2%*	*47.7%*	*3.5%*
Operating Income/(Loss)	**4,977,098**	**1,833,309**	**988,836**	**(105,377)**	**7,693,866**
Investments and Other Non-Operating	3,104				22,320,146
CHANGE IN NET ASSETS	**$ 4,980,202**	**$ 1,833,309**	**$ 988,836**	**$ (105,377)**	**$ 30,014,012**
BUDGETED CHANGE IN NET ASSETS	(15,837,963)	(690,765)	(31,579)	(109,179)	(11,298,931)
Variance to Budget - Fav/(Unfav)	$ 20,818,165	$ 2,524,074	$ 1,020,415	$ 3,802	$ 41,312,943

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CalOptima Health - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Three Months Ending September 30, 2024

	Total Medi-Cal	OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS	2,686,962	51,900	1,517	1,440	2,740,379
REVENUES					
Capitation Revenue	$ 1,141,371,322	$ 100,894,082	$ 13,034,875	$ 651,380	$ 1,255,951,660
Total Operating Revenue	**1,141,371,322**	**100,894,082**	**13,034,875**	**651,380**	**1,255,951,660**
MEDICAL EXPENSES					
Provider Capitation	336,463,033	44,580,487			381,043,520
Claims	435,883,479	17,005,793	4,126,602		457,015,873
MLTSS	149,488,843		19,645	99,657	149,608,145
Prescription Drugs		24,485,409	1,857,464		26,342,872
Case Mgmt & Other Medical	213,933,329	4,276,910	3,701,085	539,276	222,450,600
Total Medical Expenses	**1,135,768,684**	**90,348,599**	**9,704,795**	**638,933**	**1,236,461,011**
Medical Loss Ratio	*99.5%*	*89.5%*	*74.5%*	*98.1%*	*98.4%*
GROSS MARGIN	**5,602,639**	**10,545,484**	**3,330,080**	**12,446**	**19,490,649**
ADMINISTRATIVE EXPENSES					
Salaries & Benefits	33,157,048	3,276,991	469,325	272,476	37,175,840
Non-Salary Operating Expenses	7,829,000	1,097,736	159,031	4,264	9,090,031
Depreciation & Amortization	2,153,380		2,817		2,156,196
Other Operating Expenses	6,816,955	81,288	17,808	21,420	6,937,471
Indirect Cost Allocation, Occupancy	(1,893,116)	2,951,868	48,962	19,057	1,126,772
Total Administrative Expenses	**48,063,267**	**7,407,883**	**697,943**	**317,217**	**56,486,311**
Administrative Loss Ratio	*4.2%*	*7.3%*	*5.4%*	*48.7%*	*4.5%*
Operating Income/(Loss)	**(42,460,628)**	**3,137,601**	**2,632,136**	**(304,771)**	**(36,995,662)**
Investments and Other Non-Operating	62,465				70,178,274
CHANGE IN NET ASSETS	**$ (42,398,163)**	**$ 3,137,601**	**$ 2,632,136**	**$ (304,771)**	**$ 33,182,612**
BUDGETED CHANGE IN NET ASSETS	(59,790,520)	(3,049,319)	(347,032)	(338,417)	(47,322,714)
Variance to Budget - Fav/(Unfav)	$ 17,392,357	$ 6,186,920	$ 2,979,168	$ 33,646	$ 80,505,326

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CalOptima Health

Unaudited Financial Statements as of September 30, 2024

MONTHLY RESULTS:

- Change in Net Assets is $30.0 million, favorable to budget $41.3 million
- Operating surplus is $7.7 million, with a surplus in non-operating income of $22.3 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $33.2 million, favorable to budget $80.5 million
- Operating deficit is $37.0 million, with a surplus in non-operating income of $70.2 million

Change in Net Assets by Line of Business (LOB) ($ millions):

September 2024				July - September 2024		
Actual	**Budget**	**Variance**	**Operating Income (Loss)**	**Actual**	**Budget**	**Variance**
5.0	(15.8)	20.8	Medi-Cal	(42.5)	(59.8)	17.3
1.8	(0.7)	2.5	OneCare	3.1	(3.0)	6.2
1.0	0.0	1.0	PACE	2.6	(0.3)	3.0
(0.1)	(0.1)	0.0	MSSP	(0.3)	(0.3)	0.0
7.7	**(16.7)**	**24.4**	**Total Operating Income (Loss)**	**(37.0)**	**(63.5)**	**26.5**
			Non-Operating Income (Loss)			
22.5	6.7	15.8	Net Investment Income/Expense	72.7	20.0	52.7
(0.1)	(0.1)	0.0	Net Rental Income/Expense	(0.1)	(0.4)	0.3
0.0	(1.2)	1.2	Grant Expense	(2.5)	(3.4)	0.9
0.0	0.0	0.0	Other Income/Expense	0.1	0.0	0.1
22.3	**5.4**	**16.9**	**Total Non-Operating Income/(Loss)**	**70.2**	**16.2**	**54.0**
30.0	**(11.3)**	**41.3**	**TOTAL**	**33.2**	**(47.3)**	**80.5**

CalOptima Health - Consolidated
Enrollment Summary
For the Three Months Ending September 30, 2024

September 2024					July - September 2024			
Actual	**Budget**	**$ Variance**	**%Variance**	**Enrollment (by Aid Category)**	**Actual**	**Budget**	**$ Variance**	**%Variance**
144,652	136,567	8,085	5.9%	SPD	433,367	408,570	24,797	6.1%
269,485	271,892	(2,407)	(0.9%)	TANF Child	812,510	819,103	(6,593)	(0.8%)
131,865	137,428	(5,563)	(4.0%)	TANF Adult	391,996	413,794	(21,798)	(5.3%)
2,480	2,598	(118)	(4.5%)	LTC	7,395	7,838	(443)	(5.7%)
337,385	321,770	15,615	4.9%	MCE	1,011,686	974,979	36,707	3.8%
9,849	9,549	300	3.1%	WCM	30,008	28,734	1,274	4.4%
895,716	**879,804**	**15,912**	**1.8%**	**Medi-Cal Total**	**2,686,962**	**2,653,018**	**33,944**	**1.3%**
17,282	**17,428**	**(146)**	**(0.8%)**	**OneCare**	**51,900**	**52,176**	**(276)**	**(0.5%)**
503	**473**	**30**	**6.3%**	**PACE**	**1,517**	**1,411**	**106**	**7.5%**
487	**568**	**(81)**	**(14.3%)**	**MSSP**	**1,440**	**1,704**	**(264)**	**(15.5%)**
913,501	**897,705**	**15,796**	**1.8%**	**CalOptima Health Total**	**2,740,379**	**2,706,605**	**33,774**	**1.2%**
				Enrollment (by Network)				
290,207	302,451	(12,244)	(4.0%)	HMO	876,175	911,888	(35,713)	(3.9%)
176,218	178,413	(2,195)	(1.2%)	PHC	532,544	537,983	(5,439)	(1.0%)
143,705	132,376	11,329	8.6%	Shared Risk Group	431,262	402,355	28,907	7.2%
285,586	266,564	19,022	7.1%	Fee for Service	846,981	800,792	46,189	5.8%
895,716	**879,804**	**15,912**	**1.8%**	**Medi-Cal Total**	**2,686,962**	**2,653,018**	**33,944**	**1.3%**
17,282	**17,428**	**(146)**	**(0)**	**OneCare**	**51,900**	**52,176**	**(276)**	**(0)**
503	**473**	**30**	**6.3%**	**PACE**	**1,517**	**1,411**	**106**	**7.5%**
487	**568**	**(81)**	**(14.3%)**	**MSSP**	**1,440**	**1,704**	**(264)**	**(15.5%)**
913,501	**897,705**	**15,796**	**1.8%**	**CalOptima Health Total**	**2,740,379**	**2,706,605**	**33,774**	**1.2%**

Note:* Total membership does not include MSSP

CalOptima Health
Enrollment Trend by Network
Fiscal Year 2025

	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	YTD Actual	YTD Budget	Variance
HMOs															
SPD	17,150	16,511	16,610										50,271	49,011	1,260
TANF Child	66,405	65,921	65,198										197,524	206,912	(9,388)
TANF Adult	54,590	55,734	55,056										165,380	188,925	(23,545)
LTC	2												2		2
MCE	153,578	153,602	152,129										459,309	462,903	(3,594)
WCM	1,241	1,234	1,214										3,689	4,137	(448)
Total	292,966	293,002	290,207										876,175	911,888	**(35,713)**
PHCs															
SPD	4,906	4,644	4,820										14,370	13,536	834
TANF Child	140,053	138,903	137,874										416,830	425,367	(8,537)
TANF Adult	3,994	4,186	4,191										12,371	14,721	(2,350)
LTC													0		0
MCE	22,999	22,762	22,600										68,361	64,997	3,364
WCM	6,571	7,308	6,733										20,612	19,362	1,250
Total	178,523	177,803	176,218										532,544	537,983	**(5,439)**
Shared Risk Groups															
SPD	7,270	7,077	7,057										21,404	19,455	1,949
TANF Child	32,783	32,842	32,545										98,170	94,894	3,276
TANF Adult	27,519	29,041	28,870										85,430	87,186	(1,756)
LTC													0	3	(3)
MCE	74,704	74,918	74,517										224,139	198,614	25,525
WCM	702	701	716										2,119	2,203	(84)
Total	**142,978**	**144,579**	**143,705**										**431,262**	**402,355**	**28,907**
Fee for Service (Dual)															
SPD	100,293	99,792	100,297										300,382	282,439	17,943
TANF Child													0	5	(5)
TANF Adult	1,145	1,159	1,123										3,427	5,442	(2,015)
LTC	2,178	2,203	2,209										6,590	7,009	(419)
MCE	4,008	4,703	4,593										13,304	27,021	(13,717)
WCM	6	7	8										21	27	(6)
Total	**107,630**	**107,864**	**108,230**										**323,724**	**321,943**	**1,781**
Fee for Service (Non-Dual - Total)															
SPD	15,636	15,436	15,868										46,940	44,129	2,811
TANF Child	32,741	33,377	33,868										99,986	91,925	8,061
TANF Adult	40,618	42,145	42,625										125,388	117,520	7,868
LTC	278	254	271										803	826	(23)
MCE	80,536	82,491	83,546										246,573	221,444	25,129
WCM	1,205	1,184	1,178										3,567	3,005	562
Total	**171,014**	**174,887**	**177,356**										**523,257**	**478,849**	**44,408**
Grand Totals															
SPD	145,255	143,460	144,652										433,367	408,570	24,797
TANF Child	271,982	271,043	269,485										812,510	819,103	(6,593)
TANF Adult	127,866	132,265	131,865										391,996	413,794	(21,798)
LTC	2,458	2,457	2,480										7,395	7,838	(443)
MCE	335,825	338,476	337,385										1,011,686	974,979	36,707
WCM	9,725	10,434	9,849										30,008	28,734	1,274
Total MediCal MM	**893,111**	**898,135**	**895,716**										**2,686,962**	**2,653,018**	**33,944**
OneCare	**17,311**	**17,307**	**17,282**										**51,900**	**52,176**	**(276)**
PACE	**506**	**508**	**503**										**1,517**	**1,411**	**106**
MSSP	**473**	**480**	**487**										**1,440**	**1,704**	**(264)**
Grand Total	**910,928**	**915,950**	**913,501**										**2,740,379**	**2,706,605**	**33,774**

Note:* Total membership does not include MSSP

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ENROLLMENT:

Overall, September enrollment was 913,501

- Favorable to budget 15,796 or 1.8%
- Decreased 2,449 or 0.3% from Prior Month (PM) (August 2024)
- Decreased 65,647 or 6.7% from Prior Year (PY) (September 2023)

Medi-Cal enrollment was 895,716

- Favorable to budget 15,912 or 1.8%
- Medi-Cal Expansion (MCE) favorable to budget 15,615
- Seniors and Persons with Disabilities (SPD) favorable to budget 8,085
- Whole Child Model (WCM) favorable to budget 300
- Temporary Assistance for Needy Families (TANF) unfavorable to budget 7,970
- Long-Term Care (LTC) unfavorable to budget 118
- Decreased 2,419 from PM

OneCare enrollment was 17,282

- Unfavorable to budget 146 or 0.8%
- Decreased 25 from PM

PACE enrollment was 503

- Favorable to budget 30 or 6.3%
- Decreased 5 from PM

MSSP enrollment was 487

- Unfavorable to budget 81 or 14.3%
- Increased 7 from PM

CalOptima Health
Medi-Cal
Statement of Revenues and Expenses
For the Three Months Ending September 30, 2024

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
895,716	**879,804**	**15,912**	**1.8%**	**Member Months**	**2,686,962**	**2,653,018**	**33,944**	**1.3%**
				Revenues				
489,892,830	315,447,769	174,445,061	55.3%	Medi-Cal Capitation Revenue	1,141,371,322	950,458,623	190,912,699	20.1%
489,892,830	**315,447,769**	**174,445,061**	**55.3%**	**Total Operating Revenue**	**1,141,371,322**	**950,458,623**	**190,912,699**	**20.1%**
				Medical Expenses				
116,680,117	111,265,347	(5,414,770)	(4.9%)	Provider Capitation	336,463,033	335,757,033	(706,000)	(0.2%)
65,953,556	63,450,932	(2,502,624)	(3.9%)	Facilities Claims	216,320,102	194,881,866	(21,438,236)	(11.0%)
69,745,016	68,387,889	(1,357,127)	(2.0%)	Professional Claims	219,563,376	209,794,282	(9,769,094)	(4.7%)
48,601,129	47,531,559	(1,069,570)	(2.3%)	MLTSS	149,488,843	145,636,928	(3,851,915)	(2.6%)
15,026,973	10,132,225	(4,894,748)	(48.3%)	Incentive Payments	38,797,385	30,611,149	(8,186,236)	(26.7%)
7,638,527	8,778,603	1,140,076	13.0%	Medical Management	24,122,559	27,041,488	2,918,929	10.8%
145,790,103	1,830,209	(143,959,894)	(7,865.8%)	Other Medical Expenses	151,013,386	5,490,627	(145,522,759)	(2,650.4%)
469,435,421	**311,376,764**	**(158,058,657)**	**(50.8%)**	**Total Medical Expenses**	**1,135,768,684**	**949,213,373**	**(186,555,311)**	**(19.7%)**
20,457,408	**4,071,005**	**16,386,403**	**402.5%**	**Gross Margin**	**5,602,639**	**1,245,250**	**4,357,389**	**349.9%**
				Administrative Expenses				
10,459,674	11,579,157	1,119,483	9.7%	Salaries, Wages & Employee Benefits	33,157,048	35,952,822	2,795,774	7.8%
873,443	1,434,418	560,975	39.1%	Professional Fees	2,345,669	4,183,254	1,837,585	43.9%
1,198,746	2,237,410	1,038,664	46.4%	Purchased Services	4,489,002	6,708,745	2,219,743	33.1%
595,176	525,341	(69,835)	(13.3%)	Printing & Postage	994,330	1,676,204	681,874	40.7%
719,097	1,026,358	307,261	29.9%	Depreciation & Amortization	2,153,380	3,079,074	925,694	30.1%
2,346,172	3,712,715	1,366,543	36.8%	Other Operating Expenses	6,816,955	11,254,964	4,438,009	39.4%
(711,998)	(606,431)	105,567	17.4%	Indirect Cost Allocation, Occupancy	(1,893,116)	(1,819,293)	73,823	4.1%
15,480,311	**19,908,968**	**4,428,657**	**22.2%**	**Total Administrative Expenses**	**48,063,267**	**61,035,770**	**12,972,503**	**21.3%**
				Non-Operating Income (Loss)				
2,614	-	2,614	100.0%	Net Operating Tax	6,753	-	6,753	100.0%
490	-	490	100.0%	Other Income/Expense	55,712	-	55,712	100.0%
3,104	**-**	**3,104**	**100.0%**	**Total Non-Operating Income (Loss)**	**62,465**	**-**	**62,465**	**100.0%**
4,980,202	**(15,837,963)**	**20,818,165**	**131.4%**	**Change in Net Assets**	**(42,398,163)**	**(59,790,520)**	**17,392,357**	**29.1%**
95.8%	***98.7%***	***(2.9%)***		***Medical Loss Ratio***	***99.5%***	***99.9%***	***(0.4%)***	
3.2%	***6.3%***	***3.2%***		***Admin Loss Ratio***	***4.2%***	***6.4%***	***2.2%***	

MEDI-CAL INCOME STATEMENT– SEPTEMBER MONTH:

REVENUES of $489.9 million are favorable to budget $174.4 million driven by:

- Favorable volume related variance of $5.7 million
- Favorable price related variance of $168.7 million
  - $142.4 million due to Calendar Year (CY) 2022 Hospital Directed Payments (DP)
  - $19.7 million due to net release of accruals relating to the updated CY 2024 premium capitation rates received from the Department of Health Care Services (DHCS)

MEDICAL EXPENSES of $469.4 million are unfavorable to budget $158.1 million driven by:

- Unfavorable volume related variance of $5.6 million
- Unfavorable price related variance of $152.4 million due to:
  - Other Medical Expenses unfavorable variance of $143.9 million due primarily to CY 2022 DP and Board-approved provider rate increases
  - Incentive Payments expenses unfavorable variance of $4.7 million
  - Provider Capitation expenses unfavorable variance of $3.4 million
  - Facilities Claims expenses unfavorable variance of $1.4 million
  - Managed Long-Term Services and Supports (MLTSS) expenses unfavorable variance of $0.2 million
  - Professional Claims expenses unfavorable variance of $0.1 million
  - Offset by Medical Management expenses favorable variance of $1.3 million

ADMINISTRATIVE EXPENSES of $15.5 million are favorable to budget $4.4 million driven by:

- Non-Salary expenses favorable to budget $3.3 million
- Salaries, Wages & Employee Benefits expense favorable to budget $1.1 million

CHANGE IN NET ASSETS is $5.0 million, favorable to budget $20.8 million

CalOptima Health
OneCare
Statement of Revenues and Expenses
For the Three Months Ending September 30, 2024

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
17,282	**17,428**	**(146)**	**(0.8%)**	**Member Months**	**51,900**	**52,176**	**(276)**	**(0.5%)**
				Revenues				
24,169,264	25,569,092	(1,399,828)	(5.5%)	Medicare Part C Revenue	73,533,483	77,036,242	(3,502,759)	(4.5%)
6,993,863	9,389,301	(2,395,438)	(25.5%)	Medicare Part D Revenue	27,360,599	28,125,513	(764,914)	(2.7%)
31,163,127	**34,958,393**	**(3,795,266)**	**(10.9%)**	**Total Operating Revenue**	**100,894,082**	**105,161,755**	**(4,267,673)**	**(4.1%)**
				Medical Expenses				
14,436,141	15,616,242	1,180,101	7.6%	Provider Capitation	44,580,487	47,045,722	2,465,235	5.2%
3,521,217	4,679,512	1,158,295	24.8%	Inpatient	11,727,999	14,263,723	2,535,724	17.8%
1,630,059	1,701,286	71,227	4.2%	Ancillary	5,277,793	5,189,619	(88,174)	(1.7%)
5,204,434	8,678,405	3,473,971	40.0%	Prescription Drugs	24,485,409	26,596,275	2,110,866	7.9%
905,466	525,266	(380,200)	(72.4%)	Incentive Payments	1,262,888	1,538,973	276,085	17.9%
976,983	1,332,950	355,967	26.7%	Medical Management	3,014,022	4,112,569	1,098,547	26.7%
26,674,300	**32,533,661**	**5,859,361**	**18.0%**	**Total Medical Expenses**	**90,348,599**	**98,746,881**	**8,398,282**	**8.5%**
4,488,827	**2,424,732**	**2,064,095**	**85.1%**	**Gross Margin**	**10,545,484**	**6,414,874**	**4,130,610**	**64.4%**
				Administrative Expenses				
1,043,179	1,166,177	122,998	10.5%	Salaries, Wages & Employee Benefits	3,276,991	3,616,233	339,242	9.4%
301,001	121,483	(179,518)	(147.8%)	Professional Fees	313,436	325,649	12,213	3.8%
202,651	436,300	233,649	53.6%	Purchased Services	485,107	1,347,700	862,593	64.0%
137,041	243,950	106,909	43.8%	Printing & Postage	299,193	731,850	432,657	59.1%
60,738	121,504	60,767	50.0%	Other Operating Expenses	81,288	364,512	283,224	77.7%
910,908	1,026,083	115,175	11.2%	Indirect Cost Allocation, Occupancy	2,951,868	3,078,249	126,381	4.1%
2,655,518	**3,115,497**	**459,979**	**14.8%**	**Total Administrative Expenses**	**7,407,883**	**9,464,193**	**2,056,310**	**21.7%**
1,833,309	**(690,765)**	**2,524,074**	**365.4%**	**Change in Net Assets**	**3,137,601**	**(3,049,319)**	**6,186,920**	**202.9%**
85.6%	***93.1%***	***(7.5%)***		***Medical Loss Ratio***	***89.5%***	***93.9%***	***(4.4%)***	
8.5%	***8.9%***	***0.4%***		***Admin Loss Ratio***	***7.3%***	***9.0%***	***1.7%***	

ONECARE INCOME STATEMENT– SEPTEMBER MONTH:

REVENUES of $31.2 million are unfavorable to budget $3.8 million driven by:

- Unfavorable volume related variance of $0.3 million
- Unfavorable price related variance of $3.5 million due to changes to the Part D payment reconciliation estimates

MEDICAL EXPENSES of $26.7 million are favorable to budget $5.9 million driven by:

- Favorable volume related variance of $0.3 million
- Favorable price related variance of $5.6 million due to increase in prescription drug rebates received and lower than expected utilization

ADMINISTRATIVE EXPENSES of $2.7 million are favorable to budget $0.5 million driven by:

- Non-Salary expenses favorable to budget $0.3 million
- Salaries, Wages & Employee Benefits expense favorable to budget $0.1 million

CHANGE IN NET ASSETS is $1.8 million, favorable to budget $2.5 million

CalOptima Health
PACE
Statement of Revenues and Expenses
For the Three Months Ending September 30, 2024

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
503	**473**	**30**	**6.3%**	**Member Months**	**1,517**	**1,411**	**106**	**7.5%**
				Revenues				
3,240,937	2,969,540	271,397	9.1%	Medi-Cal Capitation Revenue	9,741,402	8,862,277	879,125	9.9%
770,887	716,606	54,281	7.6%	Medicare Part C Revenue	2,311,193	2,154,651	156,542	7.3%
276,237	236,767	39,470	16.7%	Medicare Part D Revenue	982,279	708,422	273,857	38.7%
4,288,061	**3,922,913**	**365,148**	**9.3%**	**Total Operating Revenue**	**13,034,875**	**11,725,350**	**1,309,525**	**11.2%**
				Medical Expenses				
1,232,966	1,327,823	94,857	7.1%	Medical Management	3,701,085	4,097,397	396,312	9.7%
535,468	723,348	187,880	26.0%	Facilities Claims	1,649,843	2,202,715	552,872	25.1%
544,563	798,243	253,680	31.8%	Professional Claims	1,803,173	2,427,031	623,858	25.7%
563,421	530,343	(33,078)	(6.2%)	Prescription Drugs	1,857,464	1,610,149	(247,315)	(15.4%)
4,657	24,061	19,404	80.6%	MLTSS	19,645	64,904	45,259	69.7%
194,413	260,447	66,034	25.4%	Patient Transportation	673,586	781,341	107,755	13.8%
3,075,488	**3,664,265**	**588,777**	**16.1%**	**Total Medical Expenses**	**9,704,795**	**11,183,537**	**1,478,742**	**13.2%**
1,212,573	**258,648**	**953,925**	**368.8%**	**Gross Margin**	**3,330,080**	**541,813**	**2,788,267**	**514.6%**
				Administrative Expenses				
147,712	166,095	18,383	11.1%	Salaries, Wages & Employee Benefits	469,325	516,619	47,294	9.2%
2,292	8,708	6,416	73.7%	Professional Fees	4,583	26,424	21,841	82.7%
46,265	60,033	13,768	22.9%	Purchased Services	152,197	180,099	27,902	15.5%
1,127	24,525	23,398	95.4%	Printing & Postage	2,251	73,575	71,324	96.9%
939	1,600	661	41.3%	Depreciation & Amortization	2,817	4,800	1,983	41.3%
5,207	12,698	7,491	59.0%	Other Operating Expenses	17,808	37,794	19,986	52.9%
20,195	16,568	(3,627)	(21.9%)	Indirect Cost Allocation, Occupancy	48,962	49,534	572	1.2%
223,737	**290,227**	**66,490**	**22.9%**	**Total Administrative Expenses**	**697,943**	**888,845**	**190,902**	**21.5%**
988,836	**(31,579)**	**1,020,415**	**3,231.3%**	**Change in Net Assets**	**2,632,136**	**(347,032)**	**2,979,168**	**858.5%**
71.7%	***93.4%***	***(21.7%)***		***Medical Loss Ratio***	***74.5%***	***95.4%***	***(20.9%)***	
5.2%	***7.4%***	***2.2%***		***Admin Loss Ratio***	***5.4%***	***7.6%***	***2.2%***	

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CalOptima Health
Multipurpose Senior Services Program
Statement of Revenues and Expenses
For the Three Months Ending September 30, 2024

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
487	**568**	**(81)**	**(14.3%)**	**Member Months**	**1,440**	**1,704**	**(264)**	**(15.5%)**
				Revenues				
222,093	253,517	(31,424)	(12.4%)	Revenue	651,380	760,551	(109,171)	(14.4%)
222,093	**253,517**	**(31,424)**	**(12.4%)**	**Total Operating Revenue**	**651,380**	**760,551**	**(109,171)**	**(14.4%)**
				Medical Expenses				
186,047	207,784	21,737	10.5%	Medical Management	539,276	623,352	84,076	13.5%
35,516	32,957	(2,559)	(7.8%)	Waiver Services	99,657	98,871	(786)	(0.8%)
186,047	207,784	21,737	10.5%	Total Medical Management	539,276	623,352	84,076	13.5%
35,516	32,957	(2,559)	(7.8%)	Total Waiver Services	99,657	98,871	(786)	(0.8%)
221,563	**240,741**	**19,178**	**8.0%**	**Total Program Expenses**	**638,933**	**722,223**	**83,290**	**11.5%**
530	**12,776**	**(12,246)**	**(95.9%)**	**Gross Margin**	**12,446**	**38,328**	**(25,882)**	**(67.5%)**
				Administrative Expenses				
92,500	104,955	12,455	11.9%	Salaries, Wages & Employee Benefits	272,476	325,745	53,269	16.4%
1,417	1,417	0	0.0%	Professional Fees	4,250	4,251	1	0.0%
14	-	(14)	(100.0%)	Purchased Services	14	-	(14)	(100.0%)
7,579	8,250	671	8.1%	Other Operating Expenses	21,420	24,750	3,330	13.5%
4,397	7,333	2,936	40.0%	Indirect Cost Allocation, Occupancy	19,057	21,999	2,942	13.4%
105,907	**121,955**	**16,048**	**13.2%**	**Total Administrative Expenses**	**317,217**	**376,745**	**59,528**	**15.8%**
(105,377)	**(109,179)**	**3,802**	**3.5%**	**Change in Net Assets**	**(304,771)**	**(338,417)**	**33,646**	**9.9%**
99.8%	***95.0%***	***4.8%***		***Medical Loss Ratio***	***98.1%***	***95.0%***	***3.1%***	
47.7%	***48.1%***	***0.4%***		***Admin Loss Ratio***	***48.7%***	***49.5%***	***0.8%***	

CalOptima Health
Building - 505 City Parkway
Statement of Revenues and Expenses
For the Three Months Ending September 30, 2024

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
				Revenues				
-	-	-	0.0%	Rental Income	-	-	-	0.0%
-	-	-	**0.0%**	**Total Operating Revenue**	-	-	-	**0.0%**
				Administrative Expenses				
42,470	22,905	(19,565)	(85.4%)	Purchased Services	134,646	68,715	(65,931)	(95.9%)
181,030	195,000	13,970	7.2%	Depreciation & Amortization	542,360	585,000	42,640	7.3%
24,795	26,654	1,859	7.0%	Insurance Expense	74,384	79,962	5,578	7.0%
120,133	181,186	61,053	33.7%	Repair & Maintenance	332,791	543,558	210,767	38.8%
70,640	56,824	(13,816)	(24.3%)	Other Operating Expenses	247,135	170,472	(76,663)	(45.0%)
(439,066)	(482,569)	(43,503)	(9.0%)	Indirect Cost Allocation, Occupancy	(1,331,316)	(1,447,707)	(116,391)	(8.0%)
-	-	-	**0.0%**	**Total Administrative Expenses**	-	-	-	**0.0%**
-	-	-	**0.0%**	**Change in Net Assets**	-	-	-	**0.0%**

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CalOptima Health
Building - 500 City Parkway
Statement of Revenues and Expenses
For the Three Months Ending September 30, 2024

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
				Revenues				
156,423	135,866	20,557	15.1%	Rental Income	469,270	407,598	61,672	15.1%
156,423	**135,866**	**20,557**	**15.1%**	**Total Operating Revenue**	**469,270**	**407,598**	**61,672**	**15.1%**
				Administrative Expenses				
-	-	-	0.0%	Professional Fees	-	-	-	0.0%
34,890	9,330	(25,560)	(274.0%)	Purchased Services	104,080	27,990	(76,090)	(271.8%)
34,573	51,000	16,427	32.2%	Depreciation & Amortization	103,719	153,000	49,281	32.2%
8,676	8,746	70	0.8%	Insurance Expense	24,947	26,238	1,291	4.9%
35,978	94,592	58,614	62.0%	Repair & Maintenance	129,691	283,776	154,085	54.3%
32,410	25,978	(6,432)	(24.8%)	Other Operating Expenses	135,632	77,934	(57,698)	(74.0%)
93,329	-	(93,329)	(100.0%)	Indirect Cost Allocation, Occupancy	(52,746)	-	52,746	100.0%
239,856	**189,646**	**(50,210)**	**(26.5%)**	**Total Administrative Expenses**	**445,322**	**568,938**	**123,616**	**21.7%**
(83,433)	**(53,780)**	**(29,653)**	**(55.1%)**	**Change in Net Assets**	**23,948**	**(161,340)**	**185,288**	**114.8%**

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CalOptima Health
Building - 7900 Garden Grove Blvd
Statement of Revenues and Expenses
For the Three Months Ending September 30, 2024

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
				Revenues				
-	-	-	0.0%	Rental Income	9,600	-	9,600	100.0%
-	**-**	**-**	**0.0%**	**Total Operating Revenue**	**9,600**	**-**	**9,600**	**100.0%**
				Administrative Expenses				
-	-	-	0.0%	Professional Fees	-	-	-	0.0%
29,962	42,500	12,538	29.5%	Purchased Services	80,939	127,500	46,561	36.5%
9,397	21,000	11,603	55.3%	Depreciation & Amortization	28,192	63,000	34,808	55.3%
4,415	-	(4,415)	(100.0%)	Insurance Expense	13,244	-	(13,244)	(100.0%)
298	-	(298)	(100.0%)	Repair & Maintenance	893	-	(893)	(100.0%)
583	-	(583)	(100.0%)	Other Operating Expenses	2,479	-	(2,479)	(100.0%)
-	-	-	0.0%	Indirect Cost Allocation, Occupancy	-	-	-	0.0%
44,655	**63,500**	**18,845**	**29.7%**	**Total Administrative Expenses**	**125,747**	**190,500**	**64,753**	**34.0%**
(44,655)	**(63,500)**	**18,845**	**29.7%**	**Change in Net Assets**	**(116,147)**	**(190,500)**	**74,353**	**39.0%**

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OTHER PROGRAM INCOME STATEMENTS – SEPTEMBER MONTH:

PACE

- **CHANGE IN NET ASSETS** is $1.0 million, favorable to budget $1.0 million driven primarily by favorable enrollment and medical expenses

MSSP

- **CHANGE IN NET ASSETS** is ($105,377), favorable to budget $3,802 due primarily to favorable Salaries, Wages and Employee Benefits expenses

NON-OPERATING INCOME STATEMENTS – SEPTEMBER MONTH

BUILDING 500

- **CHANGE IN NET ASSETS** is ($83,433), unfavorable to budget $29,653
  - Net of $156,423 in rental income and $239,856 in expenses

BUILDING 7900

- **CHANGE IN NET ASSETS** is ($44,655), favorable to budget $18,845

INVESTMENT INCOME

- Favorable variance of $15.8 million due to $8.5 million of interest income and $7.3 million of realized and unrealized gain on investments

CalOptima Health
Balance Sheet
September 30, 2024

		September-24	August-24	$ Change	% Change
ASSETS					
Current Assets					
	Cash and Cash Equivalents	594,419,494	622,026,017	(27,606,523)	(4.4%)
	Short-term Investments	1,746,560,045	1,718,793,400	27,766,645	1.6%
	Premiums due from State of CA and CMS	678,504,967	522,619,056	155,885,911	29.8%
	Prepaid Expenses and Other	12,803,262	13,430,249	(626,987)	(4.7%)
	Total Current Assets	**3,032,287,768**	**2,876,868,723**	**155,419,046**	**5.4%**
Board Designated Assets					
	Board Designated Reserves	1,036,123,723	1,027,460,092	8,663,631	0.8%
	Statutory Designated Reserves	136,448,560	135,204,247	1,244,313	0.9%
	Total Designated Assets	**1,172,572,283**	**1,162,664,339**	**9,907,944**	**0.9%**
Restricted Deposit		**300,000**	**300,000**	**-**	**0.0%**
Capital Assets, Net		103,887,079	104,139,779	(252,699)	(0.2%)
Total Assets		**4,309,047,131**	**4,143,972,841**	**165,074,290**	**4.0%**
Deferred Outflows of Resources					
	Advance Discretionary Payment	49,999,717	49,999,717	-	0.0%
	Net Pension	24,549,290	24,549,290	-	0.0%
	Other Postemployment Benefits	1,350,000	1,350,000	-	0.0%
	Total Deferred Outflows of Resources	**75,899,007**	**75,899,007**	**-**	**0.0%**
TOTAL ASSETS AND DEFERRED OUTFLOWS OF RESOURCES		**4,384,946,138**	**4,219,871,848**	**165,074,290**	**3.9%**
LIABILITIES					
Current Liabilities					
	Medical Claims Liability	1,147,863,597	1,184,240,188	(36,376,591)	(3.1%)
	Provider Capitation and Withholds	175,031,470	164,897,896	10,133,574	6.1%
	Accrued Reinsurance Costs to Providers	6,290,371	12,711,531	(6,421,160)	(50.5%)
	Unearned Revenue	17,952,241	49,940,490	(31,988,249)	(64.1%)
	Accounts Payable and Other	336,158,208	135,669,296	200,488,912	147.8%
	Accrued Payroll and Employee Benefits and Other	23,921,387	22,969,190	952,197	4.1%
	Other Current Liabilities	6,701	10,032	(3,331)	(33.2%)
	Total Current Liabilities	**1,707,223,977**	**1,570,438,623**	**136,785,353**	**8.7%**
GASB 96 Subscription Liabilities		21,616,375	21,616,375	0	0.0%
Community Reinvestment		105,737,300	107,479,220	(1,741,920)	(1.6%)
Postemployment Health Care Plan		17,475,895	17,459,050	16,845	0.1%
Net Pension Liability		45,981,359	45,981,359	-	0.0%
Total Liabilities		**1,898,034,906**	**1,762,974,627**	**135,060,278**	**7.7%**
Deferred Inflows of Resources					
	Net Pension	2,248,445	2,248,445	-	0.0%
	Other Postemployment Benefits	6,398,000	6,398,000	-	0.0%
	Total Deferred Inflows of Resources	**8,646,445**	**8,646,445**	**-**	**0.0%**
Net Position					
	Required TNE	131,917,008	131,121,016	795,992	0.6%
	Funds in excess of TNE	2,346,347,779	2,317,129,759	29,218,020	1.3%
	Total Net Position	**2,478,264,787**	**2,448,250,775**	**30,014,012**	**1.2%**
TOTAL LIABILITIES & DEFERRED INFLOWS & NET POSITION		**4,384,946,138**	**4,219,871,848**	**165,074,290**	**3.9%**

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BALANCE SHEET – SEPTEMBER MONTH:

ASSETS of $4.4 billion increased $165.1 million from August or 3.9%

- Premiums due from State of California (CA) and Centers for Medicare & Medicaid Services (CMS) increased $155.9 million primarily due to an increase in the CY 2024 Managed Care Organization (MCO) tax rate. CalOptima Health anticipates the payment to be received from DHCS in January 2025
- Total Designated Assets increased $9.9 million due to interest income, realized gains and change in unrealized gains in long-term investments

LIABILITIES of $1.9 billion increased $135.1 million from August or 7.7%

- Accounts Payable and Other increased $200.5 million due primarily to additional liabilities due to the increase in CY 2024 MCO tax
- Medical Claims Liabilities decreased $36.4 million due to timing of claim payments
- Unearned Revenue decreased $32.0 million due to timing of capitation payments received from CMS for September that was received in August

NET ASSETS of $2.5 billion, increased $30.0 million from September or 1.2%

CalOptima Health
Board Designated Reserve and TNE Analysis
as of September 30, 2024

Board Designated Reserves

Investment Account Name	Market Value	Benchmark		Variance	
		Low	High	Mkt - Low	Mkt - High
Payden & Rygel Tier One	518,158,442				
MetLife Tier One	517,965,281				
Board Designated Reserves	1,036,123,723	932,399,027	1,118,878,833	103,724,696	(82,755,110)
Current Reserve Level (X months of average monthly revenue) [1]	*2.78*	*2.50*	*3.00*		

Statutory Designated Reserves

Investment Account Name	Market Value	Benchmark		Variance	
		Low	High	Mkt - Low	Mkt - High
Payden & Rygel Tier Two	68,365,839				
MetLife Tier Two	68,082,721				
Statutory Designated Reserves	136,448,560	131,917,008	145,108,709	4,531,552	(8,660,149)
Current Reserve Level (X min. TNE) [1]	*1.03*	*1.00*	*1.10*		

[1] *See CalOptima Health policy GA.3001 Statutory and Board-Designasted Reserve Funds for more information*

CalOptima Health
Statement of Cash Flow
September 30, 2024

	September 2024	July - September 2024
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	30,014,012	33,182,612
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Depreciation & Amortization	945,036	2,830,467
Changes in assets and liabilities:		
Prepaid expenses and other	626,987	(1,634,143)
Capitation receivable	(155,885,911)	(123,818,483)
Medical claims liability	(42,797,751)	2,309,843
Deferred revenue	(31,988,249)	2,691,078
Payable to health networks	10,133,574	(1,202,224)
Accounts payable	200,488,912	163,838,602
Accrued payroll	969,042	(1,859,386)
Other accrued liabilities	(1,745,251)	3,711,498
Net cash provided by/(used in) operating activities	10,760,402	80,049,866
GASB 68, GASB 75 and Advance Discretionary Payment Adjustments	-	-
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES:		
Net Asset transfer from Foundation	-	-
Net cash provided by (used in) in capital and related financing activities	-	-
CASH FLOWS FROM INVESTING ACTIVITIES		
Change in Investments	(27,766,645)	31,335,894
Change in Property and Equipment	(692,337)	(10,156,739)
Change in Restricted Deposit & Other	-	-
Change in Board designated reserves	(9,907,944)	(34,808,845)
Change in Homeless Health Reserve	-	-
Net cash provided by/(used in) investing activities	(38,366,926)	(13,629,689)
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	(27,606,523)	66,420,177
CASH AND CASH EQUIVALENTS, beginning of period	622,026,017	527,999,317
CASH AND CASH EQUIVALENTS, end of period	**594,419,494**	**594,419,494**

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CalOptima Health
Spending Plan
For the Three Months Ending September 30, 2024

Category	Item Description	Amount (millions)	Approved Initiative	Expense to Date	%
	Total Net Position @ 9/30/2024	**$2,478.3**			**100.0%**
Resources Assigned	Board Designated Reserve[1]	**$1,036.1**			**41.8%**
	Statutory Designated Reserve[1]	**$136.4**			**5.5%**
	Capital Assets, net of Depreciation[2]	**$103.9**			**4.2%**
Resources Allocated[3]	Homeless Health Initiative[4]	$17.1	$61.7	44.6	0.7%
	Housing and Homelessness Incentive Program[4]	22.3	87.4	65.1	0.9%
	Intergovernmental Transfers (IGT)	55.0	111.7	56.7	2.2%
	Digital Transformation and Workplace Modernization[5]	53.3	100.0	46.7	2.2%
	CalFresh Outreach Strategy	0.1	2.0	1.9	0.0%
	CalFresh and Redetermination Outreach Strategy	2.0	6.0	4.0	0.1%
	Coalition of Orange County Community Health Centers Grant	30.0	50.0	20.0	1.2%
	OneCare Member Health Rewards and Incentives	0.2	0.5	0.3	0.0%
	General Awareness Campaign	1.3	4.7	3.4	0.1%
	Member Health Needs Assessment	1.1	1.3	0.2	0.0%
	Five-Year Hospital Quality Program Beginning MY 2023	132.9	153.5	20.6	5.4%
	Medi-Cal Annual Wellness Initiative	2.5	3.8	1.3	0.1%
	Skilled Nursing Facility Access Program	10.0	10.0	0.0	0.4%
	In-Home Care Pilot Program with the UCI Family Health Center	2.0	2.0	0.0	0.1%
	National Alliance for Mental Illness Orange County Peer Support Program Grant	3.5	5.0	1.5	0.1%
	Community Living and PACE center (previously approved for project located in Tustin)	17.6	18.0	0.4	0.7%
	Wellness & Prevention Program Grant	2.1	2.7	0.6	0.1%
	CalOptima Health Provider Workforce Development Fund Grant	45.6	50.0	4.4	1.8%
	Distribution Event- Naloxone Grant	2.3	15.0	12.7	0.1%
	Garden Grove Bldg. Improvement	10.0	10.5	0.5	0.4%
	Post-Pandemic Supplemental	7.6	107.5	99.9	0.3%
	CalOptima Health Community Reinvestment Program	38.0	38.0	0.0	1.5%
	Dyadic Services Program Academy	1.0	1.9	0.9	0.0%
	Outreach Strategy for newly eligible Adult Expansion members	4.2	5.0	0.8	0.2%
	Quality Initiatives from unearned Pay for Value Program	23.3	23.3	0.0	0.9%
	Expansion of CalOptima Health OC Outreach and Engagement Strategy	0.7	1.0	0.3	0.0%
	Medi-Cal Provider Rate Increases	473.6	526.2	52.6	19.1%
	Subtotal:	**$959.3**	**$1,398.7**	**$439.4**	**38.7%**
Resources Available for New Initiatives	Unallocated/Unassigned[1]	**$242.5**			**9.8%**

[1] Total Designated Reserves and unallocated reserve amount can support approximately 119 days of CalOptima Health's current operations
[2] Increase due to the adoption of GASB 96 Subscription-Based Information Technology Arrangements
[3] Initiatives that have been paid in full in the previous year are omitted from the list of Resources Allocated
[4] See HHI and HHIP summaries and Allocated Funds for list of Board approved initiatives. Amount reported includes only portion funded by reserves
[5] On June 6, 2024, the Board of Directors approved an update to the Digital Transformation Strategy which will impact these figures beginning July 2024

CalOptima Health
Key Financial Indicators
As of September 30, 2024

	Item Name	September 2024					July - September 2024				
		Actual	Budget	Variance	%		Actual	Budget	Variance	%	
Income Statement	*Member Months*	913,501	897,705	15,796	1.8%		2,740,379	2,706,605	33,774	1.2%	
	Operating Revenue	525,566,111	354,582,592	170,983,519	48.2%		1,255,951,660	1,068,106,279	187,845,381	17.6%	
	Medical Expenses	499,406,773	347,815,431	(151,591,342)	(43.6%)		1,236,461,011	1,059,866,014	(176,594,997)	(16.7%)	
	General and Administrative Expense	18,465,473	23,436,647	4,971,174	21.2%		56,486,311	71,765,553	15,279,242	21.3%	
	Non-Operating Income/(Loss)	22,320,146	5,370,555	16,949,591	315.6%		70,178,274	16,202,574	(53,975,700)	(333.1%)	
	Summary of Income & Expenses	30,014,012	(11,298,931)	41,312,943	365.6%		33,182,612	(47,322,714)	80,505,326	170.1%	
Ratios	Medical Loss Ratio (MLR)	Actual	Budget	Variance			Actual	Budget	Variance		
	Consolidated	95.0%	98.1%	(3.1%)			98.4%	99.2%	(0.8%)		
	Administrative Loss Ratio (ALR)	Actual	Budget	Variance			Actual	Budget	Variance		
	Consolidated	3.5%	6.6%	3.1%			4.5%	6.7%	2.2%		

Key:

> 0%
> -20%, < 0%
< -20%

Investment	Investment Balance (excluding CCE)	Current Month	Prior Month	Change	%
	@9/30/2024	2,888,632,805	2,837,740,160	50,892,644	1.8%

Unallocated/Unassigned Reserve Balance	Current Month @ September 2024	Fiscal Year Ending June 2024	Change	%
Consolidated	242,520,895	187,643,914	54,876,980	29.2%
*Days Cash On Hand**	119			

*Total Designated Reserves and unallocated reserve amount can support approximately 119 days of CalOptima Health's current operations.

CalOptima Health
Digital Transformation Strategy ($100 million total reserve)
Funding Balance Tracking Summary
For the Three Months Ending September 30, 2024

	September 2024				July - September 2024				All Time to Date			
	Actual Spend	**Approved Budget**	**Variance $**	**Variance %**	**Actual Spend**	**Approved Budget**	**Variance $**	**Variance %**	**Actual Spend**	**Approved Budget**	**Variance $**	**Variance %**
Capital Assets (Cost, Information Only):												
Total Capital Assets	**612,817**	**114,923**	**(497,894)**	**(433.2%)**	**1,798,003**	**315,679**	**(1,482,324)**	**(469.6%)**	**10,240,863**	**24,316,388**	**14,075,525**	**57.9%**
Operating Expenses:												
Salaries, Wages & Benefits	532,486	589,848	57,362	9.7%	1,636,701	1,769,544	132,843	7.5%	12,642,968	12,775,811	132,843	1.0%
Professional Fees	231,274	522,875	291,601	55.8%	842,791	1,568,625	725,834	46.3%	2,603,854	3,329,688	725,834	21.8%
Purchased Services	52,381	142,000	89,619	63.1%	104,181	426,000	321,819	75.5%	254,181	576,000	321,819	55.9%
GASB 96 Amortization Expenses	46,878	293,417	246,539	84.0%	140,633	880,251	739,618	84.0%	2,111,837	2,851,454	739,618	25.9%
Other Expenses	545,665	747,888	202,223	27.0%	1,924,783	2,243,664	318,881	14.2%	15,454,275	15,773,156	318,881	2.0%
Medical Management	229,257	-	(229,257)	0.0%	687,770	-	(687,770)	0.0%	3,438,848	2,751,078	(687,770)	(25.0%)
Total Operating Expenses	**1,637,941**	**2,296,028**	**658,087**	**28.7%**	**5,336,859**	**6,888,084**	**1,551,225**	**22.5%**	**36,505,962**	**38,057,187**	**1,551,225**	**4.1%**

Funding Balance Tracking:	**Approved Budget**	**Actual Spend**	**Variance**
Beginning Funding Balance	100,000,000	100,000,000	-
Less:			
Capital Assets[1]	31,525,709	10,240,863	21,284,846
FY2023 Operating Budget[2]	8,381,011	8,381,011	-
FY2024 Operating Budget	22,788,092	22,788,092	-
FY2025 Operating Budget	27,552,335	5,336,859	22,215,476
Ending Funding Balance	**9,752,853**	**53,253,175**	**43,500,322**
Add: Prior year unspent Operating Budget	-		
Total available Funding	**9,752,853**		

[1] Staff will continue to monitor the project status of DTS' Capital Assets
[2] Unspent budget from this period is added back to available DTS funding
[3] On June 6, 2024, the Board of Directors approved an update to the Digital Transformation Strategy which will impact these figures beginning July 2024.

Note: Report includes applicable transactions for GASB 96, Subscription.

CalOptima Health
Summary of Homeless Health Initiatives (HHI) and Allocated Funds
As of September 30, 2024

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000	11,400,000	-
Recuperative Care	6,194,190	6,194,190	-
Medical Respite	250,000	250,000	-
Day Habilitation (County for HomeKey)	2,500,000	2,500,000	-
Clinical Field Team Start-up & Federally Qualified Health Center (FQHC)	1,600,000	1,600,000	-
CalOptima Health Homeless Response Team	1,681,734	1,681,734	-
Homeless Coordination at Hospitals	10,000,000	9,956,478	43,522
CalOptima Health Days, Homeless Clinical Access Program (HCAP) and FQHC Administrative Support	963,261	817,918	145,343
FQHC (Community Health Center) Expansion	21,902	21,902	-
HCAP and CalOptima Health Days	9,888,914	3,446,240	6,442,675
Vaccination Intervention and Member Incentive Strategy	123,348	54,649	68,699
Street Medicine[1]	10,076,652	6,666,229	3,410,423
Outreach and Engagement	7,000,000	-	7,000,000
Housing and Homelessness Incentive Program (HHIP)[2]	40,100,000	-	40,100,000
Subtotal of Approved Initiatives	**$101,800,000**	**$44,589,340**	**$57,210,661**
Transfer of funds to HHIP[2]	(40,100,000)	-	(40,100,000)
Program Total	**$61,700,000**	**$44,589,340**	**$17,110,661**

Notes:

[1]On March 7, 2024, CalOptima Health's Board of Directors approved $5M. $3.2 million remaining from Street Medicine Initiative (from the HHI reserve) and $1.8 million from existing reserves to fund 2-year agreements to Healthcare in Action and Celebrating Life Community Health Center

[2]On September 1, 2022, CalOptima Health's Board of Directors approved reallocation of $40.1M from HHI to HHIP

CalOptima Health

Summary of Housing and Homelessness Incentive Program (HHIP) and Allocated Funds

As of September 30, 2024

Summary by Funding Source:	Total Funds	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funds Available for New Initiatives
DHCS HHIP Funds	72,931,189	35,200,994	28,812,256	6,388,739	37,730,195[1]
Existing Reserves & HHI Transfer	87,384,530	87,384,530	65,127,247	22,257,283	-
Total	**160,315,719**	**122,585,524**	**93,939,503**	**28,646,022**	**37,730,195**

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funding Source(s)
Office of Care Coordination	2,200,000	2,200,000	-	HHI
Pulse For Good	800,000	684,600	115,400	HHI
Consultant	600,000	-	600,000	HHI
Equity Grants for Programs Serving Underrepresented Populations	4,021,311	3,271,805	749,507	HHI & DHCS
Infrastructure Projects	5,832,314	5,391,731	440,583	HHI
Capital Projects	98,247,369	77,195,575	21,051,794	HHI, DHCS & Existing Reserves
System Change Projects	10,184,530	4,863,856	5,320,674	DHCS
Non-Profit Healthcare Academy	700,000	331,935	368,065	DHCS
Total of Approved Initiatives	**$122,585,524[1]**	**$93,939,502**	**$28,646,022**	

Notes:

[1]Total funding $160.3 million: $40.1 million Board-approved reallocation from HHI, $47.2 million from CalOptima Health existing reserves and $73.0 million from DHCS HHIP incentive payments

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CalOptima Health
Budget Allocation Changes
Reporting Changes as of September 2024

Transfer Month	Line of Business	From	To	Amount	Expense Description	Fiscal Year
July	Medi-Cal	ITS - Applications Management - System Development Enhancement for CalAIM	ITS - Applications Management - Care Management System - ZeOmega JIVA	$249,000	To reallocate funds from ITS - Applications Management - System Development Enhancement for CalAIM to Care Management System – ZeOmega JIVA for reporting post Go Live.	2024-25
July	Medi-Cal	ITS - Infrastructure - Other Operating Expenses - Maintenance HW/SW - Server - VMWare	ITS - Infrastructure - Other Operating Expenses - Maintenance HW/SW - DocuSign	$32,650	To repurpose funds from ITS - Infrastructure - Maintenance HW/SW - VMWare to Maintenance HW/SW – DocuSign to provide funding for additional signatures needed to avoid overage fees.	2024-25
July	Medi-Cal	Accounting - Purchased Services	Accounting - Printing and Postage	$20,000	To reallocate funds from Accounting - Purchased Services to Accounting – Printing and Postage to provide additional funding for toner purchase.	2024-25
August	Medi-Cal	ITS - Infrastructure - Other Operating Expenses - VMWare	ITS - Infrastructure - Other Operating Expenses - IT Service Management	$38,490	To reallocate funds from ITS - Infrastructure - Maintenance HW/SW - Server - VMWare to IT Service Management to address additional licensing needs and increased costs for the Impact Guide.	2024-25
August	Medi-Cal	IS - Applications Management - Professional Fees - Salesforce CRM	ITS - Applications Management - Other Operating Expenses - Crowe Subscription License Fee	$38,500	To reallocate funds from ITS - Applications Management - Salesforce CRM to Crowe Subscription License Fee to provide funding needed for its licensing.	2024-25
August	Medi-Cal	ITS - Infrastructure - Modern Customer Contact Center	ITS - Infrastructure - Network Bandwidth Upgrade for All Sites (Wide Area Network)	$10,349	To reallocate funds from ITS - Infrastructure - Modern Customer Contact Center to Network Bandwidth Upgrade for All Sites (Wide Area Network) due to increase in expenses.	2024-25
August	Medi-Cal	ITS - Infrastructure - Modern Customer Contact Center	ITS - Application Development - Digital Transformation Strategy Planning and Execution Support	$32,425	To reallocate funds from ITS - Infrastructure - Modern Customer Contact Center to Digital Transformation Strategy Planning and Execution Support due to increase in expenses.	2024-25
August	Medi-Cal	ITS - Infrastructure - Modern Customer Contact Center	ITS - Applications Management - Clinical Data Sets Quality Assurance & Data Aggregator Validation	$70,000	To reallocate funds from ITS - Infrastructure - Modern Customer Contact Center to Clinical Data Sets Quality Assurance & Data Aggregator Validation due to increase in expenses.	2024-25
August	Medi-Cal	ITS - Application Development - Other Operating Expenses - Veracode Code Scanning	Executive Office - Other Operating Expenses - CEO Leadership Alliance of Orange County (CLAOC)	$40,000	To reallocate funds from ITS - Application Development - Veracode Code Scanning to Executive Office - CEO Leadership Alliance of Orange County (CLAOC) Associations dues.	2024-25
September	OneCare	Communications - Purchased Services - Advertising	Communications - Professional Fees	$144,000	To reallocate funds from Communications - Advertising - Outdoor to Professional Fees to provide additional funding for Runyon Saltzman for Marketing.	2024-25
September	Medi-Cal	ITS - Applications Management - Other Operating Expenses - HW/SW Maintenance	Executive Office - Other Operating Expenses - Professional Dues	$50,000	To reallocate funds from ITS - Applications Management - HW/SW Maintenance to Executive Office - Professional Dues for coverage of expenses.	2024-25
September	Medi-Cal	Accounting - Purchased Services	Accounting - Other Operating Expenses - Office Supplies	$15,000	To reallocate funds from Accounting - Change Health Care - Claims Processing/Mailing to Office Supplies to provide additional funding needed to replenish check stock.	2024-25
September	PACE	PACE Administrative - Professional Fees	PACE Administrative - Other Operating Expenses - Subscriptions	$15,000	To reallocate funds from PACE Administrative - DHCS Annual Fee to Subscriptions to provide funding for DHCS PACE Licensing Fees.	2024-25
September	Medi-Cal	ITS - Application Development - Other Operating Expenses - HW/SW Maintenance	ITS - Applications Management - Other Operating Expenses - Care Management System - HealthEdge	$158,000	To reallocate funds from ITS - Application Development - Capital Software Expense to ITS - Applications Management - HealthEdge to help pay for Guiding Care Read Only invoice.	2024-25
September	OneCare	Sales & Marketing - Purchased Services	ITS - Applications Management - Professional Fees	$50,000	To reallocate funds from Sales & Marketings - Purchased Services - General to ITS - Applications Management – Enthrive to engage Enthrive for additional builds to the agent portal.	2024-25
September	Medi-Cal	ITS - Infrastructure - Professional Fees	ITS - Infrastructure - Other Operating Expenses - Subscriptions	$32,000	To reallocate funds from ITS - Infrastructure - MSFT Azure Assistance to Delphix - Continuous Data FACETS to cover the renewal subscription being higher than the anticipated amount.	2024-25

This report summarizes budget transfers between general ledger classes that are greater than $10,000 and less than $250,000.
This is the result of Board Resolution No. 12-0301-01 which permits the CEO to make budget allocation changes within certain parameters.

Board of Directors Meeting
November 7, 2024

Monthly Compliance Report

The purpose of this report is to provide compliance updates to CalOptima Health's Board of Directors including, but not limited to, updates on internal and health network monitoring and audits conducted by CalOptima Health's Delegation Oversight and Internal Audit departments, regulatory audits, privacy updates, fraud, waste, and abuse (FWA) updates, and any notices of non-compliance or enforcement action issued by regulators.

A. Updates on Regulatory Audits

1. California State Auditor – Joint Legislative Audit Committee audit

- October 22, 2024, the California State Auditor (CSA) confirmed that CalOptima Health has fully implemented all audit recommendations and has **officially closed the audit** with no further responses or actions required.
- CSA indicated it expects to formally publish the final audit status on its website within two weeks of October 22, 2024.
- As a recap, CSA released a report on May 2, 2023, following a comprehensive nine-month audit of CalOptima Health that covered an eight-year period from January 2014 through June 2022. In accordance with the terms of the audit, CalOptima Health was required to submit 60-day, six-month and one-year status updates to CSA regarding the implementation of the report's seven recommendations.
- As of the one-year update submitted on May 2, 2024, four of the seven audit recommendations required further updates.
- CSA reviewed the updates for the four recommendations and provided notification via email to CalOptima Health on October 22, 2024, that the four remaining recommendations were accepted as fully implemented.
- ALL the recommendations have been successfully completed and closed.

2. Medicare

- **Calendar Year (CY) 2022 Centers for Medicare & Medicaid Services (CMS) 1/3 Financial Audit (*applicable to OneCare*):**

  Note: The findings described below pertain to a portion of the samples tested.
  Update:
  - September 12, 2024 – CalOptima Health received the Final Audit Report, which included two (2) Findings and two (2) Observations.
    - Finding #1: Section E, Medicare Secondary Payer (MSP) – The Plan did not coordinate benefits with other insurers and paid claims as primary when they should have been paid as secondary.

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- Finding #2: Section F, General Payments to Medical Service Providers-Copayments/Coinsurance were not in accordance with the Plan Benefit Package (PBP).
- Observation #1: Section A, Bid Reconciliation – The Plan underestimated Direct and Indirect Remuneration (DIR) in the Part D Bid.
- Observation #2: Section E, Part B Drugs – The Plan paid Prescription Drug Events (PDEs) under Part D when they should have been paid under Part B.

➢ CMS is requesting the remediation of all findings through the submission of a corrective action plan (CAP), due by Dember 11, 2024.
➢ CalOptima Health is currently working with the business areas to finalize all CAP documents.

Background:

➢ CMS is required by statute to audit at least one-third of Medicare Advantage (MA) organizations' financial records each year which will include data relating to Medicare utilization, costs and development of the bid.
➢ CMS notified CalOptima Health that its OneCare plan had been selected for the CY 2022 CMS Financial Audit and Davis Farr LLP (CPA firm) will conduct the audit. Davis Farr LLP acted in the capacity of CMS agents and requested records and supporting documentation for, but not limited to, the following items:
- Claims data
- Solvency
- Enrollment
- Base year entries on the bids
- Medical and/or drug expenses
- Related party transactions
- General administrative expenses
- Direct and Indirect Remuneration (DIR)

- **2024 Compliance Program Effectiveness (CPE) Audit:**

Update:

➢ September 19, 2024 - CalOptima Health submitted the CPE audit deliverables.
➢ Below are key updates for the audit:
- October 7, 2024 - Tracer presentations due to auditor
- Audit Webinar Week is October 15, 2024 – October 21, 2024
- October 22, 2024 – Exit Conference
- November 5, 2024 – Draft Report available

***Background*:**

➢ CalOptima Health is required to conduct an independent audit on the effectiveness of its Compliance program on an annual basis, and to share the results with its governing body.
➢ CalOptima Health engaged an independent consultant to conduct the audit to ensure that its Compliance Program is administering the elements of an effective compliance program as outlined in the CMS Medicare Parts C and D Program Audit Protocols.
➢ The audit commenced in early August and will continue through November 2024.
➢ The audit review period will be from February 1, 2024, through August 1, 2024.

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- **2025 Department of Managed Care (DMHC) Routine Financial Examination:**

Update:

- September 5, 2024 – the DMHC engaged CalOptima Health for the 2025 DMHC Routine Examination. The examination will be of the Plan's fiscal and administrative affairs, including an examination of CalOptima Health's financial reports.
- December 16, 2024 – Pre-audit deliverables due to DMHC
- January 13, 2025 – Examination to commence and will be conducted remotely via audio/video conference.
- Regulatory Affairs and Compliance (RAC) Medicare has provided a copy of the Entrance Letter and pre-audit deliverables to the business areas and will continue to work with the areas impacted to ensure audit readiness.

Background:

- Pursuant to Section 1382 of the Knox-Keene Health Care Service Plan Act, the DMHC is responsible for conducting routine financial examinations of each health plan and issuing a public report for each plan.
- The purpose of the financial examinations is to evaluate and report on regulatory compliance with the Knox Keene Act. Each financial examination discusses plan performance in the areas of health plan fiscal and administrative functions.

- **2025 Medicare Part C and Data Part D Data Validation Audit (MDVA) (*applicable to OneCare*)**

Update:

- An independent third-party audit firm has provided the CMS Medicare Data Validation file layouts for the following measures to CalOptima Health:
  - Part C and D Grievances (GRVC_D)
  - Coverage Determinations and Redeterminations (CDR)
  - Improving Drug Utilization Controls (IDURC)
  - Organization Determinations and Reconsiderations (ODR)
  - Special Needs Plans (SNPs) Care Management

Background:

- CMS requires Medicare Advantage Organizations (MAOs) to participate in a yearly independent review to validate the accuracy and completeness of data reported to CMS per the Medicare Part C and Part D Reporting Requirements. CMS requires plans to contract with an auditing firm that meets the CMS data validation contractor standards to perform an independent audit on the plan. CalOptima Health has contracted with a CMS-recognized audit organization with over 25 years of Medicare data validation experience to perform this audit.

2. Medi-Cal

- **2024 Department of Health Care Services (DHCS) Routine Medical Audit:**

Update:

- September 23, 2024 – CalOptima Health provided its timely Corrective Action Plan (CAP) submission to DHCS.

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- CalOptima Health is required to submit monthly updates, on the 15th of each month, to DHCS until the final CAP deliverable is completed.
- Final CAP deliverable is scheduled to be completed by January 2025.

- October 15, 2024 – CalOptima Health provided its first monthly update to DHCS following the initial CAP submission in September.

Background:

- August 22, 2024 – CalOptima Health received a formal request for corrective action plan (CAP) from DHCS.
- September 23, 2024 – CAP response due to DHCS.
- The DHCS Routine Medical Audit consists of DHCS's review of both the Primary (aka "Main Contract") and Secondary contracts (aka "State Supported Services"). The findings are as follows:
  - Primary/Main Contract
    - Draft & Final Report Identified **10 Findings**
  - Secondary Contract - State Supported Services (SSS)
    - Draft & Final Report Identified **No Findings**

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- **2023 DHCS Routine Medical Audit (Focused Scope):**

Update:

- October 7, 2024 – CAP response was submitted timely to DHCS.
  - DHCS' previously indicated date of October 6, 2024, was a Sunday and as such confirmed a Monday submission was acceptable.
- September 6, 2024 – CalOptima Health received a formal request for corrective action plan (CAP) from DHCS.

Background:

- In 2022, DHCS notified all Medi-Cal managed care health plans (MCPs) that it would be conducting focused audits to assess performance in certain identified high-risk areas. DHCS scheduled these focused audits concurrently with the routine annual medical audit. CalOptima Health's annual audit was conducted in February-March 2023 and the corresponding CAP was closed on 12/29/23; the draft report with findings for the *focused audit* were issued 6/19/24.
- CalOptima Health submitted its response to DHCS on Tuesday, July 9, 2024, and did not dispute the contents of the draft report.
- The areas reviewed and results are as follows:

▪ **Audit Period:** 2/1/22-1/31/23 ▪ **Audit Dates:** 2/27/23-3/10/23 ▪ **Draft Report Date:** 6/19/24	
▪ **Transportation** o Non-Emergency Medical Transportation (NEMT) o Non-Medical Transportation (NMT)	No findings
▪ **Behavioral Health** o Specialty Mental Health Services (SMHS) o Non-Specialty Mental Health Services (NSMHS) o Substance Use Disorder Services (SUDS)	Two Findings

- **California State Audit (CSA):**

Update:

- As of September 30, 2024, CalOptima Health awaits a response from CSA to its 1-year response.

Background:

- As directed by the Joint Legislative Audit Committee, the California State Auditor (CSA) conducted an audit of certain aspects of CalOptima Health's budget, services and programs, and organizational changes.

B. Regulatory Notices of Non-Compliance

- CalOptima Health did not receive any notices of non-compliance from its regulators for the month of September 2024.

C. Updates on Health Network Monitoring and Audits

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- **Health Network Audits:**

  - CalOptima Health's Delegation Oversight (DO) department completed annual audits on the following delegated health networks to assess their capabilities and performance with delegated activities:
    - United Care Medical Group (UCMG) – Lookback: April 1, 2023 – May 31, 2024

D. Internal Audit Updates

- The following annual audits are currently in progress:
  - 2024 Grievances and Appeals (OneCare) Annual Audit
    - Preliminary results issued on 10/3/2024
  - 2024 Grievances and Appeals (Medi-Cal) Annual Audit
    - Webinar week will commence 10/7/2024
  - 2024 Exempt Grievances Annual Audit (Customer Service Department)
    - Webinar week will commence 10/9/2024
  - 2024 Utilization Management (OneCare) Annual Audit
    - File selections have been sent to the department. Evidence is due by 10/7/2024.
  - 2024 Utilization Management (Medi-Cal) Annual Audit
    - Dept file selection submission due on 10/23/20

- **Board-Approved Initiatives Review:**

  Update:
  - Renewal of Ankura Consulting's engagement received Board approval at the September 5, 2024, Board of Directors meeting.
  - Phase II Scope of Work includes assistance to implement phase I recommendations and close-out review of grants as they are completed.
  - Consultant has completed preliminary close out reviews for the following grants:
    - Be Well/Mind OC, Irvine
    - Be Well/Mind OC, Orange
    - Expanded scope review to be performed on Mind OC Irvine and Orange grants

  Background:
  - CalOptima Health's Internal Audit department is currently in the process of reviewing CalOptima Health's Board-approved initiatives. Internal Audit's goal is to identify opportunities to strengthen the oversight of the fund's surplus expenditure management process, including the structure for reviewing and signing off on grant programs and initiatives as they are completed.

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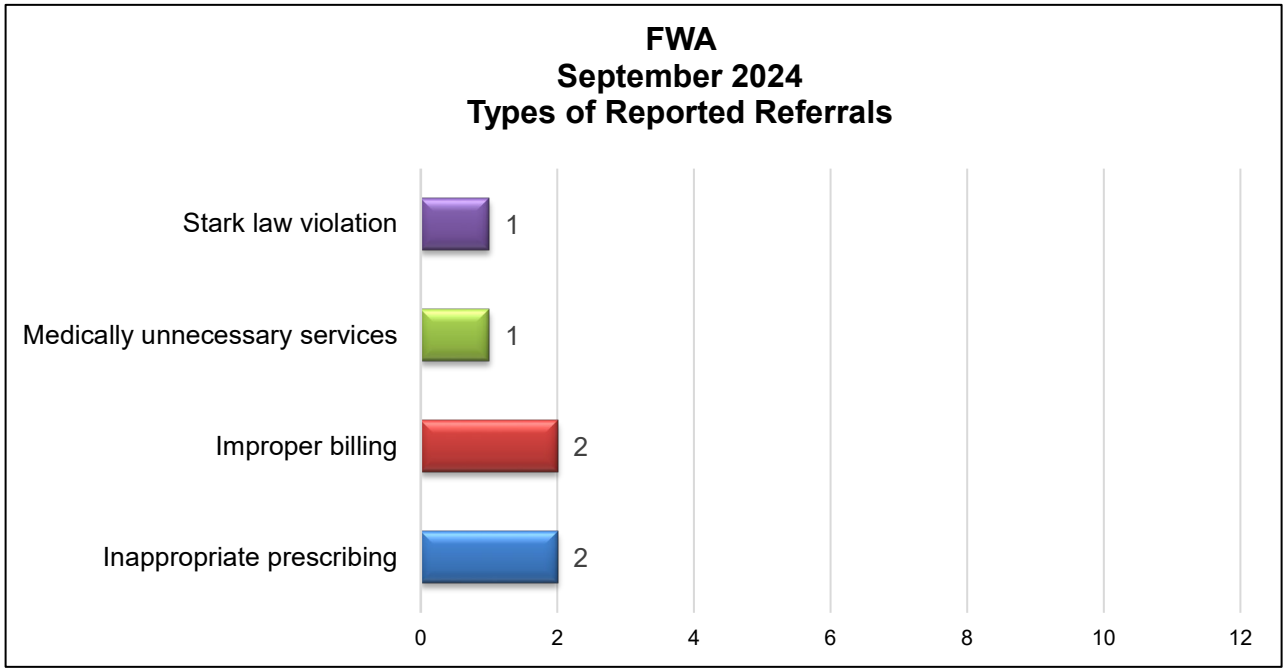
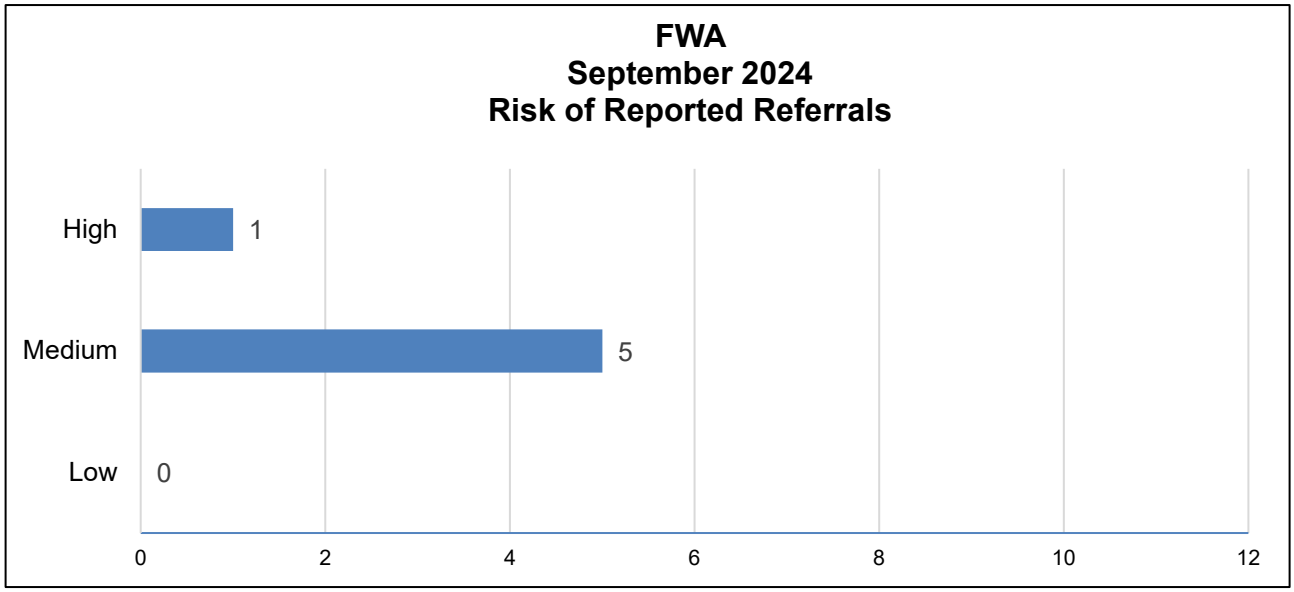
E. Fraud, Waste & Abuse (FWA) Investigations (September 2024)





Total Number of New Cases Referred to DHCS (State)	6
Total Number of New Cases Referred to DHCS and CMS	5
Total Number of Referrals Reported	**6**

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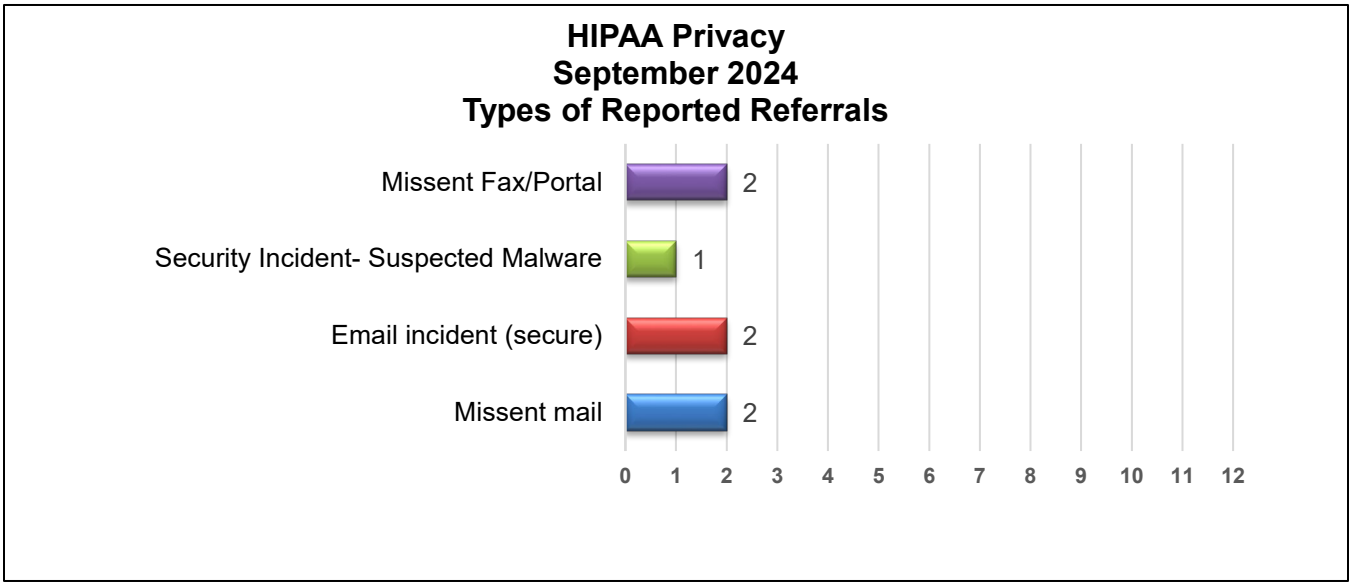
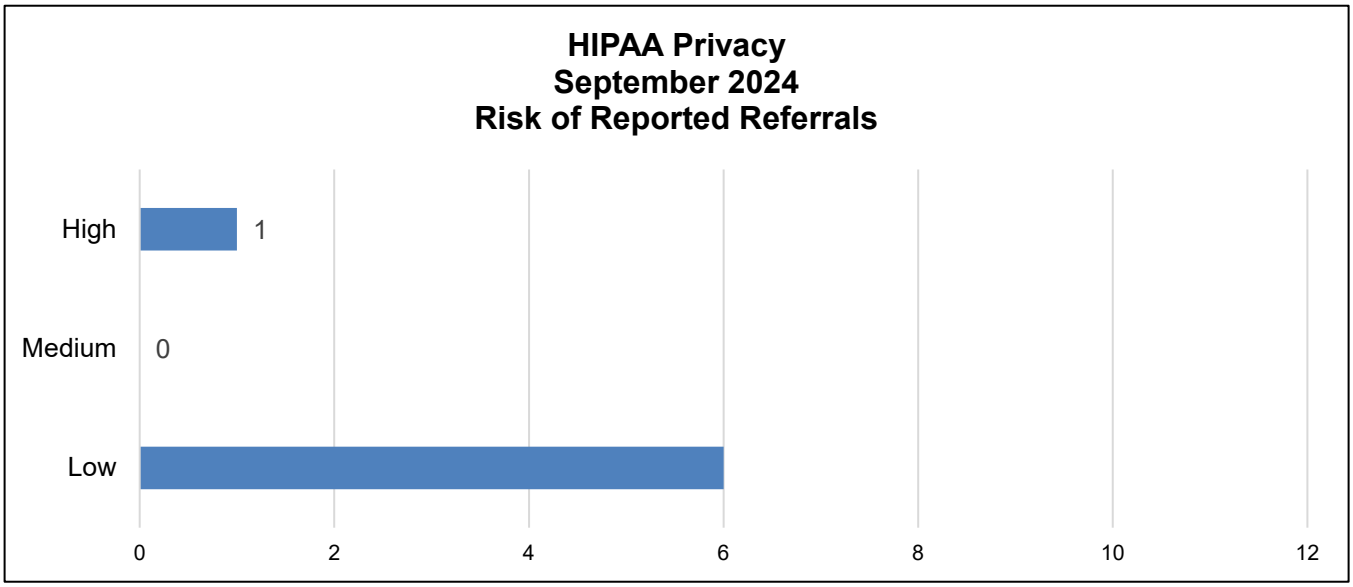
F. Privacy Update (September 2024)





Total Number of Referrals Reported to DHCS (State)	7
Total Number of Referrals / Breaches Reported to DHCS and Office for Civil Rights (OCR)	0

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CHAMBER HILL

MEMORANDUM

TO: CalOptima Health
Board of Directors

FROM: Chamber Hill Strategies

DATE: October 29, 2024

SUBJECT: November Board of Directors Report

Chamber Hill Strategies Continues Outreach on CalOptima Health Move to Covered California
Chamber Hill Strategies continued to be in communication with California's U.S. Senate offices and members of the Orange County congressional delegation regarding CalOptima Health's move to join Covered California in 2027. The outreach included updating offices about the CalOptima Health Board of Directors unanimous recommendation that the Orange County Board of Supervisors (BOS) remove the current prohibition on CalOptima Health participating in Covered California as well as an explanation of the next steps in the consideration process. In addition, Chamber Hill Strategies (CHS) shared Chief Executive Officer Michael Hunn's letter that was sent to the Orange County BOS requesting timely consideration of the request. CHS contact with the offices was a follow-up to previous outreach, which had included in-person meetings with several offices in September. Offices contacted included Senator Laphonza Butler (D-CA), Senator Alex Padilla (D-CA), Representative Lou Correa (D-CA-46), Representative Young Kim (R-CA-40), Representative Michelle Steel (R-CA-45), Representative Katie Porter (D-CA-47), Representative Linda Sanchez (D-CA-38), and Representative Mike Levin (D-CA-49).

Congressional Outlook for Government Funding and Health Legislation
While Congress has yet to reach an agreement on appropriations bills to fully fund the government for Fiscal Year 2025 (FY2025), congressional leaders reached an agreement in September to fund government operations past the November elections. Because the legislation (H.R. 9747) only continues funding government programs at FY2024 levels through December 20, it also means that Congress will need to revisit its work to pass legislation to fund the federal government for FY2025, which began on October 1, following the election. As of this writing, it is unclear if congressional leadership and House and Senate Appropriations Committee leaders will be able to reach an agreement to fully fund all government departments and agencies for FY2025 before year's end. Moreover, election outcomes both at the presidential and congressional levels could impact the motivation for some lawmakers to actively legislate and reach an agreement on appropriations. Should a full agreement for FY2025 not be reached, it is expected that congressional leaders will agree to extend funding for government programs through early 2025, tasking the new Congress and Administration with reaching an agreement on FY2025 government funding in the new year.

In addition, while the House moved several health-related bills with bipartisan support in September, it is not clear if congressional leaders will be able to reach an agreement on a larger health legislative package this year. Late last year, the House, in a 320-71 vote, passed the Lower Costs, More Transparency Act (H.R. 5378), which included provisions addressing concerns regarding the practices of pharmacy benefit managers (PBMs). Yet, despite broad bipartisan support, it is uncertain at best if the House and Senate will be able to reach an

agreement on PBM reform this year. Before the end of the year, Congress will also have to address several expiring health provisions, which include telehealth flexibility and funding for community health centers among several others. While Congress is expected to extend and fund these expiring health programs past December, it remains an open question if Congress will extend these programs through all of 2025. Much like with government funding, election outcomes will likely impact whether congressional leaders are inclined to negotiate a longer agreement or one that only extends through early 2025.

Regulatory Outlook – Rules on the Horizon for November and December

Washington is preparing for the Centers for Medicare & Medicaid Services (CMS) to release several final rules in the coming weeks. While release before the November elections is unlikely, we do expect final rules for physician, home health, and hospital outpatient prospective payments to be released in November. In addition, CMS is also slated to release the proposed rule on Medicare Advantage and Part D rates in November.

MedPAC Holds October Meeting

On October 10 and 11, the Medicare Payment Advisory Commission (MedPAC) held its second set of meetings of the 2024-2025 cycle. On the first day, MedPAC discussed issues related to nursing homes, findings from MedPAC's annual beneficiary and provider focus group survey, and supplemental benefits in Medicare Advantage (MA). In examining nursing homes, MedPAC staff identified challenges to improving nursing home care, including financial incentives that encourage hospitalization, low Medicaid payment rates, concerns about quality reporting, and the propensity of certain racial and ethnic minority groups to live in areas where nursing homes often have fewer staff and are of lower quality. MedPAC staff identified next steps in the area, including examining managed care-based approaches with a focus on Institutional special needs plans (I-SNPs) and fee-for-service (FFS) approaches. The review of MedPAC's annual beneficiary and provider focus group findings included reports of general satisfaction among both MA and FFS beneficiaries, but concerns were raised about the accuracy of MA plan networks, prior authorization requirements in MA, and certain MA plan coding practices that yield higher MA reimbursement. The third session focused on supplemental benefits available to MA beneficiaries. While there was agreement on the value of supplemental benefits, MedPAC commissioners also debated the cost of providing MA supplemental benefits and to what extent Medicare should be paying for services that are not primarily healthcare related.

The second day's sessions focused on home health and included a discussion of recent changes to the Medicare Home Health Prospective Payment System (PPS) and home health use among MA enrollees. The discussion of home health covered MedPAC's plans for a congressionally mandated report on changes to the Home Health PPS that were included in the Balanced Budget Act (BBA) of 2018. The mandated changes included moving from a 60-day period to a 30-day period for the payment unit and a new patient classification system. MedPAC is required to analyze and report on how these changes impact payments, costs, and quality and to assess any unintended consequences. The last session focused on home health use among MA enrollees. Overall, MedPAC estimated that the MA home health care use rate is 1% lower than in Medicare FFS. The analysis also found that skilled nursing care made up a higher percentage of visits in FFS than in MA and that physical and occupational therapy made up higher percentages of visits in MA. Commissioners were cautioned that differences in MA and FFS beneficiary characteristics can affect utilization and that the current estimate has not been adjusted for those differences. MedPAC staff noted that future analysis will use beneficiary demographic and health characteristics to better adjust comparisons.

CALOPTIMA HEALTH - STATE LEGISLATIVE REPORT
October 28, 2024

General Update

Governor Newsom signed 1,017 bills this year and vetoed 189 by the September 30th deadline. His veto rate was just below 16%, which was slightly higher than previous years.

The Governor quickly shifted his focus to the Special Session called to address an oil and gas bill package aimed at curbing gasoline price spikes – ABX2-1. In the first two weeks of October, the legislature returned to session and passed the Governor's bill, which he promptly signed on October 14. Orange County delegation member Assemblymember Cottie Petrie-Norris (D-Irvine) was tasked with leading the effort and chaired the Assembly Committee on Gasoline and Petroleum Supply.

Legislators were anxious to then get back to their districts, preparing for the upcoming elections. There will be at least 35 (and possibly up to 43) new legislators taking seats in December. While Democratic supermajorities will hold in both houses, significant changes are expected in committee assignments.

Budget Update

As anticipated, the Governor signed seven final budget cleanup bills and a Health Omnibus bill before the September 30th deadline. A bit of good news: general fund cash receipts have been higher than expected, resulting in about $4.1 billion more than anticipated six months ago. The more difficult news: the state continues to face a second-year budget deficit of approximately $30 billion. There are also several unknown factors which could have a significant fiscal impact, including:

Managed Care Organization (MCO) Tax – Several provisions of the current year budget's MCO tax agreement will become inoperable if voters approve the related MCO Tax Initiative (Proposition 35) on the November 5th ballot. If Proposition 35 passes, the Department of Finance (DOF) estimates it will amount to a $12 billion decrease in funds that the state had planned to balance the budget through 2027.

Health Care Worker $25/Hour Minimum Wage Increase – DHCS notified the legislature on October 1, 2024, that the minimum wage increase for health care workers would become effective on October 16, 2024. As part of the original budget agreement, trigger language required implementation when the first quarter of the fiscal year cash receipts were 3% higher than what was projected at budget passage.

Key Legislation Update

Medi-Cal Medically Supportive Food – AB 1975 (Bonta) – AB 1975 was vetoed by the Governor on September 25, because of the unbudgeted, significant cost. This bill made medically supportive food and nutrition services under Medi-Cal a permanent benefit when determined to be medically necessary. Currently, these services are covered through a temporary waiver program under CalAIM. This bill was supported by the Local Health Plans of CA (LHPC) and the CA Association of Health Plans (CAHP).

Key Legislation Update *(continued)*

Claim Reimbursement – AB 3275 (Soria) – AB 3275 was signed by the Governor on September 27th and requires health plans to reimburse a complete claim no later than 30 calendar days after receipt of the claim with a major goal of getting timely payments to distressed hospitals. CAHP, LHPC and the DOF all opposed the bill because of the significant costs of the shortening of the window to pay claims, particularly those that have not been submitted properly.

Prior Authorization – SB 516 (Skinner) – This bill died August 27th for failure to meet the policy committee deadline. SB 516 mandated that health plans provide specific information about the use of prior authorizations. Originally a "gut and amend" bill at the end of the 2023 session, this bill became active again on August 7, 2024, and was subsequently amended to exempt Medi-Cal plans. This bill may resurface under a new author in the upcoming session since Skinner is termed out.

Utilization Review for Health Care – SB 1120 (Becker) – This bill was signed by the Governor on September 28th. Sponsored by California Medical Association, SB 1120 mandates that health plans using artificial intelligence (AI) for utilization review/utilization management decisions comply with specified requirements. Decisions must be based on medical history, individual clinical circumstances, and be fairly and equitably applied. The DOF and CAHP removed their opposition in the final version of the bill, easing its success.

Propositions and Initiatives

Proposition 1 – Behavioral Health Transformation (BHT) – After being passed by voters in March, the request for applications for Round 1 of bond funding ($3.3 billion) was released in July and applications are due in December. Counties, cities, tribes, non-profits, and for-profits are eligible to apply. DHCS prioritizes collaborative partnerships and campus-type models. County mental health departments must support the proposed projects, and matching funds/collateral are required by the proposer.

Proposition 35 – "Protect Access to Health Care Act of 2024" (MCO Tax) – If passed by voters on November 5th, it would be the first time this tax, which leverages federal reimbursement dollars, is made a permanent tax on health plans. The MCO Tax deal in the current budget will become inoperable should Proposition 35 succeed. The Governor has indicated opposition to the measure because it would "hamstring" the flexibility in balancing the state budget. However, the Governor has not formally opposed Proposition 35. The campaign in support has raised almost $49 million, and there is no organized campaign in opposition. The latest polling suggests a 62% chance of success.

2023–24 Legislative Tracking Matrix

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Behavioral Health			
S. 3430 Wyden (OR) Crapo (ID)	**Better Mental Health Care, Lower-Cost Drugs, and Extenders Act:** Would expand access to behavioral health services, reduce prescription drugs costs through pharmacy benefit manager (PBM) reforms and extend certain expiring provisions of the Medicare and Medicaid programs. Specific notable elements include but are not limited to the following: • Increasing all Medicare physician fee schedule payments by 2.5% (rather than 1.25%) for 2024 services. • Increasing Medicare physician fee schedule payments for certain behavioral health integration services in primary care settings during 2026–28. • Increasing Medicare bonus payments to providers that furnish mental health and substance use disorder (SUD) services in health professional shortage areas; expanding such bonus payments to include non-physician health care professionals. • Expanding access to behavioral telehealth services across state lines and for those with limited English proficiency. • Medicaid funding of up to seven days for services delivered to incarcerated individuals diagnosed with an SUD and pending disposition of charges. • Eliminating cuts to Medicaid disproportionate share hospital payments through September 30, 2025. Additionally, would include provisions from S. 3059, the Requiring Enhanced & Accurate Lists of (REAL) Health Providers Act, to require accurate provider directories on public websites updated every 90 days. ***Potential CalOptima Health Impact:*** Increased access to behavioral health services for CalOptima Health members; increased funding for contracted providers; increased staff oversight of CalOptima Health's OneCare provider directory.	**12/07/2023** Introduced; referred to Senate Finance Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
S. 923 Bennet (CO)	**Better Mental Health Care for Americans Act:** Would require parity for mental health services in Medicaid, Medicare Advantage (MA) and Medicare Part D. Would also enhance Medicaid and Medicare payments for integrating mental health and SUD services with physical care. Finally, would create a 54-month Medicaid demonstration project to increase state funding for enhanced access to mental health services for children. In addition, would require MA plans to verify and update provider directories at least every 90 days and remove a non-participating provider within two business days of notification. ***Potential CalOptima Health Impact**:* Increased access to behavioral health services for CalOptima Health members; increased funding for contracted providers; increased staff oversight of OneCare provider directory.	**03/22/2023** Introduced; referred to Senate Finance Committee	CalOptima Health: Watch
S. 1378 Cortez Masto (NV)	**Connecting Our Medical Providers with Links to Expand Tailored and Effective (COMPLETE) Care Act:** Would improve access to timely, effective mental health care in the primary care setting by increasing Medicare payments to providers for implementing integrated care models. ***Potential CalOptima Health Impact**:* Increased resources and access to behavioral health services for CalOptima Health OneCare members; increased funding for contracted providers.	**04/27/2023** Introduced; referred to Senate Finance Committee	CalOptima Health: Watch
SB 363 Eggman	**Behavioral Health Facilities Database:** No later than January 1, 2026, would require the California Department of Health Care Services (DHCS) to develop a real-time, internet-based database to display information about beds in certain facilities, including chemical dependency recovery hospitals, acute psychiatric hospitals and mental health rehabilitation centers, to identify the availability of inpatient and residential mental health or SUD treatment. ***Potential CalOptima Health Impact:*** Increased resources and access to behavioral health services for CalOptima Health Medi-Cal members.	**08/16/2024** Died in Assembly Appropriations Committee **06/13/2023** Passed Assembly Health Committee **05/24/2023** Passed Senate floor	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 492 Pellerin	**Reproductive and Behavioral Health Integration Pilot Programs:** Would provide grants, incentive payments or other financial support to Medi-Cal managed care plans (MCPs) to partner with providers for the development and implementation of behavioral health integration pilot programs to improve access to services. Partnering providers must be enrolled in the Family Planning, Access, Care, and Treatment (Family PACT) program and provide reproductive health services. ***Potential CalOptima Health Impact*:** Increased funding and access to reproductive and behavioral health services.	**07/03/2024** Died in Senate Health Committee **05/31/2023** Passed Assembly floor	CalOptima Health: Watch
AB 512 Waldron	**Behavioral Health Facilities Database:** Would require the California Health and Human Services Agency (CalHHS) to create a committee to study how to develop a real-time, internet-based system, usable by hospitals, clinics, law enforcement, paramedics and emergency medical technicians, and other health care providers to display information about available beds in inpatient psychiatric facilities, crisis stabilization units, residential community mental health facilities and residential alcoholism or substance abuse treatment facilities in order to identify available facilities for the temporary treatment of individuals experiencing a mental health or SUD crisis. ***Potential CalOptima Health Impact*:** Increased efficiency and timeliness of facility referrals; decreased visits to the emergency department.	**01/19/2024** Died in Assembly Appropriations Committee **03/14/2023** Passed Assembly Health Committee	CalOptima Health: Watch
AB 940 Villapudua	**Eating Disorder Treatment:** Would expand the approved facilities for inpatient treatment of eating disorders to include psychiatric health facilities. ***Potential CalOptima Health Impact*:** Increased access to treatment for eating disorders.	**01/12/2024** Died in Assembly Health Committee	CalOptima Health: Watch
AB 1316 Irwin	**Psychiatric Emergency Medical Conditions:** Would require the Medi-Cal program to cover emergency services and care necessary to treat a psychiatric emergency medical condition, including post-stabilization care services, emergency room professional services, and facility charges for emergency room visits — regardless of whether the beneficiary was voluntarily or involuntarily admitted. ***Potential CalOptima Health Impact*:** Increased scope of behavioral health services for CalOptima Health Medi-Cal members.	**09/27/2024** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 1470 Quirk-Silva	**Behavioral Health Documentation Standards:** Would require DHCS to standardize data elements relating to documentation requirements, including medically necessary criteria and develop standard forms containing information necessary to properly adjudicate claims. No later than July 1, 2025, regional personnel training on documentation should be completed along with the exclusive use of the standard forms. ***Potential CalOptima Health Impact*:** New data requirements; additional training for CalOptima Health behavioral health staff on new documentation.	**09/14/2024** Vetoed *(see **veto message**)*	CalOptima Health: Watch
AB 1936 Cervantes	**Maternal Mental Health Screenings:** Would require a health plan's maternal mental health program to consist of at least one maternal mental health screening during pregnancy, at least one additional screening during the first six weeks of the postpartum period, and additional postpartum screenings, if determined medically necessary and clinically appropriate, to improve treatment and referrals to other maternal mental health services, including coverage for doulas. ***Potential CalOptima Health Impact:*** Expanded Medi-Cal benefit for CalOptima Health Medi-Cal members.	**09/28/2024** Signed into law	CalOptima Health: Watch
Budget			
H.R. 2872 Graves (LA)	**Further Additional Continuing Appropriations and Other Extensions Act, 2024:** Enacts a third Continuing Resolution (CR) to further extend Fiscal Year (FY) 2023 federal spending levels from January 19, 2024, through March 1, 2024, for certain agencies, and from February 2, 2024, through March 8, 2024, for other agencies. ***Potential CalOptima Health Impact:*** Continuation of current federal spending on programs impacting CalOptima Health members.	**01/19/2024** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 2882 Ciscomani (AZ)	**Further Consolidated Appropriations Act, 2024:** Enacts the remaining six FY 2024 appropriations bills, as follows, to fund several federal departments and agencies in the amount of $1.2 trillion through September 30, 2024: • Department of Defense Appropriations Act, 2024 • Financial Services and General Government Appropriations Act, 2024 • Department of Homeland Security Appropriations Act, 2024 • Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2024 • Legislative Branch Appropriations Act, 2024 • Department of State, Foreign Operations, and Related Programs Appropriations Act, 2024 Of note, funding for the U.S. Department of Health and Human Services (HHS) remains relatively flat with only a 1% increase compared to FY 2023. However, approximately $4.3 billion in unspent COVID-19 relief funding is rescinded. ***Potential CalOptima Health Impact:*** Adjusted but broadly sustained funding for federal programs impacting CalOptima Health members.	**03/23/2024** Signed into law	CalOptima Health: Watch
H.R. 4366 Carter (TX)	**Consolidated Appropriations Act, 2024:** Enacts six of the 12 regular FY 2024 appropriations bills, as follows, to fund several federal departments and agencies in the amount of $459 billion through September 30, 2024: • Military Construction, Veterans Affairs, and Related Agencies Appropriations Act, 2024 • Agriculture, Rural Development, Food and Drug Administration, and Related Agencies Appropriations Act, 2024 • Commerce, Justice, Science, and Related Agencies Appropriations Act, 2024 • Energy and Water Development and Related Agencies Appropriations Act, 2024 • Department of the Interior, Environment, and Related Agencies Appropriations Act, 2024 • Transportation, Housing and Urban Development, and Related Agencies Appropriations Act, 2024 In addition, extends several expiring programs and authorities, including several public health programs. ***Potential CalOptima Health Impact:*** Adjusted but broadly sustained funding for federal programs impacting CalOptima Health members.	**03/09/2024** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 7463 Granger (TX)	**Extension of Continuing Appropriations and Other Matters Act, 2024:** Enacts a fourth CR to further extend FY 2023 federal spending levels from March 1, 2024, through March 8, 2024, for federal agencies through March 8, 2024, and through March 22, 2024, for other agencies. ***Potential CalOptima Health Impact:*** Continuation of current federal spending on programs impacting CalOptima Health members.	**03/01/2024** Signed into law	CalOptima Health: Watch
SB 136 Committee on Budget and Fiscal Review	**Managed Care Organization (MCO) Provider Tax Amendment Trailer Bill I:** Subject to approval by the Centers for Medicare and Medicaid Services (CMS), increases the Medi-Cal per enrollee tax amount on health plans in Medi-Cal taxing tier II to $205 during the 2024, 2025 and 2026 calendar years. ***Potential CalOptima Health Impact:*** Increased tax liability on CalOptima Health to be reimbursed at an approximately equivalent amount; increased funding for Medi-Cal programs and provider rates.	**03/25/2024** Signed into law	CalOptima Health: Watch
SB 159 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 2024-25 state budget. ***Potential CalOptima Health Impact:*** Impacts are discussed in the enclosed analysis of the FY 2024–25 Enacted State Budget.	**06/29/2024** Signed into law	CalOptima Health: Watch
AB 106 Gabriel	**Budget Acts of 2022 and 2023:** Amends the Budget Act of 2022 and the Budget Act of 2023 to support appropriations for FYs 2023–24 as part of the early action agreement that includes a combination of $3.6 billion in reductions (primarily to one-time funding), $5.2 billion in revenue and borrowing, $5.2 billion in delays and deferrals, and $3.4 billion in shifts of costs from the General Fund to other state funds. Significant health care provisions include the following: • Behavioral Health Continuum Infrastructure Program: $140.4 million delay • Behavioral Health Bridge Housing: $235 million delay • MCO Provider Tax: $3.8 billion in revenue borrowing ***Potential CalOptima Health Impact*:** Adjusted but broadly sustained funding for behavioral health programs impacting CalOptima Health members.	**04/03/2024** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 107 Gabriel **SB 108** Wiener	**Budget Act of 2024:** Makes appropriations for the government of the State of California for FY 2024–25. Total spending is $293 billion, of which $211.5 billion is from the General Fund. ***Potential CalOptima Health Impact:*** Impacts are discussed in the enclosed analysis of the FY 2024–25 Enacted State Budget.	**06/29/2024** Signed into law	CalOptima Health: Watch
AB 160 Committee on Budget	**MCO Provider Tax Amendment Trailer Bill II:** Subject to approval by CMS, further increases the Medi-Cal per enrollee tax amount on health plans in Medi-Cal taxing tier II from $205 to $274 during the 2024, 2025 and 2026 calendar years. ***Potential CalOptima Health Impact:*** Impacts are discussed in the enclosed analysis of the FY 2024–25 Enacted State Budget.	**06/29/2024** Signed into law	CalOptima Health: Watch
California Advancing and Innovating Medi-Cal (CalAIM)			
AB 586 Calderon	**Community Support: Climate Change or Environmental Remediation Devices:** Would add "climate change or environmental remediation devices" as a Medi-Cal Community Support option, defined as the coverage and installation of devices to address health-related complications, barriers or other factors linked to extreme weather, poor air quality or other climate events, including air conditioners, electric heaters, air filters and backup power sources. ***Potential CalOptima Health Impact:*** New services available for CalOptima Health Medi-Cal members to address social determinants of health (SDOH).	**01/19/2024** Died in Assembly Appropriations Committee **04/11/2023** Passed Assembly Health Committee	CalOptima Health: Watch
AB 1338 Petrie-Norris	**Community Support: Fitness**: Would add fitness, physical activity, or recreational sports programs, activities, or memberships as a Medi-Cal Community Support option. ***Potential CalOptima Health Impact:*** New services available for CalOptima Health Medi-Cal members to address SDOH.	**01/19/2024** Died in Assembly Appropriations Committee **04/18/2023** Passed Assembly Health Committee	CalOptima Health: Watch
Covered Benefits			
SB 324 Limón	**Endometriosis:** Would add any clinically indicated treatment for endometriosis as a covered benefit without prior authorization or other utilization review. ***Potential CalOptima Health Impact:*** Expanded covered benefit for CalOptima Health Medi-Cal members.	**08/16/2024** Died in Assembly Appropriations Committee **06/27/2023** Passed Assembly Health Committee **05/24/2023** Passed Senate floor	CalOptima Health: Watch CAHP: Oppose

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 339 Wiener	**Human Immunodeficiency Virus (HIV) Preexposure Prophylaxis (PrEP) and Postexposure Prophylaxis (PEP):** Increases Medi-Cal coverage of PrEP and PEP furnished by a *pharmacist* from a 60-day maximum course to a 90-day maximum course, which could be further extended under certain conditions. ***Potential CalOptima Health Impact:*** Expanded Medi-Cal Rx benefit for CalOptima Health Medi-Cal members.	**02/06/2024** Signed into law	CalOptima Health: Watch CAHP: Oppose
SB 953 Menjivar	**Menstrual Products:** Would add menstrual products as covered Medi-Cal benefits. ***Potential CalOptima Health Impact:*** New covered benefits for CalOptima Health Medi-Cal members.	**05/17/2024** Died in Senate Appropriations Committee **03/20/2024** Passed Senate Health Committee	CalOptima Health: Watch
SB 1180 Ashby	**Emergency Medical Services:** Would add services provided by a community paramedicine program, triage to alternate destination program, or mobile integrated health program as covered Medi-Cal benefits, subject to an appropriation by the Legislature. ***Potential CalOptima Health Impact:*** Expanded covered benefits for CalOptima Health Medi-Cal members.	**09/28/2024** Signed into law	CalOptima Health: Watch
AB 47 Boerner	**Pelvic Floor Physical Therapy**: Beginning January 1, 2024, would require health plans to provide coverage for pelvic floor physical therapy after pregnancy. ***Potential CalOptima Health Impact:*** New covered benefit for CalOptima Health Medi-Cal members.	**01/12/2024** Died in Assembly Health Committee	CalOptima Health: Watch CAHP: Oppose
AB 365 Aguiar-Curry	**Continuous Glucose Monitors (CGMs):** Would add CGMs and related supplies as a covered Medi-Cal benefit for the treatment of diabetes when medically necessary, subject to utilization controls. Would also allow DHCS to require a manufacturer of CGMs to enter into a rebate agreement with DHCS. ***Potential CalOptima Health Impact:*** Expanded covered benefits for CalOptima Health Medi-Cal members.	**08/31/2024** Died on Senate floor **08/21/2023** Re-referred to Senate floor **06/21/2023** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/31/2023** Passed Assembly floor	CalOptima Health: Watch CalPACE: Support

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 1036 Bryan	**Emergency Medical Transportation:** Would require a physician to certify upon patient arrival at an emergency room via emergency medical transportation whether an emergency medical condition existed and required emergency medical transportation. If certified, would require a health plan to provide coverage for emergency medical transportation. ***Potential CalOptima Health Impact:*** Increased CalOptima Health costs for reimbursement of emergency transportation services.	**01/12/2024** Died in Assembly Health Committee	CalOptima Health: Watch
AB 1975 (AB 1644) Bonta	**Medically Supportive Food**: No sooner than July 1, 2026, and subject to an appropriation by the Legislature, would add medically supportive food and nutrition intervention plans as covered Medi-Cal benefits, when determined to be medically necessary to a patient's medical condition by a provider or plan. The benefit would be based in part on the following Community Support offered through CalAIM: Medically Tailored Meals. ***Potential CalOptima Health Impact:*** Formalization and expansion of certain Community Support services as covered benefits for eligible CalOptima Health Medi-Cal members.	**09/25/2024** Vetoed *(see veto message)*	CalOptima Health: Watch LHPC: Support CAHP: Support
AB 2105 (AB 907) Lowenthal	**PANDAS and PANS**: Beginning January 1, 2025, would require a health plan to provide coverage for prophylaxis, diagnosis and treatment of Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal Infections (PANDAS) and Pediatric Acute-onset Neuropsychiatric Syndrome (PANS), prescribed or ordered by a provider as medically necessary. ***Potential CalOptima Health Impact:*** Continued covered benefit for pediatric CalOptima Health Medi-Cal members.	**09/28/2024** Signed into law	CalOptima Health: Watch CAHP: Oppose
AB 2446 Ortega	**Diapers:** Would add diapers as a covered Medi-Cal benefit for the following individuals, contingent upon an appropriation by the Legislature: • Children greater than three years of age diagnosed with a condition that contributes to incontinence • Other individuals under 21 years of age to address a condition pursuant to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) standards ***Potential CalOptima Health Impact:*** New covered benefit for pediatric CalOptima Health Medi-Cal members.	**09/27/2024** Vetoed *(see veto message)*	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 2668 Berman	**Cranial Prostheses:** Beginning January 1, 2025, would add cranial prostheses as a covered Medi-Cal benefit as part of a prescribed course of treatment for individuals experiencing permanent or temporary medical hair loss. Coverage would be limited to a maximum of $750 for each instance, no more than once per year. ***Potential CalOptima Health Impact:*** Expanded covered benefit for CalOptima Health Medi-Cal members.	**05/17/2024** Died in Assembly Appropriations Committee **04/23/2024** Passed Assembly Health Committee	CalOptima Health: Watch CAHP: Oppose
AB 2843 Petrie-Norris	**Rape and Sexual Assault Care:** Beginning July 1, 2025, would require a health plan to provide coverage without cost-sharing for emergency room medical care and follow-up treatment following a rape or sexual assault. Would also prohibit a health plan from requiring members to provide a police report or press charges for rape or sexual assault in order to receive care. ***Potential CalOptima Health Impact:*** Expanded covered benefits for CalOptima Health Medi-Cal members.	**09/29/2024** Signed into law	CalOptima Health: Watch
Medi-Cal Eligibility and Enrollment			
S. 423 Van Hollen (MD) **H.R. 1113** Bera (CA)	**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, the Children's Health Insurance Program (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 were subject to a zero net premium. Would also make individuals eligible for Medicaid or CHIP based on a prior finding of eligibility for the Temporary Assistance for Needy Families program or the Supplemental Nutrition Assistance Program. ***Potential CalOptima Health Impact*:** Expanded eligibility standards and procedures for enrollment of CalOptima Health members.	**02/14/2023** Introduced; referred to committees	CalOptima Health: Watch
H.R. 8084 Bilirakis (FL)	**LIVE Beneficiaries Act:** Beginning January 1, 2026, would require states to verify the Medicaid eligibility of current enrollees by checking the Social Security Death Master File quarterly to ensure deceased individuals are no longer enrolled in Medicaid. ***Potential CalOptima Health Impact:*** Improved accuracy of member data files from DHCS.	**09/17/2024** Passed House floor; referred to Senate Finance Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 8111 Miller-Meeks (IA)	**Medicaid Program Improvement Act:** Beginning January 1, 2026, would require Medicaid programs to implement a process to obtain updated addresses for enrollees. Would also require all Medicaid MCPs to report addresses that are directly verified by enrollees to the state. ***Potential CalOptima Health Impact:*** Additional transmission of member data to DHCS.	**09/17/2024** Passed House floor; referred to Senate Finance Committee	CalOptima Health: Watch
SB 1289 Roth	**Medi-Cal Call Center Data:** Beginning on January 1, 2026, would require county Medi-Cal call centers to collect and submit monthly data metrics to DHCS. Beginning on May 15, 2026, would require DHCS to prepare a publish online a quarterly report on submitted call center. ***Potential CalOptima Health Impact:*** Increased resources for CalOptima Health members; increased number of CalOptima Health members as a result of additional new enrollments and fewer disenrollments.	**09/27/2024** Signed into law	CalOptima Health: Watch
AB 1608 Patterson	**Regional Center Clients:** Would exempt from mandatory Medi-Cal MCP enrollment any dual-eligible and non-dual-eligible Medi-Cal beneficiaries who receive services from a regional center and use the Medi-Cal fee-for-service (FFS) delivery system as secondary form of health coverage. ***Potential CalOptima Health Impact:*** Decreased number of CalOptima Health members.	**01/12/2024** Died in Assembly Health Committee	CalOptima Health: Watch
AB 1783 Essayli	**Unsatisfactory Immigration Status:** States the intent of the Legislature to enact legislation to prohibit state funding of health care benefits for individuals with unsatisfactory immigration status. ***Potential CalOptima Health Impact:*** Decreased number of CalOptima Health members	**05/03/2024** Died without referral to committee	CalOptima Health: Watch
AB 2956 Boerner	**Adult Continuous Eligibility and Redetermination:** Would require DHCS to seek federal approval to extend continuous Medi-Cal eligibility to individuals over 19 years of age. Would also require a county to attempt communication through all additional available channels before completing a redetermination and to conduct an additional review of information in an attempt to renew eligibility without needing a response., Would require counties to accept self-attested information from beneficiary for the purpose of income verification during a redetermination. ***Potential CalOptima Health Impact*:** Expanded eligibility standards and procedures for enrollment and re-enrollment of CalOptima Health members.	**05/17/2024** Died in Assembly Appropriations Committee **04/16/2024** Passed Assembly Health Committee	CalOptima Health: Watch LHPC: Support

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Medi-Cal Operations and Administration			
H.R. 2811 Arrington (TX)	**Limit, Save, Grow Act of 2023:** Would require Medicaid beneficiaries ages 19–55 without dependents to work, complete community service and/or participate in a work training program for at least 80 hours per month for at least three months per year. Exemptions would be provided for those who are pregnant, physically or mentally unfit for employment, complying with work requirements under a different federal program, participating in a drug or alcohol treatment program, or enrolled in school at least half-time. HHS estimates that 294,981 Medi-Cal beneficiaries in Orange County would be subject to the proposed work requirements without an exemption. ***Potential CalOptima Health Impact:*** Disenrollment of certain CalOptima Health Medi-Cal members, especially those who experience homelessness, who are not exempt from work requirements.	**04/26/2023** Passed House floor; referred to Senate Budget Committee	CalOptima Health: Concerns ACAP: Oppose
SB 1120 Becker	**Artificial Intelligence (AI) in Utilization Review:** Would require a health plan's use of algorithms, AI, and other software tools for utilization management (UM) purposes to comply with specified fairness and equity requirements and to be based on individual clinical history and circumstances. ***Potential CalOptima Health Impact:*** Implementation of new UM procedures.	**09/28/2024** Signed into law	CalOptima Health: Watch
AB 1690 Kalra	**Universal Health Care Coverage**: States the intent of the Legislature to guarantee accessible, affordable, equitable and high-quality health care for all Californians through a comprehensive universal single-payer health care program. ***Potential CalOptima Health Impact:*** Unknown but potentially significant impacts to the Medi-Cal and commercial health care delivery systems, including changes to administration, covered benefits, financing and organization.	**01/19/2024** Died without referral to committee	CalOptima Health: Watch
AB 2200 Kalra	**Guaranteed Health Care for All:** Would create the California Guaranteed Health Care for All program, or CalCare, to provide comprehensive universal single-payer health care coverage and a health care cost control system for the benefit of all residents of California. ***Potential CalOptima Health Impact:*** Unknown but potentially significant impacts to the Medi-Cal and commercial health care delivery systems, including changes to administration, covered benefits, financing and organization.	**05/17/2024** Died in Assembly Appropriations Committee **04/23/2024** Passed Assembly Health Committee	CalOptima Health: Watch CAHP: Oppose

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 2340 Bonta	**EPSDT Informational Materials:** Would require DHCS to standardize informational materials that effectively explain and clarify the scope and nature of EPSDT services that are available under the Medi-Cal program, including content designed for youth. Would require a Medi-Cal MCP to provide the informational materials to EPSDT-eligible beneficiaries and their parents within a certain period (as determined by DHCS) of initial enrollment into the MCP and annually thereafter. ***Potential CalOptima Health Impact:*** Standardization and increased number of mailings to certain CalOptima Health Medi-Cal members.	**09/25/2024** Signed into law	CalOptima Health: Watch
AB 2466 Carrillo	**Network Adequacy Standards:** Would deem a Medi-Cal MCP out of compliance with appointment time standards if either of the following are true: • Fewer than 85% of network providers had an appointment available within the standards • DHCS receives information establishing that the plan was unable to deliver timely, available or accessible health care services Would also require health plans to submit an annual renewal request for alternative access standards, describing the efforts made in the previous 12 months to mitigate or eliminate circumstances that justify the use of an alternative access standard. ***Potential CalOptima Health Impact:*** Increased network analysis and reporting to DHCS.	**05/17/2024** Died in Assembly Appropriations Committee **04/16/2024** Passed Assembly Health Committee	CalOptima Health: Watch LHPC: Oppose CAHP: Oppose
AB 3260 Pellerin	**Utilization Reviews and Grievances:** Would require health plans to complete utilization review decisions within 72 hours. If a plan fails to meet such deadline, the plan must automatically open a grievance on behalf of the affected beneficiary. Additionally, would require plans to review urgent grievances, as determined by the provider, within 72 hours. ***Potential CalOptima Health Impact***: Expedited and modified UM and Grievance procedures for covered Medi-Cal benefits.	**08/16/2024** Died in Senate Appropriations Committee **06/26/2024** Passed Senate Health Committee **05/21/2024** Passed Assembly floor	CalOptima Health: Watch CAHP: Oppose

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Older Adult Services			
S. 1002 Cassidy (LA)	**No Unreasonable Payments, Coding, or Diagnoses for the Elderly (No UPCODE) Act:** Would modify the MA risk adjustment model to prevent overpayment to MA plans, as follows: • Utilization of two years instead of one of diagnostic data • Exclusion of outdated diagnoses solely included on health risk assessments • Coding adjustment to account for other payment differences between MA and Medicare FFS ***Potential CalOptima Health Impact:*** Decreased reimbursement rates from the CMS for CalOptima Health OneCare members.	**03/28/2023** Introduced; referred to Senate Finance Committee	CalOptima Health: Watch
S. 1703 Carper (DE) **H.R. 3549** Wenstrup (OH)	**Program of All-Inclusive Care for the Elderly (PACE) Part D Choice Act of 2023:** 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 Health Impact:*** Increased enrollment into CalOptima Health PACE by Medicare-only beneficiaries due to decreased out-of-pocket costs.	**05/18/2023** Introduced; referred to committees	**08/30/2023** CalOptima Health: SUPPORT NPA: Support
S. 3950 Cassidy (LA)	**Delivering Unified Access to Lifesaving Services (DUALS) Act of 2024:** Would require each state to develop and implement a comprehensive, integrated health plan for beneficiaries dually eligible for Medicaid and Medicare. Would also expand PACE coverage nationwide to individuals under the age of 55 as well as allow PACE enrollment at any time of the month. ***Potential CalOptima Health Impact:*** Increased coordination and benefits for dually eligible CalOptima Health members; increased enrollment into CalOptima Health PACE.	**03/14/2024** Introduced; referred to Senate Finance Committee	CalOptima Health: Watch
AB 1022 Mathis	**PACE Rates and Assessments**: Would require PACE capitation rates to also reflect the frailty level and risk associated with participants. In addition, would expand a PACE organization's authority to use video telehealth to conduct all assessments. ***Potential CalOptima Health Impact:*** Increased capitation rates for CalOptima Health PACE participants; expanded use of video telehealth assessments.	**01/12/2024** Died in Assembly Health Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 1223 Hoover	**PACE Audits:** Would require DHCS to perform program audits of PACE organizations and to develop and maintain standards, rules and auditing protocols, including related to data collection, technical assistance, formal decisions and enforcement of non-compliance. ***Potential CalOptima Health Impact:*** Modified audit protocols for CalOptima Health PACE.	**01/12/2024** Died in Assembly Health Committee	CalOptima Health: Watch
AB 1230 Valencia	**Special Needs Plans (SNPs)**: No later than January 1, 2025, would require DHCS to offer contracts to health plans for Highly Integrated Dual Eligible Special Needs Plans (HIDE-SNPs) and Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs) to provide care to dual eligible beneficiaries. ***Potential CalOptima Health Impact:*** Increased number of SNPs in Orange County; decreased number of CalOptima Health OneCare members.	**01/12/2024** Died in Assembly Health Committee	CalOptima Health: Watch LHPC: Oppose
Providers			
S. 3059 Bennet (CO)	**Requiring Enhanced & Accurate Lists of (REAL) Health Providers Act:** Effective plan year 2026, would require MA plans to update and ensure accurate provider directory information at least once every 90 days. If a plan is unable to verify such information for a specific provider, a disclaimer indicating that the information may not be up to date is required. Would also require the removal of a provider from a directory within five business days if the plan determines they are no longer participating in the network. ***Potential CalOptima Health Impact:*** Increased staff oversight of CalOptima Health's OneCare provider directory.	**10/17/2023** Introduced; referred to Senate Finance Committee	CalOptima Health: Watch
H.R. 497 Duncan (SC)	**Freedom for Health Care Workers Act:** would repeal the rule issued by CMS on November 5, 2021, that requires health care providers participating in the Medicare and Medicaid programs to ensure staff are fully vaccinated against COVID-19**.** ***Potential CalOptima Health Impact:*** Elimination of COVID-19 vaccination mandate for CalOptima Health PACE staff and contracted providers.	**01/31/2023** Passed House floor; referred to Senate Finance Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 4758 Trahan (MA)	**Accelerating Kids' Access to Care Act:** Would require Medicaid programs to establish a process through which qualifying out-of-state providers may temporarily treat children without undergoing additional screening requirements. In addition, would require pass-through pricing models for covered drugs under Medicaid payment arrangements with pharmacy benefit managers. ***Potential CalOptima Health Impact:*** Improved access to care for pediatric CalOptima Health Medi-Cal members with complex medical conditions.	**09/17/2024** Passed House floor; referred to Senate Finance Committee	CalOptima Health: Watch
H.R. 7149 Steel (CA)	**Equal Access to Specialty Care Everywhere (EASE) Act of 2024:** Would use existing Center for Medicare and Medicaid Innovation funds to test a virtual specialty network dedicated to providing a range of virtual modalities in partnership with primary care providers in underserved and rural communities, including Federally Qualified Health Centers (FQHCs). ***Potential CalOptima Health Impact:*** Expanded telehealth access for CalOptima Health members.	**01/30/2024** Introduced; referred to House Energy and Commerce Committee	CalOptima Health: Watch
H.R. 7858 James (MI)	**TELEMH Act of 2024:** No later than January 1, 2026, would require HHS to create a new code or billing modifier related to telehealth-delivered mental health services in Medicare. ***Potential CalOptima Health Impact:*** Continued use of telehealth by CalOptima Health OneCare members to access mental health services; modified Medicare coding and claims processing.	**09/17/2024** Passed House floor; referred to Senate Finance Committee	CalOptima Health: Watch
H.R. 8089 Garcia (CA)	**Medicare and Medicaid Fraud Prevention Act of 2024:** Beginning January 1, 2027, would require states to check the Social Security Death Master File quarterly to determine whether Medicaid providers and suppliers are deceased. Would also enable the state to deactivate the National Provider Identifiers (NPIs) of deceased providers. ***Potential CalOptima Health Impact:*** Improved accuracy of provider enrollment data from DHCS.	**09/17/2024** Passed House floor; referred to Senate Finance Committee	CalOptima Health: Watch
H.R. 8112 D'Esposito (NY)	**Medicaid Provider Screening Requirements:** Beginning January 1, 2027, would require states to check monthly if a Medicaid provider's or supplier's participation in Medicare, CHIP or another state's Medicaid program is still active. ***Potential CalOptima Health Impact:*** Improved accuracy of provider enrollment data from DHCS.	**09/17/2024** Passed House floor; referred to Senate Finance Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 819 Eggman	**Medi-Cal Mobile Health Care Site Enrollment:** Would exempt intermittent or mobile health care sites from enrolling in Medi-Cal as a separate provider if operated by a government-operated clinic that is exempt from licensure by the California Department of Public Health (CDPH). ***Potential CalOptima Health Impact:*** Expansion of intermittent and mobile health care sites; increased access to care for CalOptima Health members.	**09/22/2024** Signed into law	CalOptima Health: Watch
SB 1268 Nguyen, J.	**Medi-Cal Safety Net Provider Contracts:** Would require a Medi-Cal MCP to offer and maintain a network provider contract with each safety net provider operating within the MCP's geographic service areas unless the safety net provider cannot provide necessary scope of services due to specified, covered reasons. Would prohibit a Medi-Cal MCP from initiating a contract termination for any reason. ***Potential CalOptima Health Impact*:** Revision of current provider contract language; decreased oversight and accountability of contracted providers.	**04/26/2024** Died in Senate Health Committee	**04/15/2024** CalOptima Health: OPPOSE LHPC: Oppose CAHP: Oppose
AB 236 Holden	**Provider Directory Audits:** Would require health plans to annually verify and delete inaccurate listings from its provider directories. Would also require a provider directory to be 60% accurate by July 1, 2025, with increasing percentage accuracy each year until the directories are 95% accurate by July 1, 2028. In addition, plans would be subject to penalties for failure to meet the prescribed benchmarks and for each inaccurate listing in its directories. Further, beginning July 1, 2025, would require plans to delete a provider from its directory if a plan has not reimbursed the provider in the prior year. Would also require a plan to arrange care for all covered health services provided to a beneficiary who reasonably relied on inaccurate, incomplete or misleading information contained in a plan's provider directory as well as require the plan reimburse the provider the contracted amount for those services. ***Potential CalOptima Health Impact:*** Increased oversight of CalOptima Health provider directory; increased coordination with contracted providers; increased penalty payments to DHCS.	**08/16/2024** Died in Senate Appropriations Committee **06/26/2024** Passed Senate Health Committee **01/30/2024** Passed Assembly floor	CalOptima Health: Watch LHPC: Oppose CAHP: Oppose
AB 564 Villapudua	**Medi-Cal Claim Signatures**: Would allow Medi-Cal providers to submit electronic signatures for claims and remittance forms. ***Potential CalOptima Health Impact:*** Reduced administrative burden for CalOptima Health contracted providers.	**07/03/2024** Died in Senate Health Committee **05/31/2023** Passed Assembly floor	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 2110 Arambula	**Adverse Childhood Experiences (ACEs) Trauma Screenings:** Would include Medi-Cal enrolled community-based organizations and local health jurisdictions that provide health services through community health workers and doulas as providers qualified to provide and eligible to receive payments for ACEs trauma screenings. **Potential CalOptima Health Impact:** Increased access to care for eligible CalOptima Health Medi-Cal members; additional provider contracting and credentialing.	**05/17/2024** Died in Assembly Appropriations Committee **04/09/2024** Passed Assembly Health Committee	CalOptima Health: Watch LHPC: Support
AB 2129 Petrie-Norris	**Immediate Postpartum Contraception:** No later than January 1, 2025, would authorize a provider to separately bill for devices, implants or professional services, or a combination of both, associated with immediate postpartum contraception if the birth takes place in a general acute care hospital or licensed birth center. ***Potential CalOptima Health Impact:*** Modified Claims procedures for a covered Medi-Cal benefit.	**09/29/2024** Signed into law	CalOptima Health: Watch
AB 2339 Aguiar-Curry	**Medi-Cal Asynchronous Telehealth:** Would expand telehealth capabilities to include asynchronous electronic transmission initiated directly by patients, including through mobile telephone applications. Would also authorize a health care provider to establish a new patient relationship using asynchronous store and forward when the visit is related to sensitive services. ***Potential CalOptima Health Impact:*** Expanded telehealth capabilities for CalOptima Health Medi-Cal members.	**09/20/2024** Vetoed *(see **veto message**)*	CalOptima Health: Watch
AB 2726 Flora	**Telehealth and Specialty Care Networks:** Would require CalHHS to establish a demonstration project for a grant program aimed at facilitating telehealth and other virtual services specialty care network for patients of certain safety-net providers, including community health centers and critical access hospitals. The project would focus on increasing access to behavioral and maternal health services as well as other specialties prioritized by CalHHS. ***Potential CalOptima Health Impact:*** Expanded telehealth capabilities and virtual specialty networks.	**05/17/2024** Died in Assembly Appropriations Committee **04/23/2024** Passed Assembly Health Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Rates & Financing			
S. 570 Cardin (MD) **H.R. 1342** Barragan (CA)	**Medicaid Dental Benefit Act of 2023:** Would require state Medicaid programs to cover dental and oral health services for adults. Would also increase the Federal Medical Assistance Percentage (FMAP) (i.e., federal matching rate) for such services. CMS would be required to develop oral health quality and equity measures and conduct outreach relating to dental and oral health coverage. ***Potential CalOptima Health Impact:*** Increased payments to CalOptima Health and contracted providers; additional quality metrics.	**02/28/2023** Introduced; referred to committees	CalOptima Health: Watch
S. 1038 Welch (VT) **H.R. 1613** Carter (GA)	**Drug Price Transparency in Medicaid Act of 2023:** Would prohibit "spread pricing" for payment arrangements with PBMs under Medicaid. Would also require a pass-through pricing model that focuses on cost-based pharmacy reimbursement and dispensing fees. ***Potential CalOptima Health Impact*:** Lower costs and increased transparency in drug prices under the Medi-Cal Rx program,	**03/29/2023** Introduced; referred to committees	CalOptima Health: Watch
S. 3578 Cassidy (LA)	**Protect Medicaid Act:** Would prohibit federal funding for the administrative costs of providing Medicaid benefits to individuals with unsatisfactory immigration status. If states choose to self-fund such costs, this bill would require states to submit a report describing its funding methods as well as the process utilized to bifurcate its expenditures on administrative costs. ***Potential CalOptima Health Impact:*** New financial reporting requirements.	**01/11/2024** Introduced; referred to Senate Finance Committee	CalOptima Health: Watch
H.R. 485 McMorris (WA)	**Protecting Health Care for All Patients Act of 2023:** Would prohibit all federally funded health care programs from using quality-adjusted life years (i.e., measures that discount the value of a life based on disability) to determine coverage and payment determinations for treatments and prescription drugs. ***Potential CalOptima Health Impact:*** Modified authorization limits for certain CalOptima Health members.	**02/07/2024** Passed House floor; referred to Senate Finance Committee **03/24/2023** Passed House Energy and Commerce Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 282 Eggman	**FQHCs and Rural Health Clinic (RHC) Same-Day Visits**: Would authorize reimbursement for a maximum of two separate visits that take place on the same day at a single FQHC or RHC site, whether through a face-to-face or telehealth-based encounter (e.g., a medical visit and dental visit on the same day). In addition, would add a licensed acupuncturist within those health care professionals covered under the definition of a "visit." ***Potential CalOptima Health Impact:*** Timelier access to services at CalOptima Health's contracted FQHCs.	**08/16/2024** Died in Assembly Appropriations Committee **07/11/2023** Passed Assembly Health Committee **05/25/2023** Passed Senate floor	CalOptima Health: Watch LHPC: Support
SB 340 Eggman	**Eyeglasses Reimbursement**: Would authorize a provider to purchase eyeglasses from a private entity instead of from the Prison Industry Authority for the purpose of Medi-Cal reimbursement for covered optometric services. ***Potential CalOptima Health Impact:*** Timelier access to prescription eyeglasses for CalOptima Health Medi-Cal members.	**07/03/2024** Died in Assembly Health Committee and Assembly Public Safety Committee **05/25/2023** Passed Senate floor	CalOptima Health: Watch
SB 828 Durazo	**Health Care Workers Minimum Wage Delay:** Would delay the minimum wage adjustments enacted pursuant to SB 525 (2023) by one month from June 1, 2024, to July 1, 2024, effective immediately as an urgency statute. ***Potential CalOptima Health Impact:*** No expected impact since CalOptima Health previously increased its minimum wage.	**05/31/2024** Signed into law	CalOptima Health: Watch
SB 870 Caballero	**MCO Tax:** Would renew the MCO tax on health plans, which expired on January 1, 2023, to an unspecified future date. Would also modify the tax rates to unspecified percentages that are based on the Medi-Cal membership of the health plan. ***Potential CalOptima Health Impact:*** Increased tax liability on CalOptima Health.	**01/19/2024** Died in Senate Appropriations Committee **04/26/2023** Passed Senate Health Committee	CalOptima Health: Watch
SB 1423 Dahle	**Rural Hospital Technical Advisory Group:** Would require DHCS to convene a Rural Hospital Technical Advisory Group — including representatives from Medi-Cal MCPs and their state associations — to analyze the ability of small, rural and critical access hospitals to remain financially viable under existing Medi-Cal reimbursement methodologies and to provide related recommendations by March 31, 2026. ***Potential CalOptima Health Impact:*** CalOptima Health representation on DHCS committee; consideration of modified payments to CalOptima Health contracted critical access hospitals.	**09/22/2024** Vetoed *(see **veto message**)*	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 1492 Menjivar	**Private Duty Nursing Rate Increases:** Would add private duty services, which are provided to a child under 21 years of age by a home health agency, as an eligible category for the purpose of Medi-Cal rate increases from MCO tax revenue. ***Potential CalOptima Health Impact:*** Increased payments to CalOptima Health contracted home health agencies.	**05/17/2024** Died in Senate Appropriations Committee **04/24/2024** Passed Senate Health Committee	CalOptima Health: Watch
AB 55 Rodriguez	**Ground Ambulance Transportation**: Effective January 1, 2024, would require Medi-Cal MCPs to implement a value-based purchasing model that increases reimbursement to ground ambulance transportation providers who meet certain workforce standards. ***Potential CalOptima Health Impact:*** Increased financial stability for CalOptima Health's contracted transportation providers; increased costs for CalOptima Health.	**01/19/2024** Died in Assembly Appropriations Committee **04/25/2023** Passed Assembly Health Committee	CalOptima Health: Watch
AB 488 Nguyen, S.	**Vision Loss:** Would modify the Skilled Nursing Facility (SNF) Workforce and Quality Incentive Program measures and milestones to include program access, staff training and capital improvement measures aimed at addressing the needs of SNF residents with vision loss. ***Potential CalOptima Health Impact:*** Modified payments to CalOptima Health contracted SNFs; increased data collection, tracking and reporting requirements; improved quality of life for certain members with vision loss.	**01/12/2024** Died in Assembly Health Committee	CalOptima Health: Watch
AB 1549 Carrillo	**FQHC and RHC Rates:** Would require that DHCS's per-visit rates to FQHCs and RHCs account for costs that are reasonable and related to the provision of covered services, including staffing, the intensity of activities taking place in an average visit, the length or duration of a visit, and the number of activities provided during a visit. ***Potential CalOptima Health Impact:*** Increased financial stability for CalOptima Health's contracted FQHCs.	**01/19/2024** Died in Assembly Appropriations Committee **04/25/2023** Passed Assembly Health Committee	CalOptima Health: Watch
AB 1698 Wood	**Medi-Cal Funding**: States the intent of the Legislature to enact future legislation to increase overall funding and reimbursement for the Medi-Cal program. ***Potential CalOptima Health Impact***: Increased financial stability for CalOptima Health and its contracted providers.	**01/19/2024** Died without referral to committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 2043 (AB 719) Boerner	**Public Transit Contracts**: Would authorize DHCS to direct Medi-Cal MCPs to reimburse public paratransit service operators, who are enrolled as Medi-Cal providers, at the Medi-Cal FFS rates for nonmedical transportation (NMT) and nonemergency medical transportation (NEMT) services that are not on fixed routes. Would also direct DHCS to issue updated guidance by June 1, 2026, to ensure that the financial burden of these services is not unfairly placed on such operators. ***Potential CalOptima Health Impact:*** Increased payments to public paratransit operations for NMT and NEMT services.	**08/16/2024** Died in Senate Appropriations Committee **06/12/2024** Passed Senate Health Committee **05/21/2024** Passed Assembly floor **02/01/2024** Re-introduced as AB 2043 **10/07/2023** Vetoed as AB 719 *(see **veto message**)*	CalOptima Health: Watch LHPC: Oppose CAHP: Oppose
AB 2303 Carrillo	**Minimum Wage Add-On Payment:** Would require DHCS to develop a minimum wage add-on as an alternative payment methodology to increase rates of payment to community health centers, in order to accommodate increased labor costs resulting from recently enacted minimum wage increases pursuant to SB 525 (2023). ***Potential CalOptima Health Impact***: Increased financial stability for CalOptima Health contracted community health centers.	**04/26/2024** Died in Assembly Health Committee	CalOptima Health: Watch
AB 2342 Lowenthal	**Island-Based Critical Access Hospitals:** Would require DHCS to provide an annual supplemental payment for covered Medi-Cal services to each critical access hospital that operates on an island that is located more than 10 miles offshore of the mainland coasts of the state but is still within the jurisdiction of the state. ***Potential CalOptima Health Impact:*** Increased payments to certain critical access facilities for Medi-Cal services.	**04/26/2024** Died in Assembly Health Committee	CalOptima Health: Watch
AB 2428 Calderon	**Community-Based Adult Services (CBAS) Rates:** Would require Medi-Cal MCPs to reimburse contracted CBAS provider at an amount equal to or greater than the Medi-Cal FFS rate. ***Potential CalOptima Health Impact:*** Increased payments to CalOptima Health contracted CBAS providers.	**09/14/2024** Vetoed *(see **veto message**)*	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 3275 Soria	**Claim Reimbursement:** Beginning January 1, 2026, would require health plans to reimburse, contest or deny a complete claim within 30 calendar days after receipt of the claim, or otherwise be subject to current 15% per annum interest requirements. If a plan does not automatically include any accrued interest in its payment, this bill would increase the penalty fee from $10 to the greater of $15 or 10% of accrued interest. In addition, would require health plans to treat a complaint from an enrollee about the delay or denial of a claim payment to be treated as a grievance, regardless of whether the term grievance is used. ***Potential CalOptima Health Impact*:** Decreased claim review time for CalOptima Health staff; increased number of member grievances; increased interest and penalty payments to CalOptima Health contracted providers.	**09/27/2024** Signed into law	CalOptima Health: Watch LHPC: Oppose CAHP: Oppose
Social Determinants of Health			
H.R. 1066 Blunt Rochester (DE)	**Collecting and Analyzing Resources Integral and Necessary for Guidance (CARING) for Social Determinants Act of 2023:** Would require CMS to update guidance at least once every three years to help states address SDOH under Medicaid and CHIP. ***Potential CalOptima Health Impact:*** Increased opportunities for CalOptima Health to address SDOH.	**02/17/2023** Introduced; referred to House Energy and Commerce Committee	CalOptima Health: Watch
AB 257 Hoover	**Encampment Restrictions:** Would prohibit a person from sitting, lying, sleeping or placing personal property in any street, sidewalk or other public property within 500 feet of a school, daycare center, park or library. ***Potential CalOptima Health Impact:*** Increased outreach and support services for unsheltered CalOptima Health Medi-Cal members.	**01/19/2024** Died in Assembly Public Safety Committee **03/07/2023** Failed passage in Assembly Public Safety Committee	CalOptima Health: Watch
AB 2250 (AB 85) Weber	**SDOH Screenings:** Would add SDOH screenings as a covered Medi-Cal benefit on or after January 1, 2027, contingent upon an appropriation by the Legislature. Would also require health plans to provide primary care providers with adequate access to community health workers, social workers and peer support specialists. In addition, would require FQHCs and RHCs to be reimbursed for these services at the Med-Cal FFS rate. ***Potential CalOptima Health Impact:*** New covered benefits for CalOptima Health Medi-Cal members.	**09/22/2024** Vetoed *(see **veto message**)*	CalOptima Health: Watch LHPC: Support

2023 Signed Bills

- H.R. 3746 (McHenry [NC])
- H.R. 5860 (Granger [TX])
- H.R. 6363 (Granger [TX])
- SB 43 (Eggman)
- SB 101 (Skinner)
- SB 311 (Eggman)
- SB 326 (Eggman)
- SB 525 (Durazo)
- SB 496 (Limón)
- SB 770 (Wiener)
- AB 102 (Ting)
- AB 271 (Quirk-Silva)
- AB 557 (Hart)
- AB 118 (Committee on Budget)
- AB 119 (Committee on Budget)
- AB 531 (Irwin)
- AB 425 (Alvarez)
- AB 847 (Rivas, L.)
- AB 904 (Calderon)
- AB 1481 (Boerner)
- AB 1241 (Weber)

2023 Vetoed Bills

- SB 257 (Portantino)
- SB 694 (Eggman)
- AB 608 (Schiavo)
- AB 1060 (Ortega)
- AB 1202 (Lackey)
- AB 931 (Irwin)
- AB 576 (Weber)
- AB 1085 (Maienschein)
- AB 1451 (Jackson)

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
SNP Alliance: Special Needs Plan Alliance

Last Updated: October 15, 2024

2024 Federal Legislative Dates

January 8	118th Congress, 2nd Session convenes
August 5–September 6	Summer recess
September 30–November 11	Fall recess
December 20	118th Congress adjourns

Source: Floor Calendars, United States Congress: https://www.congress.gov/calendars-and-schedules

2024 State Legislative Dates

January 3	Legislature reconvenes
January 10	Proposed budget must be submitted by Governor
January 12	Last day for policy committees to hear and report to fiscal committees any fiscal bills introduced in that house in 2023
January 19	Last day for any committee to hear and report to the floor any bill introduced in that house in 2023
January 31	Last day for each house to pass bills introduced in that house in 2023
February 16	Last day for legislation to be introduced in 2024
March 21–March 30	Spring recess
April 26	Last day for policy committees to hear and report to fiscal committees any fiscal bills introduced in that house in 2024
May 3	Last day for policy committees to hear and report to the Floor any non-fiscal bills introduced in that house in 2024
May 17	Last day for fiscal committees to hear and report to the Floor any bills introduced in that house in 2024
May 20–24	Floor session only
May 24	Last day for each house to pass bills introduced in that house in 2024
June 15	Budget bill must be passed by midnight
July 3	Last day for policy committees to hear and report bills in their second house to fiscal committees or the Floor
July 3–August 4	Summer recess
August 16	Last day for fiscal committees to report bills in their second house to the Floor
August 19–31	Floor session only
August 23	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: 2024 Legislative Deadlines, California State Assembly: http://assembly.ca.gov/legislativedeadlines

About CalOptima Health

CalOptima Health is a county organized health system that administers health insurance programs for low-income children, adults, seniors and people with disabilities. As Orange County's community health plan, our mission is to serve member health with excellence and dignity, respecting the value and needs of each person. We provide coverage through three major programs: Medi-Cal, OneCare (HMO D-SNP) and the Program of All-Inclusive Care for the Elderly (PACE).

Fiscal Year 2024–25 Enacted State Budget

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Background

On January 10, Gov. Gavin Newsom unveiled his Fiscal Year (FY) 2024–25 Proposed State Budget. With a spending plan of $291.5 billion ($223.6 billion General Fund [GF]), the governor predicted a budget deficit of $37.9 billion – about half the $68 billion initially projected by the Legislative Analyst's Office last year. Gov. Newsom attributed the past two years' shortfall to stock market declines in 2022, driving down revenue and delays in income tax collection. Most proposed budget solutions included reserve withdrawals, loans, fund shifts, and spending delays and deferrals.

To immediately address some of the budget deficit, the administration and California State Legislature attempted to minimize $17.3 billion of the overall shortfall by taking "early action" in April via a limited budget agreement that included some spending cuts that largely avoided health care programs.

Despite efforts in the early budget deal, revenues continued to come in below projections and further increase the deficit by an estimated $7 billion for a new remaining total of $27.6 billion. On May 10, Gov. Newsom released his May Revision to the Proposed State Budget, which largely reversed an agreement to fund Medi-Cal provider rate increases using Managed Care Organization (MCO) tax dollars. The May Revision also proposed several additional spending reductions to health care programs to address both the near-term budget deficit and look beyond FY 2024-25 in hopes of achieving positive operating reserves in the future. On May 29, leaders from both houses of the Legislature released a joint counterproposal to the May Revision, which would have instead delayed future rate increases funded by MCO tax revenues by one-year year from January 1, 2025, to January 1, 2026, rather than eliminate them. On June 13, the State Senate and State Assembly both passed its counterproposal (Assembly Bill [AB] 107) as a placeholder budget to meet the constitutional deadline while negotiations with the governor remained ongoing.

On June 22, Gov. Newsom and legislative leaders announced that a final budget agreement had been reached. After both houses of the Legislatures passed the agreed-upon budget revisions as Senate Bill (SB) 108 on June 26, Gov. Newsom signed both AB 107 and SB 108 into law. Additionally, the governor signed the MCO Tax Trailer Bill (AB 160) and consolidated Health Trailer Bill (SB 159) on June 29, containing policy changes needed to implement health-related budget expenditures. Together, these bills represent the FY 2024-25 Enacted State Budget.

Overview

The final budget agreement includes obligations to support further resilience by adding financial protection so that the state doesn't overcommit anticipated revenues until it has been completely realized. The enacted budget eliminates the projected FY 2024-25 shortfall of approximately $45 billion and the FY 2025-26 shortfall of over $30 billion through a combination of spending cuts, fund shifts, delays, deferrals and reserves, including utilizing approximately half of the Rainy Day Fund over the next two budget years. Another goal of the final budget agreement is to strengthen the Rainy Day Fund by increasing the maximum limit from 10% to 20% of GF tax revenue, subject to future voter approval, and creating a new "Projected Surplus Temporary Holding Account."

The final Medi-Cal budget includes $161 billion ($35 billion GF) to cover a projected 14.5 million beneficiaries in FY 2024-25 – more than one-third of the state's population.

MCO Provider Tax

The FY 2024-25 Enacted Budget restores several MCO tax investments for future Medi-Cal provider rate increases that were proposed to be eliminated in the governor's May Revision. The final agreement includes $133 million in FY 2024-25, $728 million in FY 2025-26 and $1.2 billion in FY 2026-27 in addition to the approximately $300 million in provider rate increases that already became effective January 1, 2024, and will be maintained. However, total investments are less and partially redistributed compared with the original agreement reached with the MCO tax coalition last year. Some increases will still be effective on January 1, 2025, some will be delayed until January 1, 2026, and others have been eliminated. Additional provider types not included in the MCO tax coalition will now also receive a portion of the investments, further reducing total funding for the originally included provider types.

Effective **January 1, 2025**, Medi-Cal rate increases apply to:

- Emergency Department Physician Services ($100 million)
- Abortion Care and Family Planning ($90 million)
- Ground Emergency Medical Transportation ($50 million)
- Air Emergency Medical Transportation ($8 million)
- Community-Based Adult Services ($8 million)
- Congregate Living Health Facilities ($8 million)
- Pediatric Day Health Centers ($3 million)
- Community Health Workers to achieve 100 percent of Medicare rate

Effective **January 1, 2026**, Medi-Cal rate increases apply to:

- Physician/Non-Physician Professional Health Services ($753 million)
  - » Evaluation & Management Codes for Primary Care and Specialist Office Visits, Preventative Services and Care Management (95% of Medicare rate)
  - » Obstetric Services (95% of Medicare rate)
  - » Non-Specialty Mental Health Services (87.5% of Medicare rate)
  - » Vaccine Administration (87.5% of Medicare rate)
  - » Vision (Optometric Services (87.5% of Medicare rate)
  - » Other Evaluation & Management Codes (80% of Medicare rate)
  - » Other Procedure Codes commonly utilized by Primary Care, Specialist and Emergency Department Providers (80% of Medicare rate)
- Private Duty Nursing ($62 million)
- Federally Qualified Health Centers (FQHCs)/Rural Health Clinics (RHCs) ($50 million)
- Non-Emergency Medical Transportation ($25 million)

The final agreement allows the California Department of Health Care Services (DHCS) to develop specific rate increase methodologies and supplemental payment amounts, particularly for 2025 investments.

Additional MCO tax investments include $145.4 million in FY 2024-25 to sustain Proposition 56-funded payments to address revenue decline and $40 million in FY 2026-27 for Medi-Cal workforce development through the California Department of Health Care Access and Information (HCAI). The final agreement also includes funding to enact continuous Medi-Cal eligibility for children 0-5, effective January 1, 2026. Notably, if Proposition 35 ("Protect Access to Care" MCO Tax Initiative) is approved by voters in the November 5, 2024, general election, the aforementioned provisions relating to the MCO provider tax will be inoperable since both are not financially sustainable.

CalOptima Health Budget and Provider Rate Increase

CalOptima Health developed our proposed FY 2024-25 operating budget factoring in assumptions related to Medi-Cal program and policy changes, including the state budget. On May 2, the CalOptima Health Board of Directors approved an investment of **$526 million** to increase rates paid to delegated networks, hospitals, physicians, community clinics, behavioral health providers and ancillary services providers. It is the largest provider rate increase of its kind in our nearly 30-year history. This unprecedented investment is intended to support timely access to critical health care services for members and promote longer-term financial stability of the managed care network over a 30-month period from July 2024 to December 2026. The uncertain nature of the state budget negotiations underscores why CalOptima Health's action to deliver our own separate provider rate increase is so significant.

Continuing Priorities in Medi-Cal

The enacted state budget continues to reflect funding for Medi-Cal benefits that were initially proposed to be eliminated in the May Revision. Key investments that have been protected include but are not limited to:

- Full-scope Medi-Cal coverage and In-Home Supportive Services (IHSS) for all ages, regardless of immigration status.
- **Adult Acupuncture** as a Medi-Cal covered benefit.
- Continued funding for **Health Enrollment Navigators** at clinics, but not at other entities. This does not impact CalOptima Health's own reserve-funded grants for community enrollers.
- **Free Clinics Augmentation** funding.
- Nearly all funding for the **Multifamily Housing Program**.

In addition, the final budget includes $230 million ($115 million GF) for a new directed payment program for children's hospitals to support critically ill children.

Significant Adjustments to Programs

To address the projected budget shortfall, the final budget includes several adjustments in the form of delays, triggers and reductions to certain programs and legislation that has not been implemented. Key program adjustments include but are not limited to:

- $39 million savings in the **Naloxone Distribution Project** from lower naloxone drug costs due to Medi-Cal Rx, while adding $8.3 million in special funds to expand the distribution of naloxone. This does not impact CalOptima Health's own reserve-funded naloxone distribution initiative.
- Reduced funding for **Equity and Practice Transformation (EPT) Program** payments by $111.3 million, which will eliminate the remaining funding for the program but preserve funding previously included in the 2022 Budget Act.
- Reverts all unexpended funds for the **Clinic Workforce Stabilization & Retention Payment Program**.
- Reduces or eliminates funding for several elements of the **Children and Youth Behavioral Health Initiative** (CYBHI), as follows:
  - » Eliminates funding for school-linked partnership and capacity grants for community colleges, University of California and California State University systems.
  - » Eliminates funding for the services and supports platform.
  - » Reduces funding for the public education and change campaign.
  - » Allows school districts to use a third-party administrator and/or managed care plans directly for billing related to the school-linked fee schedule.
  - » Despite overall reductions, allocates new funding to establish the **wellness coach** benefit, effective January 1, 2025, to provide wellness promotion, education, screening, care coordination, individual and group support, and crisis referral in school-linked settings and across the Medi-Cal behavioral health delivery system.
- Reduces some funding for state and local public health.
- Reverts $450.7 million from the last round of the **Behavioral Health Continuum Infrastructure Program**, which leaves $1.75 billion to support existing projects.
- Reduces and delays funding for **Behavioral Health Bridge Housing** by one year from FY 2024-25 until FY 2025-26.
- Ends continued funding for the **Medication Assisted Treatment** program, which funds startup grants for new treatment facilities.

Next Steps

State agencies, including DHCS, will begin implementing the policies included in the enacted budget. Staff will continue to monitor these policies and provide updates regarding issues that have a significant CalOptima Health impact. In addition, the Legislature will continue to advance policy bills through the legislative process. Bills with funding allocated in the enacted budget are more likely to be passed and signed into law. The Legislature has until August 31 to pass legislation, and Gov. Newsom has until September 30 to either sign or veto that passed legislation.

About CalOptima Health

CalOptima Health, 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 Health 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.

CalOptima Health Community Outreach Summary —October and November 2024

Background

CalOptima Health is committed to serving the community by sharing information with current and potential members and strengthening relationships with community partners. To this end, our team attends community coalitions, collaborative meetings and advisory groups as well as supports our community partners' public activities. Participation includes providing Medi-Cal educational materials and, if criteria is met, financial support and/or CalOptima Health-branded items.

CalOptima Health's participation in public activities promotes:

- Member interaction/enrollment in a CalOptima Health program
- Community awareness of CalOptima Health
- Partnerships that increase positive visibility and relationships with community organizations

Community Outreach Highlight

Food insecurity continues to be a critical issue faced by Orange County residents at a rate of 10.4%. Recognizing that many of our members may be impacted during the holidays, CalOptima Health is hosting an inaugural Thanksgiving Food Distribution and CalFresh Enrollment Event for our members on Saturday, November 23, from 9 a.m.–1 p.m. at the CalOptima Health building in Orange. To ensure our members have an opportunity to enjoy Thanksgiving, families will have a choice of ham, turkey or Northgate gift card with side items (while supplies last) one per family. The County of Orange Social Services Agency will also be on-site to assist with CalFresh enrollment and 211OC will be available to connect members to additional basic needs and community resources to support their comprehensive needs. Additionally, members will have an opportunity to engage with a variety of CalOptima Health departments to learn more about Medi-Cal programs, services and support services, including Customer Service, Behavioral Health Integration, Culture and Linguistics, Equity and Community Health, PACE, OneCare, Long Term Services and Supports, Case Management, and CalAIM to support our members' health care needs. We look forward to celebrating Thanksgiving with our members. We look forward to celebrating the Thanksgiving holiday with our members.

Summary of Public Activities

As of October 11, CalOptima Health plans to participate in, organize or convene 68 public activities in October and November. In October, there were 44 public activities, including 10 virtual community/collaborative meetings, 32 community events, one Cafecito and one Health Network Forum. In November, there will be 24 public activities, including 11 virtual community/collaborative meetings, two community-based presentations, 10 community events and one Health Network Forum. A summary of the agency's participation in community events throughout Orange County is attached.

Endorsements

CalOptima Health provided no 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 Health's Policy AA.1214: Guidelines for Endorsements by CalOptima Health, for Letters of Support and Use of CalOptima Health's Name and Logo. More information about policy requirements can be found at: https://www.caloptima.org/en/About/CommunityRelations/CommunityOutreach.aspx.

For additional information or questions, contact CalOptima Health Community Relations Director Tiffany Kaaiakamanu at 714-222-0637 or tkaaiakamanu@caloptima.org.

Attachment to the November 7, 2024 CalOptima Health Outreach Summary

Community events hosted by CalOptima Health and community partners in October and November 2024:

October 2024

October 1, 8:30–11:30 a.m., All about Alzheimer's, hosted by the Office of Representative Blakespear

San Juan Capistrano Community Center, 25925 Camino Del Avion, San Juan Capistrano

- At least one staff member attended (in person)
- Health/resource fair, open to the public

October 1, 10 a.m.–Noon, Senior Scam Stopper, hosted by the Office of Assemblywoman Cotie Petrie-Noris

Costa Mesa Senior Center, 695 W. 19th St., Costa Mesa

- At least one staff member attended (in person)
- Health/resource fair, open to the public

October 2, 11 a.m.–3 p.m., Health and Wellness Fair, hosted by CalOptima Health in collaboration with Orange Coast College

Orange Coast College, 2701 Fairview Rd., Costa Mesa

- At least eight staff members attended (in person)
- Health/resource fair, open to the public

October 3–4, 11 a.m.–4:30 p.m., District and Vision 2030 Noncredit Summit, hosted by North Orange Continuing Education

Westin Anaheim Resort, 1030 W. Katella Ave., Anaheim

- Sponsorship fee: $5,000; included a resource table, logo recognition on event program and website. Sponsor name tag noting level of sponsorship, half size ad in event program, and meals for two.
- At least one staff member attended (in person)
- Health/resource fair, open to the public

October 3–4, 8 a.m.–4:30 p.m., International Vietnamese Mental Health Conference, hosted by Moving Forward Psychological Institute

Westin Anaheim Resort, 1030 W. Katella Ave., Anaheim

- Sponsorship fee: $5,000; included a two-minute speaking remark at lunch, medium logo size on event banner, recognition certificate, a resource table, two tickets to attend the conference, acknowledgement on all social/media campaigns, and acknowledgment in event's digital program book.
- At least one staff member attended (in person)
- Health/resource fair, open to the public

CalOptima Health-hosted | CalFresh Outreach (e.g., colleges, food banks) | Community Presentation | Exhibitor/Attendee

October 4, 9 a.m.–1 p.m., Senior Summit, hosted by CalOptima Health in collaboration with Orange County Supervisor Katrina Foley

Aliso Creek Ranch, 100 Park Ave., Aliso Viejo

- At least six staff members attended (in person)
- Health/resource fair, open to the public

October 5, 10 a.m.–1 p.m., Walk to End Alzheimer's, hosted by Alzheimer's Association

Mike Ward Community Park, 20 Lake Rd., Irvine

- Sponsorship fee: $2,500; included a resource table and logo on flyer
- At least one staff member attended (in person)
- Health/resource fair, open to the public

October 5, 9 a.m.–1 p.m., Annual Health and Wellness Fair, hosted by Nhan Hoa Clinic

Nhan Hoa Comprehensive Health Center, 7761 Garden Grove Blvd., Garden Grove

- At least one staff member attended (in person)
- Health/resource fair, open to the public

October 5, 10 a.m.–2 p.m., Fall Community Resource Fair, hosted by Assemblywoman Sharon Quirk-Silva

Stoddard Park, 1901 9th St., Anaheim

- At least one staff member attended (in person)
- Health/resource fair, open to the public

October 5, 11 a.m.–8 p.m., Orange County Pride, hosted by OC Pride

Orange County Fairgrounds, 88 Fair Dr., Costa Mesa

- Registration fee: $515; included a resource table
- At least one staff member attended (in person)
- Health/resource fair, open to the public

October 5, 9 a.m.–1 p.m., Trunk or Treat Health Fair, hosted by Friends of Family Health Center

Friends of Family Health Center Office, 501 S. Idaho Street., La Habra

- Sponsorship fee: $10,000; includes a resource table, logo on flyer, and a speaking opportunity.
- At least one staff member attended (in person)
- Health/resource fair, open to the public

October 5, 4–8 p.m., Mid-Autumn Festival, hosted by City of Santa Ana

Centennial Park, 3000 W. Edinger Ave., Santa Ana

- At least one staff member attended (in person)
- Health/resource fair, open to the public

October 9, 11 a.m.–1 p.m., Resource Fair, hosted by Golden West College

Golden West College, 15744 Goldenwest St., Huntington Beach

- At least one staff member attended (in person)
- Health/resource fair, open to the public

CalOptima Health-hosted | CalFresh Outreach (e.g., colleges, food banks) | Community Presentation | Exhibitor/Attendee

October 10, 4–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Anna Drive Neighborhood

- At least one staff member attended (in person)
- Health/resource fair, open to the public

October 10, 11 a.m.–1 p.m., Orange Count Grantmakers Summit, hosted by Orange County Grantmakers

Orange Coast College, 2701 Fairview Rd., Costa Mesa

- Sponsorship fee: $2,500; included two event tickets, logo & link on Summit website, logo & link on all Summit e-communications, sponsor page of summit app, logo and link on bronze sponsor social media promotion, and recognition as a summit sponsor at the beginning of the event.
- At least two staff members attended (in person)
- Health/resource fair, open to the public

October 11, 9 a.m.–Noon, Naloxone Distribution, hosted by CalOptima Health

CalOptima Health, 505 City Parkway W., Orange

- At least six staff members attended (in person)
- Health/resource fair, open to the public

October 12, 8:30 a.m.–2 p.m., InflueceHER Summit, hosted by Girls Inc. of Orange County

Santa Ana College, 1530 W. 17th St., Santa Ana

- Sponsorship fee: $2,500; included a resource table, recognition and signage at breakfast and lunch, logo placement, sponsorship recognition in all summit emails, marketing materials and logo and name on event signage.
- At least two staff members attended (in person)
- Health/resource fair, open to the public

October 12, 10 a.m.–4 p.m., Native Hawaiian Pacific Islander Peace and Justice Summit, hosted by Project-Respect Inc.

Nazarene Church, 13411 S. Euclid St., Garden Grove

- Sponsorship fee: $9,500; included a resource table and logo on flyer
- At least one staff member attended (in person)
- Health/resource fair, open to the public

October 13, 9 a.m.–3 p.m., Battle of the Mariachis, hosted by the Power of One

Eddie West Stadium, 602 N. Flower St., Santa Ana

- Sponsorship fee: $10,000; included a resource table and speaking opportunity
- At least one staff member attended (in person)
- Health/resource fair, open to the public

October 15, 4–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

CalOptima Health-hosted CalFresh Outreach (e.g., colleges, food banks) Community Presentation Exhibitor/Attendee

Cabot Street Neighborhood

- At least one staff member attended (in person)
- Health/resource fair, open to the public

October 17, 4–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Chippewa/Greenleaf Neighborhood

- At least one staff member attended (in person)
- Health/resource fair, open to the public

October 17, 11 a.m.–1 p.m., State of the Second District Luncheon, hosted by the Orange County Hispanic Chamber of Commerce

Artic Anaheim, 2626 E. Katella Ave., Anaheim

- Sponsorship fee: $5,000; included sponsor name and logo in all marketing materials, on-screen recognition, sponsorship recognition from podium, invitation to VIP reception, a resource table at pre-reception and a table for ten at the event in VIP location.
- At least one staff member attended (in person)
- Health/resource fair, open to the public

October 18, 8:30 a.m.–2 p.m., Alzheimer's Latino Conference, hosted by Alzheimer's Orange County

Delhi Community Center, 505 E. Central Ave., Santa Ana

- Sponsorship fee: $1,000; included recognition at the event during opening ceremonies, logo placed around conference and on agenda, information in good bag, resource table, lunch for two, and certificate of recognition.
- At least one staff member attended (in person)
- Health/resource fair, open to the public

October 19, 9 a.m.–2 p.m., City of Fullerton Effort for Medi-Cal Expansion Community Event, hosted by Asian American Senior Citizens Service Center

Topaz Elementary School, 3232 Topaz Ln., Fullerton

- Sponsorship fee: $10,000; included a resource table and speaking opportunity
- At least one staff member attended (in person)
- Health/resource fair, open to the public

October 19, 6–11:30 p.m., Cultural Awareness & Indian Festival Diwali Event, hosted by the Shriji Mandir and Cultural Center

City of Buena Park Community Center, 8150 Knott Ave., Buena Park

- Sponsorship fee: $10,000; included a resource table and speaking opportunity
- At least one staff member attended (in person)
- Health/resource fair, open to the public

October 19, 9 a.m.–1 p.m., Health and Wellness Fair, hosted by CalOptima Health in collaboration with the City of Anaheim and the Orange County Aging Services Collaborative

CalOptima Health-hosted CalFresh Outreach (e.g., colleges, food banks) Community Presentation Exhibitor/Attendee

Brookhurst Community Center, 2271 Crescent Ave., Anaheim

- At least twenty staff members attended (in person)
- Health/resource fair, open to the public

October 20, 8:30 a.m.–12:30 p.m., Dignity Day, hosted by Sabil USA

Sports Basement Orange County, 10800 Kalama River Ave., Fountain Valley

- Sponsorship fee: $10,000; included a resource table and speaking opportunity.
- At least one staff member attended (in person)
- Health/resource fair, open to the public

October 20, 9 a.m.–2 p.m., Recognizing Promotor Excellence, hosted by Vision y Compromiso

Give for a Smile, 20861 Acacia Parkway Suite 119, Garden Grove

- Sponsorship fee: $2,500; included a resource table
- At least one staff member attended (in person)
- Health/resource fair, open to the public

October 22, 9–10:30 a.m., Cafecito Meeting, hosted by CalOptima Health

Virtual

- At least six staff members attended
- Steering committee meeting, open to collaborative members

October 22, 4–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Mayfair/Lodge Neighborhood

- At least one staff member attended (in person)
- Health/resource fair, open to the public

October 23, 4–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Laxore/Embassy Neighborhood

- At least one staff member attended (in person)
- Health/resource fair, open to the public

October 23, 4–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Acacia/Romneya Neighborhood

- At least one staff member attended (in person)
- Health/resource fair, open to the public

October 24, 4–6:30 p.m., Second Annual Trunk or Treat, hosted by Social Service Agency

Orangewood Foundation, 1575 E. 17th St., Santa Ana

- At least one staff member attended (in person)
- Health/resource fair, open to the public

CalOptima Health-hosted CalFresh Outreach (e.g., colleges, food banks) Community Presentation
Exhibitor/Attendee

November 2024

November 3, 7 a.m.–Noon, Dino Dash, hosted by the Tustin Public Schools Foundation
The Market Place, 2915 El Camino Real, Tustin
- At least one staff member attended (in person)
- Health/resource fair, open to the public

November 5, 4–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services
Lido Lane Neighborhood
- At least one staff member attended (in person)
- Health/resource fair, open to the public

November 6, 8:30–9:30 a.m., CalOptima Health Medi-Cal Overview in Spanish
Davis Elementary School, Virtual
- At least one staff member to present
- Community-based organization presentation, open to members/community

November 7, 4–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services
Provential/ Bellevue Neighborhood
- At least one staff member to attend (in person)
- Health/resource fair, open to the public

November 7, 6–7 p.m., CalOptima Health Medi-Cal Overview in English
Melinda Hoag Smith Center for Healthy Living, 307 Placentia Ave., Newport Beach
- At least one staff member to present (in person)
- Community-based organization presentation, open to members/community

November 12, 4–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services
Balsam/Curtis Neighborhood
- At least one staff member to attend (in person)
- Health/resource fair, open to the public

November 13, 4–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services
Clifton/Philadelphia Neighborhood
- At least one staff member to attend (in person)
- Health/resource fair, open to the public

November 14, 8 a.m.–5 p.m., The Future of Health Care, hosted by Advance OC
UCI Beall Center for Applied Innovation, 5270 California Ave. #100, Irvine
- Sponsorship fee: $5,000; includes a panelist speaking opportunity, and logo on flyers and website.
- At least three staff members to attend (in person)

CalOptima Health-hosted | CalFresh Outreach (e.g., colleges, food banks) | Community Presentation | Exhibitor/Attendee

- Health/resource fair, open to the public

November 14 through 15, 8 a.m.–5 p.m., Annual Conference, hosted by the American College of Healthcare Executives

Hilton Los Angeles, 555 Universal Hollywood Dr., Universal City

- Sponsorship fee: $3,000; includes a resource table, listing in conference brochure, logo on website and a complimentary pass.
- At least one staff member to attend (in person)
- Health/resource fair, open to the public

November 16, 7 a.m.–1 p.m., NAMI Walks, hosted by the National Alliance on Mental Illness (NAMI) of Orange County

Angel Stadium, 2000 E. Gene Autry Way, Anaheim

- Sponsorship fee: $2,500; includes a resource table, logo and website link on event website.
- At least one staff member to attend (in person)
- Health/resource fair, open to the public

November 16, 1–5 p.m., Thanksgiving Event, hosted by the Office of Santa Ana Mayor Pro Tem Thai Viet Phan

Cesar Chavez Campesino Park, 3311 W. 5th St., Santa Ana

- At least one staff member to attend (in person)
- Health/resource fair, open to the public

November 23, 9 a.m.–1 p.m., Thanksgiving Event, hosted by CalOptima Health

CalOptima Health, 505 City Parkway W., Orange

- At least twenty staff members to attend (in person)
- Health/resource fair, open to the public

These sponsorship request(s) and community event(s) met the requirements of CalOptima Health Policy AA.1223: Participation in Community Events Involving External Entities. More information about policy requirements can be found at:
https://www.caloptima.org/en/About/CommunityRelations/CommunityOutreach.aspx

CalOptima Health Board Action Agenda Referral

Action To Be Taken November 7, 2024
Regular Meeting of the CalOptima Health Board of Directors

Report Item
13. Approve Award Recommendations for Workforce Development Initiative Round Two Grants

Contact
Donna Laverdiere, Executive Director, Strategic Development, (714)-986-6981

Recommended Actions
1. Authorize the Chief Executive Officer, or designee, to enter into grant agreements with the recommended six grantees.
    a. Approve the selection of six recommended grantees with corresponding grant award allocations totaling $5,140,742 for provider workforce training and development innovation to increase the pipeline of health care professionals in Orange County.
    b. Authorize an increase to the Provider Workforce Development Initiative allocation from $5 million to $5,140,742 for provider workforce training and development innovation, coming from the $50 million restricted Provider Workforce Development Fund.
2. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima Health's mission and purpose.
3. Direct the Chief Executive Officer to modify the five-year Provider Workforce Development Fund to extend the timeline for an additional two years, through 2030.

Background
In June of 2023, the CalOptima Health Board of Directors (Board) created the $50 million Provider Workforce Development Fund and directed the Chief Executive Officer to create a five-year Provider Workforce Development Plan. The goals of the investment focus on identifying and addressing shortages and gaps in the Orange County health care workforce that serves the Medi-Cal population, including physicians, increasing the diversity of the health care workforce, and providing economic support to allow individuals to pursue a career in health care in service to CalOptima Health members in Orange County.

CalOptima Health performed stakeholder engagement, data analysis, and a review of research and best practices and proposed five initiatives in December 2023.

The five initiatives approved by the Board are as outlined below.

	Proposed Initiative	Funding Type	Description	Funding Allocation
1	Grants to Educational Institutions to Increase Supply of Health Care	Competitive Grant	Grants for health professional program expansion and financial support for students.	$24.6 million

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	Proposed Initiative	Funding Type	Description	Funding Allocation
	Professionals (non-physician)			
2	Workforce Training & Development Innovation Fund	Competitive Grant	Grants for innovative cross-sector partnerships supporting workforce training, upskilling, and employment pathways.	$5.0 million
3	Physician Recruitment Incentive Program	Incentive Program – Application process	Incentive payments for recruitment of providers to existing practices to close network gaps - $125,000 for primary care and $150,000 for specialty (includes psychiatry).	TBD
4	Physician Loan Repayment Program	Loan Repayment Program – Application process	Loan repayment awards of up to $5,000 per month for 36 months ($180,000 total), to eligible primary care specialties, including family medicine, internal medicine, obstetrics/gynecology, pediatrics, psychiatry, and specific specialty gaps.	TBD
5	Orange County Health Care Workforce Development Collaborative	Stakeholder Collaborative	Collaborative to bring together educational institutions, provider organizations, and county workforce development organizations to design and develop joint programs to increase the health care workforce.	TBD

In April 2024, CalOptima Health awarded a total of $24.6 million in grant funding to seven educational institutions under the first approved initiative for educational investments to increase the supply of health care professionals serving CalOptima Health members in Orange County.

On June 6, 2024, the Board approved an allocation of $5 million to fund the Round 2 Workforce Development Initiative grant funding opportunity focused on workforce development innovation. This funding opportunity sought applications from provider and community organizations to support innovative programs and partnerships focused on training, retention, and development of health professionals in Orange County, with prioritization given to applications focused on behavioral health. In order to provide equal partnership opportunities across multiple entities, this funding opportunity limited each grant award to a maximum amount of $1 million for each applicant organization.

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Discussion

In July 2024, CalOptima Health released the notice of funding opportunity (NOFO) for the Round 2 Workforce Development and Innovation Fund grants. CalOptima Health hosted a bidder's conference to describe participation requirements and provided an opportunity for questions and answers. Applications were due on August 19, 2024.

CalOptima Health received a total of 44 applications with a total requested grant funding amount of $37.9 million. The grant applications received are summarized below:

Health Care Workforce Category	# of Applications
Behavioral Health	27
Non-Physician Primary Care and Nursing, *i.e.* PA, NP, RN, LVN	14
Allied Health	3
General Student Internships	11
Other, *i.e.* Caregivers & Home-Aids	2

Organization Types:	# of Applications
Health Systems	4
Community Based Organizations	28
Provider Organizations, including FQHCs	12

CalOptima Health convened a committee of six grant reviewers to evaluate each received application against the review criteria. A scoring rubric was utilized to evaluate the applications, which included an additional weighting bonus for behavioral health-focused grant proposals. The review committee is recommending the following applicants for grant awards based on their total score.

Organization	Program Description	Funding Amount
CHOC - Children's Hospital of Orange County	Pediatric Behavioral Health Field Training Expansion: A program to train an additional 92-96 social work and psychology students over a four-year program period.	$994,824
Child Guidance Center, Inc.	Help the Helper - Strengthening Orange County's Behavioral Health Workforce: A program to train 35 graduate students pursuing master's and doctoral degrees in mental health (master's degree in social work, master's degree in marriage & family therapy, master's degree in counseling psychology) over a three-year period.	$766,920
Western Youth Services	Western Youth Services Workforce Development Program: A program to increase the supply of behavioral health professionals through financial incentives for student interns, behavioral health specialists, care managers, mental health workers, therapeutic behavioral coaches, and peer support specialists. The program will provide tuition reimbursement	$1,000,000

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	for 55 staff, licensure fee reimbursement for 80 staff, stipends for 35 master's level interns over a five-year period, and 380 continuing education units for staff.	
Special Service for Groups, Inc.	Professional Providers Pathway (Px3) Program: A paid internship opportunity for 25 graduate students over a five-year period pursuing behavioral health degrees with a focus on service provision.	$535,566
John Henry Foundation	Intern Psychologist Workforce Development Program: A program to train 25 PhD and PsyD candidates over a five-year period with the skills to treat severe mental health conditions.	$847,302
Seneca Family of Agencies	Behavioral Health Clinical Internship Program: A program to train 18 master's level graduate students in mental health-focused programs (master's degree in social work, master's degree in marriage & family therapy, master's degree in counseling psychology) over a three-year period.	$996,130
Note: All funded projects are multi-year grant programs.	***Total:***	**$5,140,742**

CalOptima Health staff also recommends allocating an additional $140,742 to fully fund the sixth grant award (Seneca Family of Agencies) out of the existing $50 million Workforce Development Initiative. This funding allocation would be in addition to the $5 million previously allocated for Round 2 Workforce Development Innovation Fund grants.

CalOptima Health staff is also requesting to extend the five-year Provider Workforce Development Plan through 2030 to account for the required time periods to implement proposed programs for the Round 2 Workforce Development and Innovation Fund grants. This will extend the duration of the program funding for an additional two years.

CalOptima Health will award and oversee these recommended grant awards in accordance with Policy AA.1400: Grants Management, including compliance with specific milestones, reporting requirements, and timelines as part of the standard grant award process.

Fiscal Impact

The recommended actions have no additional fiscal impact. A previous Board action on June 1, 2023, created a restricted Provider Workforce Development Fund in an amount not to exceed $50 million over five years. If approved, these actions will extend the program timeline and increase the allocation of funds for the second round of grants from up to $5 million to $5,140,742. This increased allocation will reduce the total funds available for allocation to the remaining three initiatives to $20,262,958. CalOptima Health reserves the right to recoup funds for lack of demonstrated effort or for not meeting grant requirements.

Rationale for Recommendation

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These grant awards will increase the supply of behavioral health professionals serving CalOptima Health members in Orange County.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Entities Covered by this Recommended Board Action
2. Workforce Development Round 2 Review Committee Scores
3. Previous Board Action June 6, 2024, "Approve Actions Related to the Workforce Development Initiative: Training and Development Innovation Fund." *
   *Which includes the following previous Board Actions:
   - April 4, 2024, "Approve Award Recommendations for Workforce Development Initiative Round 1 Grants."
   - March 7, 2024, "Approve Request to Modify Provider Workforce Development Initiative Allocations."
   - December 7, 2023, "Approve Actions Related to the Workforce Development Strategic Priority."
   - June 1, 2023, "Authorize the Creation of a CalOptima Health Provider Workforce Development Reserve Fund."
   - Previous Board Action December 7, 2023, "Approve Actions Related to the Workforce Development Strategic Priority."
4. Workforce Development Round 2 Grantee Recommendations

Board Actions

Board Meeting Dates	Action	Term	Not to Exceed Amount
June 1, 2023	Authorize the Creation of a CalOptima Health Provider Workforce Development Reserve Fund	5 Years	$50 million
December 7, 2023	Approve Actions Related to the Workforce Development Strategic Priority	5 Years	$50 million
March 7, 2024	Approve Request to Modify Workforce Development Initiative Allocations	5 Years	$25 million
April 4, 2024	Approve Award Recommendations for Workforce Development Round One Grants	5 years	$25 million
June 6, 2024	Approve Actions Related to the Workforce Development Initiative: Training and Development Innovation Fund	5 years	$5 million

/s/ Michael Hunn *11/01/2024*
Authorized Signature **Date**

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Attachment to the November 7, 2024 Board of Directors Meeting – Agenda Item 13

CONTRACTED/ IMPACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Child Guidance Center, Inc.	600 W. Santa Ana Blvd. Suite 600	Santa Ana	CA	92701
Children's Hospital Orange County	1201 W. La Veta Ave.	Orange	CA	92868
John Henry Foundation	403 N. Susan St.	Santa Ana	CA	92703
Seneca Family of Agencies	8945 Golf Links Rd.	Oakland	CA	94605
Special Service for Groups, Inc.	905 E. 8th St.	Los Angeles	CA	90021
Western Youth Services	23461 S. Pointe Dr. Suite 220	Laguna Hills	CA	92653

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Attachment to the November 7, 2024 Board of Directors Meeting – Agenda Item 13

SCORES OF ROUND TWO PROVIDER WORKFORCE DEVELOPMENT APPLICATIONS

#	Organization Name	Proposed Program Title	Score out of 100	Funding Recommendation
1	Children's Hospital Orange County	Pediatric Behavioral Health Field Training Expansion	98.00	Fund
2	Child Guidance Center, Inc.	Help The Helper: Strengthening Orange County's Behavioral Health Workforce	97.83	Fund
3	Western Youth Services	Western Youth Services Workforce Development Program	94.00	Fund
4	Special Service for Groups, Inc.	Professional Providers Pathway (Px3) Program	91.33	Fund
5	John Henry Foundation	Intern Psychologist Workforce Development Program	89.00	Fund
6	Seneca Family of Agencies	Seneca Family of Agencies Orange County Behavioral Health Clinical Internship Program	88.83	Fund
7	Providence Medical Foundation	Providence Medical Foundation Behavioral Health Workforce Development Program	86.50	Do Not Fund
8	The Regents of the University of California, Irvine	Child & adolescent psychiatry community focused workforce expansion: meeting the needs of underserved youth in Orange County	86.33	Do Not Fund
9	Easterseals Southern California	Expanding Orange County's Behavioral Health Services for Individuals with ASD and Co-Occurring Conditions	83.50	Do Not Fund
10	The Cambodian Family	Khmer Mental Health Workforce Development Initiative	81.33	Do Not Fund
11	Center for Applied Research Solutions (CARS)	The Fellowship for Affirming, Cross-Cultural, and Equitable Services (FACCES)	80.83	Do Not Fund
12	Asian American Senior Citizens Service	Asian American Pacific Islander Behavioral Health Workforce Pathways	79.50	Do Not Fund
13	KCS Health Center	OC SUD/MOUD Learning Collaborative	78.00	Do Not Fund
14	Norooz Clinic Foundation	Integrated Behavioral Specialists Training And Readiness (IBSTAR) Program	77.83	Do Not Fund
15	Project Self-Sufficiency	HEAL: Health Education and Leadership for Single Parents	76.67	Do Not Fund

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16	Vista Community Clinic	Development of a behavioral health internship program in North Orange County	76.67	Do Not Fund
17	Moving Forward Psychological Institute	MFPI's Community Mental Health Worker Apprenticeship Program	71.50	Do Not Fund
18	Community Action Partnership of Orange County (CAPOC)	CAP OC Behaviorial Health Workforce Development Training Program	71.00	Do Not Fund
19	Charitable Ventures dba Start Well	Expanding Access to Infant/Early Childhood Mental Health Consultation in Home Visiting	70.17	Do Not Fund
20	Health Career Connection	Health Career Connection and Partners Advancing a Diverse Behavioral Health Workforce in OC 2025-2029	69.33	Do Not Fund
21	Charitable Ventures of Orange County dba Thrive Together OC	Thrive Together OC Training Hub	69.00	Do Not Fund
22	Unlimited Possibilities (UP)	Provider Workforce Development for UP's Access to Care Program	67.00	Do Not Fund
23	Illumination Institute	Orange County Disability Collective Workforce Development Initiative	64.33	Do Not Fund
24	Families Together of Orange County	Provider Empowerment Pathways	62.67	Do Not Fund
25	Livingstone Community Development Corporation	Provider Connection Program	61.67	Do Not Fund
26	CARTSS, A Licensed Professional Clinical Counseling Corporation	Taking Flight Network, Inc	59.83	Do Not Fund
27	Celebrating Life CHC	Kristina Sergeyeva VIP Pre-Health Student Program/SunFlowers Strong Scholarship	59.33	Do Not Fund
28	360 Behavioral Health	Board Certified Behavior Analyst (BCBA) Development Fellowship	58.83	Do Not Fund
29	CEO Leadership Alliance Orange County	"Thriving OC for All: Strengthening the Healthcare Talent Pipeline to Boost Economic Mobility and Build Holistic Healthy Communities	57.33	Do Not Fund
30	Big Brothers Big Sisters of Orange County and the Inland Empire	Behavioral Health Workforce Mentorship and Job Placement Program	57.00	Do Not Fund

31	The Purpose of Recovery	BH Intern Program	56.00	Do Not Fund
32	Olive Community Services, Inc.	Care Champions: Developing a behavioral and preventive healthcare workforce for the SAMENA community	54.33	Do Not Fund
33	Access California Services	AccessCal's Health Care Workforce Program	52.67	Do Not Fund
34	Go RN	Orange County Healthcare Fast Track.	52.67	Do Not Fund
35	Serve the People Community Health Center	Care Team Development Program	52.33	Do Not Fund
36	The Lukes Network	Goodwill Industries of Orange County (GIOC) Healthcare Career Pathways Program	51.67	Do Not Fund
37	PHYSICIAN PARTNERS MEDICAL GROUP	Provider Workforce Development - Round 2 Workforce Training and Development Innovation Fund	49.17	Do Not Fund
38	Laguna Beach Community Clinic	Comprehensive Care Program: Personnel Retention Plan	48.33	Do Not Fund
39	UCI Health	Leadership Success Program for Senior Leaders	48.00	Do Not Fund
40	Be Well OC/Mind OC	Be Well OC Irvine Crisis Stabilization Unit	0.00	Do Not Fund - Ineligible
41	Krista Care LLC	Krista Care Workforce Expansion and Retention Program	0.00	Do Not Fund - Ineligible
42	Wellness & Prevention Foundation	Mental Health Workforce Development	0.00	Do Not Fund - Ineligible
43	Center for Family Health Initiative (CFHI)	Advancing Black Care Providers (ABC) Initiative	0.00	Do Not Fund - Ineligible
44	Right at Home Central OC	Serving Underrepresented Patients with Excellent Resources (SUPER)	0.00	Do Not Fund - Ineligible

CalOptima Health Board Action Agenda Referral

Action To Be Taken June 6, 2024
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

16. Approve Actions Related to the Workforce Development Initiative: Training and Development Innovation Fund

Contact

Donna Laverdiere, Executive Director, Strategic Development, (714)-986-6981

Recommended Actions

1. Authorize the Chief Executive Officer, or designee, to issue a notice of funding opportunity (NOFO) for the Provider Workforce Training and Development Innovation Fund.
2. Authorize from the $50 million restricted Provider Workforce Development Fund an allocation of up to $5 million to fund the grant agreements.
3. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima Health's mission and purpose.

Background

In June 2023, the CalOptima Health Board of Directors (Board) approved the $50 million Provider Workforce Development Fund. The goals of the investment focus on identifying and addressing shortages and gaps in the Orange County health care workforce that serves the Medi-Cal population (including physicians), increasing the diversity of the health care workforce, and providing economic support to allow individuals to pursue a career in health care in service of CalOptima Health members in Orange County.

CalOptima Health performed stakeholder engagement, data analysis, and a review of research and best practices and proposed five initiatives in December 2023. These five initiatives were approved by the Board as outlined below.

	Proposed Initiative	Funding Type	Description
1	Grants to Educational Institutions to Increase Supply of Health Care Professionals (non-physician)	Competitive Grant	Grants for health professional program expansion and financial support for students.
2	Workforce Training & Development Innovation Fund	Competitive Grant	Grants for innovative cross-sector partnerships supporting workforce training, upskilling, and employment pathways.
3	Physician Recruitment Incentive Program	Incentive Program – Application Process	Incentive payments for recruitment of providers to existing practices to close network gaps - $125,000 for primary care and

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	Proposed Initiative	Funding Type	Description
			$150,000 for specialty care (including psychiatry).
4	Physician Loan Repayment Program	Loan Repayment Program – Application Process	Loan repayment awards of up to $5,000 per month for 36 months ($180,000 total), to eligible primary care specialties, including family medicine, internal medicine, obstetrics/gynecology, pediatrics, psychiatry, and specific specialty gaps.
5	Orange County Health Care Workforce Development Collaborative	Stakeholder Collaborative	Collaborative to bring together educational institutions, provider organizations, and county workforce development organizations to design and develop joint programs to increase the health care workforce.

In December 2024, the Board approved up to $10 million for the first round of grants for educational investments to increase the pipeline of health professionals serving Medi-Cal members in Orange County. In March 2024, the Board increased the funding allowance for the first round of grants to up to $25 million due to the demand and interest in the grant program. In April 2024, the Board approved $24.6 million for the first round of grant awards to seven organizations.

This second NOFO corresponds to the second initiative, Workforce Training and Development Innovation Fund, as outlined above.

Discussion

CalOptima Health staff is seeking approval of up to $5 million for the second grant program for provider workforce training and development innovation. This grant round would seek applications from provider organizations and community organizations and would encourage innovative partnerships and approaches that address identified health care provider workforce shortages in Orange County. This grant round will prioritize, but not be limited to, applications addressing behavioral health provider shortages. This second round of grants will follow the same competitive review and selection process that CalOptima Health utilized during the first round of grants. CalOptima Health will award grants up to a maximum amount of $1 million per organization.

Eligible applicants for grant funding under this opportunity would be health systems, health care provider organizations, and community organizations. Potential activities that CalOptima Health would consider for funding under this opportunity include but are not limited to:

- Upskilling programs to increase capacity of advanced and highly-skilled health care workforce.
- Training, internship, and certification programs for current health care professionals to advance in their careers.
- Training and upskilling programs that include wraparound supports.
- Funding for residency programs that have a focus on the safety net.

- Retention incentives for high-need, shortage professions with high turnover rates, including salary increases, bonuses, and other financial retention strategies.

Pending Board approval, the NOFO will be released on July 12, 2024. The application deadline for grant applications will be August 19, 2024. Awardees under the second round of grants will be presented for Board approval at the November 7, 2024, Board meeting, with grant awards planned for November 2024, if approved by the Board.

Grants Management and Oversight
Staff will release the NOFO in accordance with the CalOptima Health Policy AA.1400: Grants Management. Staff will return to the Board to request review and approval of recommended grantees. Specific milestones, reporting requirements, and timelines will be developed as part of the grant award process.

Fiscal Impact
The recommended action has no additional fiscal impact. A previous Board action on June 1, 2023, created a restricted Provider Workforce Development Fund in an amount not to exceed $50 million over five years. An allocation of up to $5 million from this restricted fund will support the recommended action.

Rationale for Recommendation
Approval an allocation of up to $5 million from the $50 million total Provider Workforce Development Reserve Fund will enable CalOptima Health to make investments to grow the health care workforce in Orange County to better serve CalOptima Health members.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Notice of Funding Opportunity "Round 2: Workforce Training and Development Innovation Fund."
2. Previous Board Action April 4, 2024, "Approve Award Recommendations for Workforce Development Initiative Round 1 Grants." *
   *Which includes the following previous Board Actions:
   - March 7, 2024, "Approve Request to Modify Provider Workforce Development Initiative Allocations."
   - December 7, 2023, "Approve Actions Related to the Workforce Development Strategic Priority."
   - June 1, 2023, "Authorize the Creation of a CalOptima Health Provider Workforce Development Reserve Fund."

Board Actions

Board Meeting Dates	Action	Term	Not to Exceed Amount
June 1, 2023	Authorize the Creation of a CalOptima Health Provider Workforce Development Reserve Fund	5 Years	$50 million
December 7, 2023	Approve Actions Related to the Workforce Development Strategic Priority	5 Years	$50 million
March 7, 2024	Approve Request to Modify Workforce Development Initiative Allocations	5 Years	$25 million
April 4, 2024	Approve Award Recommendations for Workforce Development Round One Grants	5 years	$25 million

/s/ Michael Hunn *05/31/2024*
Authorized Signature **Date**

Provider Workforce Development Notice of Funding Opportunity

Round 2: Provider Workforce Training and Development Innovation Fund

CalOptima Health solicits grant requests to increase the provider workforce with a focus on training, recruitment, and retention of safety net providers in Orange County.

Application Deadline — 08/19/2024 (5:00 p.m. PST)

Background

CalOptima Health's mission is to serve member health with excellence and dignity, respecting the value and needs of each person. Health care workforce shortages in Orange County and statewide are significant, and investment is needed to increase the number of health professionals in Orange County. To address these challenges, the CalOptima Health Board approved an investment of $50 million over five years to create the Provider Workforce Development Initiative to increase the supply of safety net providers serving CalOptima Health members in Orange County. Through the Provider Workforce Development Initiative, CalOptima Health is committed to increasing the number of providers serving Orange County's most vulnerable population.

CalOptima Health engaged in a robust stakeholder listening process to inform the design of the Provider Workforce Development Initiative strategy and plan. One of the key challenges highlighted through the stakeholder engagement process was the need for training, retention, and employment pathway programs to retain and develop the health care workforce. This funding opportunity will be **open for applications July 12, 2024 – August 19, 2024.**

Description of Grant Funding Opportunity

The second round of grant funding within the Provider Workforce Development Initiative will be available to support innovative programs and partnerships that are committed to training, retention, and development of health professionals in non-physician primary care, behavioral health, and allied health. This funding round will prioritize but not be limited to programs focused on increasing the behavioral health workforce serving CalOptima Health members.

Eligible programs to train, upskill, retain and develop the current health care workforce would include, but not be limited to:

- Upskilling programs to increase capacity of advanced and highly-skilled health care workforce.

- Training, internship, and certification programs for current health care professionals to advance in their careers.
- Training and upskilling programs that include wraparound supports.
- Funding for residency programs that have a focus on the safety net.
- Retention incentives for high-need, shortage professions with high turnover rates including salary increases, bonuses, and other financial retention strategies.

Eligible programs must be located in Orange County. Projects that include components that encourage health professionals to serve Medi-Cal members in Orange County will be prioritized.

Grant Amounts and Duration

This second round of funding will make available up to $5.0 million. Applicants may only submit ***one application per organization***. The requested grant amount should not exceed $1,000,000.00. For awarded grants, payment will be made as defined in the fully executed grant agreement.

Any CalOptima Health investments will avoid supplanting or replacing existing Federal, State, and/or CalOptima Health funding sources for workforce development initiatives.

Entities Eligible to Apply

- Eligible entities to receive this funding would be health systems, health care provider organizations, and community organizations.
- Grant funds may only be utilized for supporting health care professionals in Orange County.
- Applicants that previously received funding from CalOptima Health must be in good standing with the terms of that contract or grant agreement to be eligible for new funding.
- Applicants are strongly encouraged to apply for funds when they are ready to implement the activity proposed for funding.

Proposal Evaluation Criteria

	Criteria	Max Points	Description of basis for assigning points
	Eligibility	Pass/Fail	• Must be a provider organization or community-based organization. • Maximum of one application per organization. • Does not supplant other available Federal, State or CalOptima Health opportunities/sources.
1	CalOptima Health Core Mission and Value Alignment	10	• Project aligns with the CalOptima Health mission, vision, and values statements. • Proposed program demonstrates value to the CalOptima Health membership and the Medi-Cal program. • Proposed program fills an unmet need within the CalOptima Health investment and grantmaking portfolio.

2	Provider Workforce Development Initiative Goals	20	• Proposes investments targeted towards identified shortages in the health care workforce serving CalOptima Health members including primary care, behavioral health, and allied health. Priority will be given to projects that address behavioral health provider shortages. *Applications focused on behavioral health will receive a 1.5-point value weighting.* • Demonstrates how the project increases the number of health professionals in Orange County.
3	Proposed Program Design	20	• The proposed program is in alignment with the goals and objectives of the grant program as outlined in the Notice of Funding Opportunity. • The proposed program is clearly described and addresses identified workforce shortages that are supported by data/evidence. • The proposed program includes innovative approaches to training, retention, or upskilling components that aim to increase the number of health professions in identified shortage areas. • The proposed program clearly outlines any needed partnerships to support program success. • The program includes elements that encourage or incentivize participants to remain in Orange County and serve Medi-Cal members.
4	Equity	15	• Project aims to increase representation of underrepresented groups in health professions. • Project considers the diverse needs of the Medi-Cal population and the workforce investments needed to improve access to care for underserved groups.
5	Project Implementation Plan & Performance Measures	10	• Provides a clear and complete implementation plan with well-defined project milestones and timeframes. • Clearly states specific SMART objectives and defined measures of success for the project. • Clearly indicates that the program will be up and running within 6 months of grant award.
6	Budget & Financial Management	15	• Budget and financial plan are sound and aligned with the objectives and activities of the project. • Outlines direct and indirect costs, including partner budgets and expenditures. • Proposed budget prioritizes program activities that benefit participants and has a reasonable allocation for administrative expenses. • Project includes no more than 10% for indirect expenses.
7	Organization Experience and Program Capacity	10	• Applicant has demonstrated experience needed to perform the program.

			• Applicant is a stable organization and has demonstrated capacity to perform the functions of the program. • Identifies potential funding sources for sustainability of the project/program after the end of the grant agreement.
Total Earnable Points		**100**	*110 total points available with behavioral health weighting.*

Timeline

Activity	Date
NOFO Released and Portal Opens	7/12/2024 at 9 a.m.
Bidder's Conference *(virtual)*	7/15/2024 at 3 p.m.
Questions Posted from Bidder's Conference Session	7/22/2024
Application Deadline	**8/19/2024 at 5 p.m.**
Internal Review	8/20/2024-9/30/2024
CalOptima Health Board of Directors Meeting	**11/7/2024**
Announcement of Approved Grants	11/8/2024
Grant Agreements Processed	11/8/2024-12/9/2024
Grant Start Dates	12/16/2024

Documents and Portal Access

All documents related to this Notice of Funding Opportunity and application portal access will be made available at this site:
https://www.caloptima.org/en/About/CurrentInitiatives/WorkforceDev

Bidder's Conference Session

Join our Bidder's Conference Session for this funding opportunity by registering below:

Bidder's Conference Session
Date and Time: Monday, July 15, 2024, time to be announced.
Link: TBD

Questions about the funding opportunity or application? Contact Strategic Development at strategicdevelopment@caloptima.org

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 4, 2024
Regular Meeting of the CalOptima Health Board of Directors

Report Item
17. Approve Award Recommendations for Workforce Development Initiative Round One Grants

Contact
Donna Laverdiere, Executive Director, Strategic Development, (714)-986-6981

Recommended Actions
1. Approve the selection of seven recommended grantees with corresponding grant award allocations totaling $24,596,300 for educational investments to increase the pipeline of health care professionals in Orange County.
2. Approve the recommendation of a maximum grant award of $5 million per applicant organization.
3. Authorize the Chief Executive Officer, or designee, to enter into grant agreements with the recommended grantees.
4. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima Health's mission and purpose.

Background
In June of 2023, the CalOptima Health Board of Directors (Board) approved the $50 million Provider Workforce Development Fund. The goals of the investment focus on identifying and addressing shortages and gaps in the Orange County health care workforce that serves the Medi-Cal population, including physicians, increasing the diversity of the health care workforce, and providing economic support to allow individuals to pursue a career in health care in service to CalOptima Health members in Orange County.

CalOptima Health performed stakeholder engagement, data analysis, and a review of research and best practices and proposed five initiatives in December 2023. These five initiatives were approved by the Board as outlined below.

	Proposed Initiative	Funding Type	Description
1	Grants to Educational Institutions to Increase Supply of Health Care Professionals (non-physician)	Competitive Grant	Grants for health professional program expansion and financial support for students.
2	Workforce Training & Development Innovation Fund	Competitive Grant	Grants for innovative cross-sector partnerships supporting workforce training, upskilling, and employment pathways. *Notice of funding opportunity currently in development.*

	Proposed Initiative	Funding Type	Description
3	Physician Recruitment Incentive Program	Incentive Program – Application process	Incentive payments for recruitment of providers to existing practices to close network gaps - $125,000 for primary care and $150,000 for specialty (includes psychiatry).
4	Physician Loan Repayment Program	Loan Repayment Program – Application process	Loan repayment awards of up to $5,000 per month for 36 months ($180,000 total), to eligible primary care specialties, including family medicine, internal medicine, obstetrics/gynecology, pediatrics, psychiatry, and specific specialty gaps.
5	Orange County Health Care Workforce Development Collaborative	Stakeholder Collaborative	Collaborative to bring together educational institutions, provider organizations, and county workforce development organizations to design and develop joint programs to increase the health care workforce.

CalOptima Health requested an initial allocation of up to $10 million to fund the first grant initiative for educational investments to increase the supply of health care professionals serving CalOptima Health members in Orange County. The Board approved an initial allocation of up to $10 million for the first grant funding opportunity out of the total $50 million Provider Workforce Development Fund.

On March 7, 2024, due to the overwhelming response and interest in the first round of grant funding, the Board approved an increase in the initial allocation of $10 million to $25 million within the Workforce Development Initiative. This adjusted allocation will be used to award the first round of funding for educational investments.

Discussion

In December 2023, CalOptima Health released the first notice of funding opportunity (NOFO) for grants to increase health care workforce pipeline through educational investments. CalOptima Health hosted a bidder's conference to describe participation requirements and provided an opportunity for questions and answers. Interested grantees submitted grant applications from December 15, 2023, through January 31, 2024. CalOptima Health received a total of 30 applications with a total requested amount of $96.5 million. The grant applications received are summarized below.

Health Care Profession	Universities/Colleges		*Community-Based Organizations	
	# of Applications	Requested $ (in million)	# of Applications	Requested $ (in million)
Allied Health	4	$10.7	-	-
Behavioral	2	$2.0	8	$12.7
Nursing	5	$35.3	1	$4.6

Primary Care	1	$5.8	-	-
Multiple Professions	4	$18.8	5	$6.7
Total	**16**	**$72.6**	**14**	**$24.0**
*Must have partnerships with educational institutions.				

CalOptima Health convened a committee of six grant reviewers to evaluate each received application against the review criteria included in the NOFO. CalOptima Health review committee utilized a scoring rubric to evaluate the applications. The review committee is recommending the following applicants for grant awards based on their total score. In order to provide equal partnership opportunity across multiple entities, staff also recommends limiting each grant award to a maximum amount of $5 million for each applicant organization.

Organization	Proposal(s)	Requested Amount	Funding Amount
Coast Community College District	Expanding registered nurse pipeline at Golden West College by 40 students per year and develop a pathway to the radiologic technology certificate program at Orange Coast College for 30 students per year.	$2,040,000	$2,040,000
Santiago Canyon College	Increasing the behavioral technician program from 25-50 to 50-100 students annually; medical assistant program from 50 to 175 students annually; and develop a licensed vocational nursing curriculum/attain program accreditation to produce 60+ licensed graduates annually.	$1,200,000	$1,200,000
Sue & Bill Gross School of Nursing, University of California Irvine	Creating a program to provide a 1-year externship to 120 prelicensure nursing students and a 1-year residency for 8 family nurse practitioners and 4 psychiatric mental health nurse practitioners graduates to address Orange County's shortage of registered nurses and primary and behavioral healthcare providers.	$9,126,399	$5,000,000
Chapman University	Providing full tuition physician assistant scholarships (10 for first year and 10 for second year students), training, and local practice physician assistant education for academically qualified, low-income students.	$5,684,162	$5,000,000

CSU Fullerton Auxiliary Services Corporation	Increasing the Concurrent Enrollment Program admission number by 25-40 students annually to admit 200 associate degree nursing to bachelor of science in nursing (BSN) students and an expansion of the BSN program by eight students, from 80 to 88 admissions each year, following Board of Registered Nursing approval.	$9,999,732	$5,000,000
Orange County United Way	Expanding the UpSkill program, focusing on gaps within the healthcare workforce, and providing career coaching, connections to paid training and certification programs, and job placements in the healthcare industry to serve an additional 25 clients each year.	$1,356,300	$1,356,300
Concordia University, Irvine	Increasing the accelerated bachelor of science in nursing (ABSN) program and providing scholarships to 10 pre-nursing students per year and 20 ABSN students per year.	$5,629,907	$5,000,000
	Total:	**$35,036,500**	**$24,596,300**

Note: All funded projects are multi-year grant programs.

CalOptima Health will award and oversee these recommended grant awards in accordance with Policy AA.1400: Grants Management. Specific milestones and reporting requirements and timelines will be developed as part of the grant award process.

Fiscal Impact

The recommended action has no additional fiscal impact. Previous Board actions on December 7, 2023, and March 7, 2024, allocated $25.0 million, in aggregate, to fund the first round of grants to educational institutions to increase the supply of health care professionals. CalOptima Health reserves the right in the applicable grant agreements to recoup funds for lack of demonstrated effort or not meeting grant commitments.

Rationale for Recommendation

This action approves grant awards from the allocated $25 million for investments in increasing the pipeline of health care professionals in Orange County. These grant awards will help to increase the number of students seeking non-physician health professions in Orange County and will increase the supply of health professionals serving CalOptima Health members.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Entities Covered by this Recommended Board Action
2. Workforce Development Round One Review Committee Scores
3. Previous Board Action March 7, 2024, "Approve Request to Modify Provider Workforce Development Initiative Allocations."
4. Previous Board Action December 7, 2023, "Approve Actions Related to the Workforce Development Strategic Priority."
5. Previous Board Action June 1, 2023, "Authorize the Creation of a CalOptima Health Provider Workforce Development Reserve Fund."
6. NOFO Round 1 Recommended Funding Decisions Presentation

/s/ Michael Hunn *03/29/2024*
Authorized Signature **Date**

Attachment to the April 4, 2024 Board of Directors Meeting – Agenda Item 17

CONTRACTED/ IMPACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Chapman University	One University Drive	Orange	CA	92866
Coast Community College District	1370 Adams Avenue	Costa Mesa	CA	92626
Concordia University	1530 Concordia	Irvine	CA	92612
CSU Fullerton Auxiliary Services Corporation	1121 N State College Blvd	Fullerton	CA	92831
OC United Way	18012 Mitchell South	Irvine	CA	92614
Santiago Canyon College	8045 East Chapman Avenue	Orange	CA	92869
Sue & Bill Gross School of Nursing, University of California, Irvine	854 Health Sciences Quad, 2555	Irvine	CA	92617

Attachment to the April 4, 2024 Board of Directors Meeting – Agenda Item 17

SCORES OF ROUND ONE PROVIDER WORKFORCE DEVELOPMENT APPLICATIONS

#	Organization Name	Proposed Program Title	Score out of 100	Funding Recommendation
1	Coast Community College District	Orange County Dual Enrollment Nursing and Allied Health Pathways	87.33	Fund
2	Santiago Canyon College	Santiago Canyon College Healthcare Pathway - Behavior Technicians	87.33	Fund
3	Sue & Bill Gross School of Nursing, University of California, Irvine	NURSE-OC: University of California, Irvine Nursing Workforce Pipeline through Externships and Residencies in Orange County (OC)	86.50	Fund
4	Santiago Canyon College	Santiago Canyon College Healthcare Pathway - Licensed Vocation Nurse	84.83	Fund
5	Chapman University	Reflecting Orange County Communities: Building a Culture of Health through Physician Assistant Scholarships, Training, and Local Practice Physician Assistant Education for Academically Qualified Low Income Students	84.67	Fund
6	CSU Fullerton Auxiliary Services Corporation	Expanding Numbers of CSUF Baccalaureate-Prepared Registered Nurses in Orange County	84.50	Fund
7	Santiago Canyon College	Santiago Canyon College Healthcare Pathway - Medical Assistant	84.17	Fund
8	CSU Fullerton Auxiliary Services Corporation	CalOptima Stipend Program for CSUF Accelerated Baccalaureate Nursing Students	83.17	Do Not Fund (Grantee exceeded maximum allowed grant award with highest scoring application)
9	Orange County United Way	UpSkill OC	83.00	Fund
10	Concordia University Irvine	Concordia Nursing Pipeline Program	81.83	Fund
11	CHOC	Health and Behavioral Health Field Practicum Expansion	80.17	Do Not Fund
12	Easterseals Southern California	Building Orange County's Mental Health Service Capacity	79.33	Do Not Fund
13	Big Brothers Big Sisters of Orange County and the Inland Empire	Mentoring Orange County's Next Healthcare Workers	78.83	Do Not Fund

14	Access California Services	AccessCal's Health Care Workforce Program	78.33	Do Not Fund
15	John Henry Foundation	Intern Psychologist Workforce Development Program	78.00	Do Not Fund
16	Santiago Canyon College	Santiago Canyon College Healthcare Pathway - Lactation Education Pathway to International Board Certified Lactation Consultant (IBCLC)	77.83	Do Not Fund
17	UC Irvine Program in Public Health	Orange County Health Pathways Program	77.83	Do Not Fund
18	AltaMed Health Services Corporation	AltaMed Orange County Community Health Workforce Pipeline	76.83	Do Not Fund
19	North Orange County Regional Occupational Program - Adult Career Education	North Orange County ROP Healthcare Workforce Training Expansion Program	76.67	Do Not Fund
20	The Cambodian Family	Cambodian Mental Health Workforce Development Initiative	75.83	Do Not Fund
21	South Orange County Community College District dba Saddleback College	Orange County Surgical Technologist Career Pathway	75.00	Do Not Fund
22	UCI Susan Samueli Integrative Health Institute	Health and Wellness - Behavioral Health Track Coaching Certificate Program	74.67	Do Not Fund
23	Seneca Family of Agencies	Seneca Family of Agencies' OC Behavioral Health Clinical Internship Program	72.67	Do Not Fund
24	YMCA of Orange County	Developmental Disabilities Workforce Development Collaborative	72.67	Do Not Fund
25	Celebrating Life Community Health Center	Path to Medical Provider for Underserved Populations Academic Award Program	71.83	Do Not Fund
26	Orange County Asian and Pacific Islander Community Alliance, Inc.	Project VOICE-BH	71.33	Do Not Fund
27	Anaheim Union High School District	Connecting Students' Strengths, Interests, and Aspirations to Build a Better Healthcare Workforce through Daily Classroom Instruction	70.67	Do Not Fund
28	Camino Health Center	Camino Pathways	70.17	Do Not Fund
29	Orange County Department of Education	Orange County Health Careers Center	64.33	Do Not Fund

30	Sowing Seeds Health, Inc.	Clinical Rotation Position Expansion	63.50	Do Not Fund

CalOptima Health Board Action Agenda Referral

Action To Be Taken March 7, 2024
Regular Meeting of the CalOptima Health Board of Directors

Report Item
11. Approve Request to Modify Provider Workforce Development Initiative Allocations

Contact
Donna Laverdiere, Executive Director, Strategic Development, (714)-986-6981

Recommended Actions
Authorize an increase to the Provider Workforce Development Initiative Allocation from $10 million to $25 million for educational investments to increase the supply of health care professionals from the $50 million restricted CalOptima Health Provider Workforce Development Fund, accounting for the high volume of funding applications received.

Background
In June of 2023, the CalOptima Health Board of Directors (Board) approved the $50 million Provider Workforce Development Fund. The goals of the investment focus on identifying and addressing shortages and gaps in the Orange County health care workforce that serves the Medi-Cal population, including physicians, increasing the diversity of the health care workforce, and providing economic support to allow individuals to pursue a career in health care in service to CalOptima Health members in Orange County.

CalOptima Health performed stakeholder engagement, data analysis, and a review of research and best practices and proposed five initiatives in December 2023. These five initiatives were approved by the Board as outlined below.

	Proposed Initiative	Funding Type	Description
1	Grants to Educational Institutions to Increase Supply of Health Care Professionals (non-physician)	Competitive Grant	Grants for health professional program expansion and financial support for students.
2	Workforce Training & Development Innovation Fund	Competitive Grant	Grants for innovative cross-sector partnerships supporting workforce training, upskilling, and employment pathways. *Notice of funding opportunity currently in development.*
3	Physician Recruitment Incentive Program	Incentive Program – Application process	Incentive payments for recruitment of providers to existing practices to close network gaps - $125,000 for primary care and $150,000 for specialty (includes psychiatry).

	Proposed Initiative	Funding Type	Description
4	Physician Loan Repayment Program	Loan Repayment Program – Application process	Loan repayment awards of up to $5,000 per month for 36 months ($180,000 total), to eligible primary care specialties, including family medicine, internal medicine, obstetrics/gynecology, pediatrics, psychiatry, and specific specialty gaps.
5	Orange County Health Care Workforce Development Collaborative	Stakeholder Collaborative	Collaborative to bring together educational institutions, provider organizations, and county workforce development organizations to design and develop joint programs to increase the health care workforce.

CalOptima Health requested an initial allocation of up to $10 million to fund the first grant initiative for educational investments to increase the supply of health care professionals serving CalOptima Health members in Orange County. The Board approved an initial allocation of up to $10 million for the first grant funding opportunity out of the total $50 million Provider Workforce Development Program.

Discussion

In December 2023, CalOptima Health released the first notice of funding opportunity for up to $10 million for investments related to increasing the supply of health professionals serving CalOptima Health members. CalOptima Health hosted a bidder's conference to describe participation requirements and provided an opportunity for questions and answers. Interested grant bidders submitted applications from December 15, 2023, through January 31, 2024.

CalOptima Health received an overwhelming response and interest in the first round of grant funding. In total, CalOptima Health received 30 applications with a total requested amount of $96.5 million. The wide range of applications spanned workforce shortage professions and proposed innovative and comprehensive solutions to addressing the affordability of education, supports for students completing their education, targeted recruitment efforts to increase participation by underrepresented groups, and investments in career opportunities for health professionals entering the workforce. This overwhelming response to the funding opportunity provides insight into the size and scope of the workforce development needs that exist in Orange County. The applications received are summarized below.

Workforce Shortage Area	Number of Applications	Total Grant Funds Requested
Nursing	6	$39,854,986
Varied Professions	9	$25,562,703
Behavioral Health	10	$14,729,363
Allied Health	4	$10,712,873
Primary Care	1	$5,684,162
Total	***30***	***$96,544,087***

Based on the applications listed above, CalOptima Health identified a greater need for grant investments in education to increase the pipeline of students seeking health professions in Orange County. For example, these applications identified the opportunity for nearly $40 million in investment in the nursing

professions alone.

CalOptima Health conducted a competitive scoring process for all grant applications received based on the published grant review criteria. Based on the overwhelming interest in the first grant initiative, CalOptima Health recommends an increased allocation for the first round of grants of $15 million in addition to the initial $10 million allocation requested, for a total allocation of $25 million. This increased investment will allow additional grant awards to be provided to the top scoring applicants. In addition, CalOptima Health may request grantees that requested more than $5 million for a single grant program to consider other funding sources to augment their proposed programs in order to spread the funds across more grantees and health professions.

Based on the increased allocation request of $15 million for a revised total of $25 million for the first round of grants, CalOptima Health will need to proportionately reduce investments in the remaining four initiatives for the Provider Workforce Development program approved by the Board in December 2023.

Staff will provide oversight of the grants pursuant to AA.1400p: Grants Management and will return to the Board to provide updates on the status of the initiative.

Fiscal Impact

The recommended action has no additional fiscal impact. A previous Board action on June 1, 2023, created a restricted CalOptima Health Provider Workforce Development Fund in an amount not to exceed $50 million over five years. If approved, this action will increase the allocation of funds for the first round of grants to educational institutions to increase supply of health care professionals from up to $10 million to up to $25 million. This increased allocation will reduce the total funds available for allocation to the remaining four initiatives to $25 million, in aggregate.

CalOptima Health reserves the right to recoup funds for lack of demonstrated effort or meeting grant commitments.

Rationale for Recommendation

Approval of the $15 million increased allocation for educational investments (from the $50 million total Workforce Development Fund) for a total of $25 million will enable CalOptima Health to make additional grant awards to help increase the supply of health care professionals serving CalOptima Health members in Orange County.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Previous Board Action December 7, 2023, “Approve Actions Related to the Workforce Development Strategic Priority.”
2. Previous Board Action June 1, 2023, “Authorize the Creation of a CalOptima Health Provider Workforce Development Reserve Fund.”

Board Actions

Board Meeting Dates	Action	Term	Not to Exceed Amount
December 7, 2023	Approve Actions Related to the Workforce Development Strategic Priority	N/A	$10 million
June 1, 2023	Authorize the Creation of a CalOptima Health Provider Workforce Development Reserve Fund	5 Years	$50 million

_____ _____

Authorized Signature **Date**

CalOptima Health Board Action Agenda Referral

Action To Be Taken December 7, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item

22. Approve Actions Related to the Workforce Development Strategic Priority

Contacts

Donna Laverdiere, Executive Director, Strategic Development, (714)-986-6981
Yunkyung Kim, Chief Operating Officer, (714)-923-8834

Recommended Actions

1. Approve the proposed program pillars for Provider Workforce Development initiative as:
    a. Educational Investments to Increase Supply of Health Care Professionals.
    b. Workforce Training & Development Innovation Fund.
    c. Physician Recruitment Incentive Program.
    d. Physician Loan Repayment Program.
    e. Orange County Health Care Workforce Development Collaborative.
2. Authorize the Chief Executive Officer, or designee, to issue an initial notice of funding opportunity for Educational Investments to Increase Supply of Health Care Professionals.
3. Authorize from the $50 million restricted CalOptima Health Provider Workforce Development Fund an allocation of up to $10 million to fund the grant agreements.
4. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima Health's mission and purpose.

Background

In June of 2022, the CalOptima Health Board of Directors (Board) adopted the Strategic and Tactical Priorities for 2022-2025. The strategic priority areas and tactical priorities serve as the roadmap for strategic growth and funding allocations that support CalOptima Health's mission and vision. One strategic priority adopted by the Board was Future Growth, which includes the Member Access to Quality Care tactical priority. The $50 million Provider Workforce Development initiative, approved by the Board in June of 2023, supports the Member Access to Quality Care tactical priority among others.

Further, the goals of the initiative focus on identifying and addressing shortages and gaps in the Orange County health care workforce that serves the Medi-Cal population, including physicians; increasing the diversity of the health care workforce; and providing economic support to allow individuals to pursue a career in health care in service to CalOptima Health members in Orange County.

Discussion

As part of Workforce Development Initiative development, CalOptima Health sought input from community stakeholders, including educational institutions, providers, and community organizations. CalOptima Health sought feedback on several existing meetings and forums including the Member and Provider Advisory Committee, the monthly Health Network Forum, and other provider meetings.

CalOptima Health also hosted three public listening sessions with broad stakeholder attendance. Each listening session focused on a key stakeholder group: educational institutions, provider organizations, and community organizations. Stakeholders shared information on the barriers they have observed that drive the shortages in health care providers and health professionals in Orange County. Approximately 110 attendees participated in the listening sessions. Based on all outreach, CalOptima Health developed four categories of feedback that informed the areas targeted within this initiative.

1. Overall Healthcare Workforce Shortages

Healthcare workforce shortages and gap areas identified by provider and community partners in these meetings as well as through CalOptima Health provider network data include:

- Primary care (including physicians, physician assistants, and nurse practitioners).
- Nurses.
- Behavioral health professionals.
- Specialty care professionals specifically in the specialty areas of anesthesiology, cardiology, dermatology, endocrinology, gastroenterology, neurology, plastics, psychiatry, pulmonology, rheumatology, urology, and pediatric specialties.
- Allied health professionals.

2. Educational Institutions

Educational institutions shared their perspectives on the challenges they face in increasing the pipeline of students seeking health professions. Stakeholders indicated that there is no shortage of students who are interested in entering health professions in Orange County. The barriers to an increased pipeline of students are related more to available slots in existing programs and affordability of higher education. Barriers to increasing the number of slots in existing programs include a shortage of clinical rotation placements and a shortage of clinical faculty.

3. Provider Organizations

Provider organizations shared their perspectives on the challenges they face with recruitment and retention as well as the key workforce shortages in their systems. They cited competition for talent as well as high cost of living, burnout, and physician retirements as key challenges. In addition, comparatively lower reimbursement for Medi-Cal services can result in access barriers for CalOptima Health members.

4. Community Organizations

Community organizations shared broad feedback on the challenges they observe in Orange County related to health care workforce needs and shortages as well as their perspectives on how to increase diversity in the workforce. In every community stakeholder forum, behavioral health shortages and wait times were cited as a critical shortage area. In addition, stakeholders indicated the opportunities that exist within the community health worker workforce, the need for expanded access to culturally competent care and support, shortages of care coordinators/navigators, and emerging challenges due to growth in the aging population. In terms of increasing diversity of the health care workforce, key barriers cited include affordability of educational opportunities, the need for enhanced wraparound supports, internships and mentorships, and the need to connect community members to assistance and resources available in the community.

Proposed Program Initiatives

Based on stakeholder engagement, data analysis, and a review of research and best practices, CalOptima Health proposes a set of five initiatives for Provider Workforce Development Reserve Fund investment that address several of the key barriers to health care workforce expansion and retention in Orange County. CalOptima Health staff request an initial allocation of up to $10 million from the Workforce Development Fund for the first competitive grant program, as outlined in the table below.

	Proposed Initiative	**Funding Type**	**Description**
1	Grants to Educational Institutions to Increase Supply of Health Care Professionals (non-physician)	Competitive Grant	Grants for health professional program expansion and financial support for students. *Notice of funding opportunity for Board approval.*
2	Workforce Training & Development Innovation Fund	Competitive Grant	Grants for innovative cross-sector partnerships supporting workforce training, upskilling, and employment pathways. *Notice of funding opportunity currently in development.*
3	Physician Recruitment Incentive Program	Incentive Program – Application process	Incentive payments for recruitment of providers to existing practices to close network gaps - $125,000 for primary care and $150,000 for specialty (includes psychiatry).
4	Physician Loan Repayment Program	Loan Repayment Program – Application process	Loan repayment awards of up to $5,000 per month for 36 months ($180,000 total), to eligible primary care specialties, including family medicine, internal medicine, obstetrics/gynecology, pediatrics, and psychiatry and specific specialty gaps.
5	Orange County Health Care Workforce Development Collaborative	Stakeholder Collaborative	Collaborative to bring together educational institutions, provider organizations, and county workforce development organizations to design and develop joint programs to increase the health care workforce.

Notice of Funding Opportunity for Educational Institutions to Increase Supply of Health Care Professionals

As noted above, there are two competitive grant opportunities proposed under the Workforce Development Initiative. CalOptima Health staff is seeking approval of up to $10 million for the first grant program under the outlined priority areas above for educational institutions to support investments in program expansion and student financial support.

Eligible applicants for grant funding under this opportunity would be educational institutions or partnerships among educational institutions and provider or community organizations. Potential activities that would be considered for funding under this opportunity include but are not limited to:

- Pipeline programs from high school into higher education with commitment to serve Orange County.
- Stipend programs with a commitment to serve Orange County.
- Funding to expand existing health care higher education programs to additional cohorts.
- Investments to expand clinical rotations to a greater number of students.
- Investments to develop and recruit faculty among health professions, including nurse educators, and others.

Potential types of programs that would be eligible for funding include, but are not limited to, nursing, allied health, and behavioral health. Future grant initiatives will be announced that focus on additional areas.

The notice of funding opportunity for this first round of competitive grants will be released on December 15, 2023. The application deadline for grant applications will be January 31, 2024. Awardees under the first round of grants will be presented for Board approval at the March 7, 2024 meeting of the Board, with grant awards planned for March 8, 2024 if approved.

Staff anticipates bringing an agenda item to the Board for review in April 2024 to approve the second round of competitive grants that will focus on the second identified priority initiative, Workforce Training & Development Innovation Fund.

Grants Management and Oversight
Staff will release each notice of funding opportunity in accordance with the CalOptima Health Policy AA.1400: Grants Management. Staff will return to the Board to request review and approval of recommended grantees. Specific milestones and reporting requirements and timelines will be developed as part of the grant award process.

Fiscal Impact

The recommended action has no additional fiscal impact. A previous Board action on June 1, 2023, created a restricted CalOptima Health Provider Workforce Development Fund in an amount not to exceed $50 million over five years. An allocation of up to $10 million from this restricted fund will support the recommended action.

Rationale for Recommendation

Approval of the proposed actions and the up to $10 million allocation from the $50 million total Workforce Development Fund will enable CalOptima Health to make investments to grow the health care workforce in Orange County to better serve CalOptima Health members.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Previous Board Action June 2, 2022, "Adopt Strategic and Tactical Priorities for 2022-2025"
2. Previous Board Action June 1, 2023, "Authorize the Creation of a CalOptima Health Provider Workforce Development Reserve Fund."
3. Notice of Funding Opportunity "Increasing the Health Care Workforce Pipeline Through Educational Investments."

Board Actions

Board Meeting Dates	Action	Term	Not to Exceed Amount
June 2, 2022	Adopt Strategic and Tactical Priorities for 2022-2025		
June 1, 2023	Authorize the Creation of a CalOptima Health Provider Workforce Development Reserve Fund	5 Years	$50 million

/s/ Michael Hunn *11/30/2023*
Authorized Signature **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item
18. Adopt Strategic and Tactical Priorities for 2022-2025

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

Recommended Action(s)
1. Adopt Strategic and Tactical Priorities for 2022-2025

Background and Discussion
CalOptima was created by the Orange County Board of Supervisors in 1993 as a County Organized Health System (COHS) to meet the needs or Orange County residents and providers in the Medicaid system.

In July of 1994, the CalOptima Board of Directors (Board) adopted the Mission, Goals, and Objective Statement for O.P.T.I.M.A as developed by the Provider Advisory Committee and the Consumer/Beneficiary Advisory Committee.

At that time, the Board wanted to ensure that the statement regarding the inclusion of the County-responsible indigent population in O.P.T.I.M.A was linked to the availability of adequate funding for services provided to this population.

The following mission was adopted and defined in Policy #AA. 1201:

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

CalOptima also adopted the following vision statement:

- To be a model public agency and community health plan that provides an integrated and well-coordinated system of care to ensure optimal health outcomes for all our members.

In 2013, during a strategic planning session conducted by the Board updating the mission was considered. Ultimately, it was agreed up on that the original mission statement did not require any changes.

Today, CalOptima is the single largest health insurer in Orange County, providing coverage for one in four residents through four programs:

- Medi-Cal
- OneCare
- OneCare Connect

- PACE

On March 17, 2022, the Board formally adopted new mission and vision statements.

- Mission-To serve member health with excellence and dignity, respecting the value and needs of each person.
- Vision-By 2027, remove barriers to healthcare access for our members, implement same day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.

Beginning in December of 2021, staff developed five strategic priorities and tactical priorities. Over the last six months, CalOptima has sought feedback from advisory committees, health networks, hospitals, and clinics among others. The five strategic priority areas are as follows:

- Organizational and Leadership Development
- Overcoming Health Disparities
- Finance and Resource Allocation
- Accountability and Results Tracking
- Future Growth

The strategic priority areas and tactical priorities will support planning and development for CalOptima through 2025. Staff will return to the Board with a Strategic Plan using these priorities for approval.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
Development of the proposed Strategic Priority Areas is consistent with the direction provided by the Board of Directors to support planning and development of CalOptima programs and initiatives.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Strategic Priorities One Pager
2. Resolution of New Mission and Vision Statement for CalOptima

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

Mission	*To serve member health with excellence and dignity, respecting the value and needs of each person.*				
Vision	*By 2027, remove barriers to healthcare access for our members, implement same day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.*				
Core Strategy	**The 'inter-agency' co-creation of services and programs, together with our delegated networks, providers, and community partners, to support the mission and vision.**				
Strategic Priorities 2022-2025	**Organizational and Leadership Development**	**Overcoming Health Disparities**	**Finance and Resource Allocation**	**Accountabilities & Results Tracking**	**Future Growth**
Tactical Priorities 2022-2025	• Cultural Alignment throughout CalOptima • Talent Development & Succession Planning • Effective & Efficient Organizational Structures • Aligned Operating Systems & Structures • Staff Leadership Development Institutes (Training) & Executive Coaching • Organizational Excellence Annual Priorities • On-going updated Policies & Procedures • Governance & Regulatory Compliance Trainings • Board Priorities	• CalOptima's 'Voice & Influence' • Local, Federal & State Advocacy • Collaboration with the County, HCA, BeWell, the Networks and Community Based Organizations • Support for Community Clinics & Safety Net Providers • Medical Affairs Value Based Care Delivery • CalAIM initiatives • Focus on Equity & Communities Impacted by Health Inequities • Co-Created Needs Assessment within Equity Communities & Neighborhoods • ITS Architecture that supports the Core Strategy • DHCS Comprehensive Quality Strategy	*Operating Budget Priorities* • Balanced Operating Budget • New Programs & Services Budgeting (CalAIM, DHCS Quality Strategy) • Fiscal Strategic Plan Priorities (KPI/KFI) • Quarterly Budget Reconciliation *Capital Budget Priorities* • Capital Planning & Asset Management, including Real-Estate Management and Acquisition(s) • New ITS Architecture *New Policy and Program Development based on Funding* • Reserve/Spending Policies & Priorities • Aligned Incentives for Network Quality & Compliance • Contracting & Vendor/Provider Management	• Updated By-Laws • Executive Priorities & Outcomes • COBAR Clarity • Inter-Agency Team Priorities • Public/Private Implementation Work Group • Resource Allocation for Inter-Agency Initiatives • Partner CalAIM Opportunities for Outcomes Metrics • Research Analytics for Efficacy Reporting (Metrics of Success) • Regular Board Training Sessions	• Member Access to Quality Care • Participate in Covered California • Site Utilization (PACE etc.) • Services/Programs Aligned with Future Reimbursements from DHCS and CMS • Demographic & Analytics by Micro-Community • ITS Data Sharing to benefit the member • Implement Programs & Services (CalAIM) & Plan for Site Locations • Industry Trends Analysis (Trade Associations, Lobbyists etc.) • Enhanced ITS security posture

DRAFT STRATEGIC AND TACTICAL PRIORITIES May_2022

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RESOLUTION NO. 22-0317-01

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

RESOLUTION FOR MISSION AND VISION STATEMENT

WHEREAS, the governing body of the Orange County Health Authority, dba CalOptima, ("CalOptima") adopted Mission, Goals, and Objective Statement O.P.T.I.M.A in July of 1994;

WHEREAS, this mission statement adopted in 1994 stated, the mission is to provide members with access to quality health care services delivered in a cost-effective and compassionate manner;

WHEREAS, the adoption of the mission statement was reflected in Policy #AA. 1201;

WHEREAS, the governing body of CalOptima has adopted a new mission and vision statement on March 17, 2022 and will be reflected in Policy #AA. 1201;

WHEREAS, the governing body adopted CalOptima's new mission and vision statement as follows;

- Mission: To serve member health with excellence and dignity, respecting the value and needs of each person.
- Vision: By 2027, remove barriers to healthcare access for our members, implement same day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.

NOW, THEREFORE, BE IT RESOLVED that the governing body of CalOptima adopts a new mission and vision statement.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 17th day of March 2022.

AYES: Becerra, Chaffee, Contratto, Corwin, Do, Mayorga, Schoeffel, Shivers

NOES: None

ABSENT: Tran

ABSTAIN: None

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

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

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CalOptima Health Board Action Agenda Referral

Action To Be Taken June 1, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item
22. Authorize the Creation of a CalOptima Health Provider Workforce Development Reserve Fund

Contacts
Michael Hunn, Chief Executive Officer (657) 900-1481
Yunkyung Kim, Chief Operating Officer (714) 923-8834

Recommended Actions
1. Create a restricted CalOptima Health Provider Workforce Development Fund in the amount of $50 million from existing reserves to support the education, training, recruitment, and retention of safety net providers in Orange County;
2. Direct the Chief Executive Officer to create a 5-year Provider Workforce Development Plan for the local safety net provider community; and
3. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima Health's mission and purpose.

Background
The issue of health care provider shortages is one of the biggest challenges facing CalOptima Health and its community. In 2019, the California Future Health Workforce Commission projected that within 10 years, California would face a shortfall of more than 4,100 primary care clinicians and 600,000 home care workers, and would only have two-thirds of the psychiatrists it needs (Final Report of the California Future Health Workforce Commission, February 2019). Additionally, although California's population is becoming increasingly diverse, the health workforce does not reflect those demographics. These shortages and disparities are more pronounced in Medi-Cal, and projected workforce shortages have accelerated since the COVID-19 pandemic.

Discussion
CalOptima Health staff requests that the Board of Directors (Board) create a dedicated restricted reserve fund in the amount of $50 million to help address this looming crisis in the community. The funding will be used to create opportunities for education, training, recruitment, and retention of providers needed to serve CalOptima Health members.

Further, staff requests the Board to direct the Chief Executive Officer to develop a 5-year plan for local provider workforce development to include priority provider areas, funding strategies, and implementation plans for the Board's review and approval. CalOptima Health's plan will include learnings from existing statewide health workforce initiatives and engagement of local provider and member communities.

Fiscal Impact
An appropriation of up to $50 million from existing reserves will fund the restricted CalOptima Health Provider Workforce Development Fund.

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Rationale for Recommendation
The recommended action will support ongoing access to quality health providers for CalOptima Health's diverse membership.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachment
N/A

/s/ Michael Hunn *05/26/2023*
Authorized Signature **Date**

CalOptima Health Workforce Development Fund Notice of Funding Opportunity

Round 1: Increasing the Health Care Workforce Pipeline through Educational Investments

CalOptima Health solicits grant applications to increase the pipeline of health care professionals serving CalOptima Health members.

Application Deadline — 1/31/2024 (5:00 p.m. PST)

Background

CalOptima Health's mission is to serve member health with excellence and dignity, respecting the value and needs of each person. Health care workforce shortages in Orange County and statewide are significant, and investment is needed to increase the number of health professionals in Orange County. To address these challenges, the CalOptima Health Board approved an investment of $50 million over five years to create the Workforce Development Fund to increase the supply of safety net providers serving CalOptima Health members in Orange County. Through the Workforce Development Fund, CalOptima Health is committed to increasing the number of providers who are needed to serve Orange County's most vulnerable population.

CalOptima Health engaged in a robust stakeholder listening process to inform the design of the Workforce Development Fund strategy and plan. One of the key challenges highlighted through the stakeholder engagement process was the need for greater investment to expand educational opportunities to increase the pipeline of health professionals in Orange County. To address this challenge, the first round of funding made available under the Workforce Development Fund will provide up to $10 million in grant funding to increase the health care workforce pipeline through educational investments. A second round of funding will focus on investments in workforce development innovation under a Workforce Training & Development Innovation Fund. This first funding opportunity for workforce development round one grants will be **open for applications December 15, 2023 – January 31, 2024.**

Description of Project Grant Funding Opportunity

A key driver of growing the health care workforce in Orange County is the pipeline of students that enter health professions. To increase this pipeline of students and strengthen educational affordability

and opportunity to enter health professions, this grant funding opportunity will provide funds for initiatives and programs that increase the pipeline of health professionals. Priority for these educational investments will be given to projects that focus on the health professional workforce in the areas of nursing, behavioral health, primary care (nurse practitioners and physician assistants), and allied health professions. This funding opportunity will focus on non-physician professions.

Eligible projects or programs focused on increasing the health care professional pipeline could include, but not be limited to:

- Pipeline programs from high school into higher education focused on health care professions with commitment to serve Orange County.
- Stipend programs to incentivize students from underrepresented populations and low-income students to participate in health professional programs with a commitment to serve Orange County.
- Stipend programs focused on recruiting students into health care workforce shortage professions.
- Funding to expand existing health care higher education training and education programs to additional cohorts in areas of workforce shortage.
- Investments to expand clinical rotations to a greater number of students.
- Investments to develop and recruit faculty among health professions, including nurse educators, and others.

Grant Amounts and Duration

The CalOptima Health Workforce Development Fund will invest $50 million over five years across several focus areas. Grant award requests must be proposed in the Grant Application. Any approved grant requests under this funding opportunity must avoid supplanting or replacing existing Federal, State, and/or CalOptima Health funding sources for workforce development initiatives.

If applicable, applicants may apply for more than one round of funding as it becomes available. For awarded grants, payment is made in full upon completed execution of the grant agreement.

Entities Eligible to Apply

- Eligible entities to receive this funding would be educational institutions or partnerships among educational institutions and community or provider organizations.
- Applicants must propose projects or programs that align with the funding opportunity in this document and the Grant Application.
- Applicants that previously received funding from CalOptima Health must be in good standing with the terms of that contract or grant agreement to be eligible for new funding.
- Applicants are strongly encouraged to apply for funds when they are ready to implement the activity proposed for funding.

Proposal Evaluation Criteria

	Criterion	Maximum Points	Description of Basis for Assigning Points
1	Funding Sources	Pass/ Fail	• Does not supplant other available Federal, State or CalOptima Health opportunities/sources.
2	CalOptima Health core mission and value alignment	10	• Project is inclusive and provides opportunity for more CalOptima Health members to be served with excellence and dignity.
3	Project Implementation	10	• Plan is complete and includes specific SMART objectives and defined measures of success.
4	Budget and Financial Management	10	• Budget and financial plan are sound and aligned with the objectives of the project. • Identifies potential funding sources for sustainability of the project/program after the end of the grant agreement.
5	Equity	20	• Project aims to increase representation of underrepresented groups in health professions. • Project allows for a wide representation to enter and/or advance in health care.
6	Increased number of health professionals	20	• Addresses identified shortages in the health care workforce serving CalOptima Health members. • Addresses affordability of education and employment pathways. • Demonstrates how the project increases the number of health professionals in Orange County.
7	Capacity of program	10	• Grantee's demonstrated experience and capacity to perform the program.
8	Alignment with CalOptima investments	20	• Proposed program fills an unmet need within the CalOptima Health investment and grantmaking portfolio. • Project leverages available funding partners.
	Total Earnable Points	**100**	

Timeline

Activity	Date
Notice of Funding Opportunity Released and Portal Opens	12/15/2023 at 9 a.m.
Bidder's Conference *(virtual)*	12/18/2023 at 10 a.m.
Questions Posted from Bidder's Conference	12/22/2023
Application Deadline	**1/31/2024 at 5 p.m.**
Internal Review	2/1/2024 - 2/12/2024
CalOptima Health Board of Directors Meeting	**3/7/2024**
Announcement of Approved Grants	3/8/2024
Grant Agreements Processed	3/11/2024 - 4/1/2024
Grants Start Date	4/1/2024

Documents and Portal Access

All documents related to this Notice of Funding Opportunity and application portal access will be made available at this site:
[insert link]

Bidder's Conference

Join our Bidder's Conference for this funding opportunity by registering below:

Bidder's Conference
Date and Time: Monday, December 18, 2023, XX a.m.
Link: **[insert link]**

Questions about the funding opportunity or application? Contact Strategic Development at strategicdevelopment@caloptima.org

CalOptima Health Board Action Agenda Referral

Action To Be Taken June 1, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item
22. Authorize the Creation of a CalOptima Health Provider Workforce Development Reserve Fund

Contacts
Michael Hunn, Chief Executive Officer (657) 900-1481
Yunkyung Kim, Chief Operating Officer (714) 923-8834

Recommended Actions
1. Create a restricted CalOptima Health Provider Workforce Development Fund in the amount of $50 million from existing reserves to support the education, training, recruitment, and retention of safety net providers in Orange County;
2. Direct the Chief Executive Officer to create a 5-year Provider Workforce Development Plan for the local safety net provider community; and
3. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima Health's mission and purpose.

Background
The issue of health care provider shortages is one of the biggest challenges facing CalOptima Health and its community. In 2019, the California Future Health Workforce Commission projected that within 10 years, California would face a shortfall of more than 4,100 primary care clinicians and 600,000 home care workers, and would only have two-thirds of the psychiatrists it needs (Final Report of the California Future Health Workforce Commission, February 2019). Additionally, although California's population is becoming increasingly diverse, the health workforce does not reflect those demographics. These shortages and disparities are more pronounced in Medi-Cal, and projected workforce shortages have accelerated since the COVID-19 pandemic.

Discussion
CalOptima Health staff requests that the Board of Directors (Board) create a dedicated restricted reserve fund in the amount of $50 million to help address this looming crisis in the community. The funding will be used to create opportunities for education, training, recruitment, and retention of providers needed to serve CalOptima Health members.

Further, staff requests the Board to direct the Chief Executive Officer to develop a 5-year plan for local provider workforce development to include priority provider areas, funding strategies, and implementation plans for the Board's review and approval. CalOptima Health's plan will include learnings from existing statewide health workforce initiatives and engagement of local provider and member communities.

Fiscal Impact
An appropriation of up to $50 million from existing reserves will fund the restricted CalOptima Health Provider Workforce Development Fund.

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Rationale for Recommendation
The recommended action will support ongoing access to quality health providers for CalOptima Health's diverse membership.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachment
N/A

/s/ Michael Hunn *05/26/2023*
Authorized Signature **Date**

Provider Workforce Development Round One Grantee Recommendations

Increasing the Health Care Workforce Pipeline through Educational Investments

Board of Directors Meeting

April 4, 2024

Donna Laverdiere, Executive Director, Strategic Development

Our Mission

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

Our Vision

By 2027, remove barriers to health care access for our members, implement same-day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.

Round 1 Funding Opportunity:

Increasing the Health Care Workforce Pipeline through Educational Investments

- **Up to $25 million** in grant funding to increase the health care workforce pipeline through **educational investments**.
- Focus is on **non-physician professions**. Priority areas for investments include nursing, behavioral health, primary care (nurse practitioners and physician assistants), and allied health.
- Eligible entities were **educational institutions** or **partnerships among educational institutions and community or provider organizations**.

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Summary of Applications Received & Review Process

- Received 30 applications totaling $96.5 million that spanned identified workforce shortage areas.
- Based on the breadth and scope of applications received, the Board approved an increase for Round 1 grant funding to up to $25 million from the original $10 million allocation.

Workforce Shortage Area	Number of Applications	Total Grant Funds Requested
Nursing	6	$39,854,986
Varied Professions	9	$25,562,703
Behavioral Health	10	$14,729,363
Allied Health	4	$10,712,873
Primary Care	1	$5,684,162
Total	***30***	***$96,544,087***

Evaluation Criteria

	Criterion	Maximum Points	Description of Basis for Assigning Points
1	Funding Sources	Yes/No	• Does not supplant other available Federal, State or CalOptima Health opportunities/sources.
2	CalOptima Health core mission and value alignment	10	• Project is inclusive and provides opportunity for more CalOptima Health members to be served with excellence and dignity.
3	Project Implementation	10	• Plan is complete and includes specific SMART objectives and defined measures of success.
4	Budget and Financial Management	10	• Budget and financial plan are sound and aligned with the objectives of the project. • Identifies potential funding sources for sustainability of the project/program after the end of the grant agreement.
5	Equity	20	• Project aims to increase representation of underrepresented groups in health professions. • Project allows for a wide representation to enter and/or advance in health care.
6	Increased number of health professionals	20	• Addresses identified shortages in the health care workforce serving CalOptima Health members. • Addresses affordability of education and employment pathways. • Demonstrates how the project increases the number of health professionals in Orange County.
7	Capacity of program	10	• Grantee has demonstrated experience to perform the program. • If applicable, grantee is able to expand the capacity of an existing program.
8	Alignment with CalOptima investments	20	• Proposed program fills an unmet need within the CalOptima Health investment and grantmaking portfolio. • Project leverages available funding partners.
	Total Earnable Points	**100**	

Awardee Recommendations

- Applications that scored 81 points and above through the competitive scoring process are recommended to receive a grant award.
- A maximum grant award per organization of $5 million is recommended to ensure equitable distribution of funds.
- Awards are recommended for 9 applications from 7 organizations based on the competitive scoring process and maximum grant award amount.

Recommended Grant Awards

Organization	Requested Amount	Recomm. Award	Brief Description
Coast Community College District	$2,040,000	$2,040,000	Expanding registered nurse pipeline at Golden West College by 40 students/year and developing a pathway to the radiologic technology certificate program at Orange Coast College for 30 students/year.
Santiago Canyon College (Recommending to fund 3 out of 4 applications)	$1,200,000	$1,200,000	Increase the behavioral technician (BHT) program from 25-50 to 50-100 students annually; medical assistant program from 50 to 175 students annually; and develop a licensed vocational nursing (LVN) curriculum/attain program accreditation to produce 60+ licensed graduates annually.
Sue & Bill Gross School of Nursing, University of California Irvine	$9,126,399	$5,000,000	A program to provide a 1-year externship to prelicensure nursing students and a 1-year residency for Family Nurse Practitioners (FNP) and Psychiatric Mental Health Nurse Practitioners (PMHNP) graduates to address OC's shortage of registered nurses (RN) and primary and behavioral healthcare providers.
Chapman University	$5,684,162	$5,000,000	Providing full tuition physician assistant scholarships, training, and local practice physician assistant education for academically qualified, low-income students.
CSU Fullerton Auxiliary Services Corporation	$9,999,732	$5,000,000	Increase the Concurrent Enrollment Program to an increased number of Associate Degree Nursing to Bachelor of Science in Nursing (BSN) students and an expansion of the BSN program.
Orange County United Way	$1,356,300	$1,356,300	Expand the UpSkill program, focusing on gaps within the healthcare workforce, and provide career coaching, connections to paid training and certification programs, and job placements in the healthcare industry to serve an additional 25 clients each year.
Concordia University, Irvine	$5,629,907	$5,000,000	Increase the Accelerated Bachelor of Science in Nursing (ABSN) program and provide scholarships to pre-nursing students and ABSN students.
	$35,036,500	$24,596,300	

Scoring of All Applications

Organization Name	Proposed Program Title	Score out of 100	Funding Recommendation
Coast Community College District	Orange County Dual Enrollment Nursing and Allied Health Pathways	87.33	Fund
Santiago Canyon College	Santiago Canyon College Healthcare Pathway - Behavior Technicians	87.33	Fund
Sue & Bill Gross School of Nursing, University of California, Irvine	NURSE-OC: University of California, Irvine Nursing Workforce Pipeline through Externships and Residencies in Orange County (OC)	86.50	Fund
Santiago Canyon College	Santiago Canyon College Healthcare Pathway - Licensed Vocation Nurse	84.83	Fund
Chapman University	Reflecting Orange County Communities: Building a Culture of Health through Physician Assistant Scholarships, Training, and Local Practice Physician Assistant Education for Academically Qualified Low Income Students	84.67	Fund
CSU Fullerton Auxiliary Services Corporation (1 of 2 applications)	Expanding Numbers of CSUF Baccalaureate-Prepared Registered Nurses in Orange County	84.50	Fund
Santiago Canyon College	Santiago Canyon College Healthcare Pathway - Medical Assistant	84.17	Fund
CSU Fullerton Auxiliary Services Corporation (2 of 2 applications)	CalOptima Stipend Program for CSUF Accelerated Baccalaureate Nursing Students	83.17	Do Not Fund (Grantee exceeded maximum allowed grant award with highest scoring application)
Orange County United Way	UpSkill OC	83.00	Fund
Concordia University Irvine	Concordia Nursing Pipeline Program	81.83	Fund

Scoring of All Applications (cont.)

Organization Name	Proposed Program Title	Score out of 100	Funding Recommendation
CHOC	Health and Behavioral Health Field Practicum Expansion	80.17	Do Not Fund
Easterseals Southern California	Building Orange County's Mental Health Service Capacity	79.33	Do Not Fund
Big Brothers Big Sisters of Orange County and the Inland Empire	Mentoring Orange County's Next Healthcare Workers	78.83	Do Not Fund
Access California Services	AccessCal's Health Care Workforce Program	78.33	Do Not Fund
John Henry Foundation	Intern Psychologist Workforce Development Program	78.00	Do Not Fund
Santiago Canyon College	Santiago Canyon College Healthcare Pathway - Lactation Education Pathway to International Board Certified Lactation Consultant (IBCLC)	77.83	Do Not Fund
UC Irvine Program in Public Health	Orange County Health Pathways Program	77.83	Do Not Fund
AltaMed Health Services Corporation	AltaMed Orange County Community Health Workforce Pipeline	76.83	Do Not Fund
North Orange County Regional Occupational Program - Adult Career Education	North Orange County ROP Healthcare Workforce Training Expansion Program	76.67	Do Not Fund
The Cambodian Family	Cambodian Mental Health Workforce Development Initiative	75.83	Do Not Fund

Scoring of All Applications (cont.)

Organization Name	Proposed Program Title	Score out of 100	Funding Recommendation
South Orange County Community College District dba Saddleback College	Orange County Surgical Technologist Career Pathway	75.00	Do Not Fund
UCI Susan Samueli Integrative Health Institute	Health and Wellness - Behavioral Health Track Coaching Certificate Program	74.67	Do Not Fund
Seneca Family of Agencies	Seneca Family of Agencies' OC Behavioral Health Clinical Internship Program	72.67	Do Not Fund
YMCA of Orange County	Developmental Disabilities Workforce Development Collaborative	72.67	Do Not Fund
Celebrating Life Community Health Center	Path to Medical Provider for Underserved Populations Academic Award Program	71.83	Do Not Fund
Orange County Asian and Pacific Islander Community Alliance, Inc.	Project VOICE-BH	71.33	Do Not Fund
Anaheim Union High School District	Connecting Students' Strengths, Interests, and Aspirations to Build a Better Healthcare Workforce through Daily Classroom Instruction	70.67	Do Not Fund
Camino Health Center	Camino Pathways	70.17	Do Not Fund
Orange County Department of Education	Orange County Health Careers Center	64.33	Do Not Fund
Sowing Seeds Health, Inc.	Clinical Rotation Position Expansion	63.50	Do Not Fund

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Workforce Training & Development Innovation Fund

Round 2 Grantee Recommendations

Board of Directors Meeting
November 7, 2024

Donna Laverdiere, Executive Director, Strategic Development

Our Mission

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

Our Vision

By 2027, remove barriers to health care access for our members, implement same-day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.

Round 2 Funding Opportunity:

Provider Workforce Training & Development Innovation Fund

- **Up to $5 million** in grant funding to support innovative programs and partnerships that are committed to training, retention, and development of health professionals in **non-physician primary care, behavioral health, and allied health**.
- Priority area for investment this funding round is on **increasing the behavioral health workforce** serving CalOptima Health members.
- Eligible entities were **health systems, health care provider organizations and community organizations**.

Summary of Applications & Review Process

- Received 44 applications totaling $37.9 million that spanned identified workforce shortage areas.
- Convened a review committee of six reviewers to review and score applications through a competitive process.

Workforce Category	# of Applications*
Behavioral Health	27
Non-Physician Primary Care and Nursing (PA, NP, RN, LVN)	14
Allied Health	3
General Student Internships	11
Others	2

* Application count by workforce category exceeds 44 due to applications that aimed to address workforce gaps across more than one category.

Evaluation Criteria

Criteria	Pts	Description
Eligibility	Pass/ Fail	• Must be a provider organization or community-based organization (one application per). • Does not supplant other available Federal, State or CalOptima Health opportunities/sources.
Mission Alignment	10	• Project aligns with the CalOptima Health mission, vision, and values statements. • Demonstrates value to the CalOptima Health membership and the Medi-Cal program. • Fills an unmet need within the CalOptima Health investment portfolio.
Workforce Development Goals	20	• Proposes investments targeted towards identified shortages in the health care workforce. Priority given to behavioral health (receive a 1.5-point value weighting). • Demonstrates how the project increases the number of health professionals in Orange County.
Program Design	20	• Alignment with the goals and objectives of the grant program as outlined in the NOFO. • Includes innovative approaches to training, retention, or upskilling components • Includes elements that encourage or incentivize participants to remain in Orange County and serve Medi-Cal members.
Equity	15	• Aims to increase representation of underrepresented groups in health professions. • Considers the diverse needs of the Medi-Cal population and the workforce investments needed to improve access to care for underserved groups.
Implementation Plan/Performance	10	• Provides a clear and complete implementation plan with well-defined project milestones and timeframes.
Budget	15	• Budget and financial plan are sound and aligned with the objectives and activities of the project.
Organizational Experience and Capacity	10	• Applicant has demonstrated experience needed to perform the program. Applicant is a stable organization and has demonstrated capacity to perform the functions of the program. • Identifies potential funding sources for sustainability of the project/program.
Total	**100**	

Award Recommendations

- Recommend approval of the selection of **6 grantees** with corresponding grant award allocations totaling $5,140,742.
  - Awarded applications scored **88 points and above** through the evaluation process.
  - This grant funding will support approximately **230 health professionals** in Orange County.
- Recommend approval of the **increase of $140,742 to the initial $5 million allocation** to allow full funding of the top 6 applications.

Recommended Grant Awards

Organization	Amount	Brief Description
Child Guidance Center, Inc.	$766,920	Help the Helper - Strengthening Orange County's Behavioral Health Workforce: A program to train 35 graduate students pursuing master's and doctoral degrees in mental health (Master's degree in Social Work, Master's degree in Marriage & Family Therapy, Master's degree in Counseling Psychology) over a three-year period.
Children's Hospital of Orange County (CHOC)	$994,824	Pediatric Behavioral Health Field Training Expansion: A program to train an additional 92-96 social work and psychology students over a four-year program period.
John Henry Foundation	$847,302	Intern Psychologist Workforce Development Program: A program to train 25 PhD and PsyD candidates over a five-year period with the skills to treat severe mental health conditions.
Seneca Family of Agencies	$996,130	Behavioral Health Clinical Internship Program: A program to train 18 master's level graduate students in mental health-focused programs (Master's degree in Social Work, Master's degree in Marriage & Family Therapy, Master's degree in Counseling Psychology) over a three-year period.
Special Service for Groups, Inc.	$535,566	Professional Providers Pathway (Px3) Program: A paid internship opportunity for 25 graduate students over a five-year period pursuing behavioral health degrees with a focus on service provision.
Western Youth Services	$1,000,000	Western Youth Services Workforce Development Program: A program to increase the flow of behavioral health professionals through financial incentives for Student Interns, Behavioral Health Specialists, Care Managers, Mental Health Workers, Therapeutic Behavioral Coaches, and Peer Support Specialists. Provides tuition reimbursement for 55 staff, licensure fee reimbursement for 80 staff, stipends for 35 master's level interns over a five-year period, and 380 continuing education units for staff.
	$5,140,742	

Scoring of All Applications

Organization Name	Proposed Program Title	Score	Recommendation
Children's Hospital Orange of County	Pediatric Behavioral Health Field Training Expansion	98.00	Fund
Child Guidance Center, Inc.	Help The Helper: Strengthening Orange County's Behavioral Health Workforce	97.83	Fund
Western Youth Services	Western Youth Services Workforce Development Program	94.00	Fund
Special Service for Groups, Inc.	Professional Providers Pathway (Px3) Program	91.33	Fund
John Henry Foundation	Intern Psychologist Workforce Development Program	89.00	Fund
Seneca Family of Agencies	Seneca Family of Agencies Orange County Behavioral Health Clinical Internship Program	88.83	Fund
Providence Medical Foundation	Providence Medical Foundation Behavioral Health Workforce Development Program	86.50	Do Not Fund
The Regents of the University of California, Irvine	Child & adolescent psychiatry community focused workforce expansion: meeting the needs of underserved youth in Orange County	86.33	Do Not Fund
Easterseals Southern California	Expanding Orange County's Behavioral Health Services for Individuals with ASD and Co-Occurring Conditions	83.50	Do Not Fund
The Cambodian Family	Khmer Mental Health Workforce Development Initiative	81.33	Do Not Fund
Center for Applied Research Solutions (CARS)	The Fellowship for Affirming, Cross-Cultural, and Equitable Services (FACCES)	80.83	Do Not Fund
Asian American Senior Citizens Service	Asian American Pacific Islander Behavioral Health Workforce Pathways	79.50	Do Not Fund
KCS Health Center	OC SUD/MOUD Learning Collaborative	78.00	Do Not Fund
Norooz Clinic Foundation	Integrated Behavioral Health Specialists Training and Readiness (IBSTAR) Program	77.83	Do Not Fund
Project Self-Sufficiency	HEAL: Health Education and Leadership for Single Parents	76.67	Do Not Fund

Scoring of All Applications (cont.)

Organization Name	Proposed Program Title	Score	Recommendation
Vista Community Clinic	Development of a behavioral health internship program in North Orange County	76.67	Do Not Fund
Moving Forward Psychological Institute	MFPI's Community Mental Health Worker Apprenticeship Program	71.50	Do Not Fund
Community Action Partnership of Orange County (CAPOC)	CAP OC Behaviorial Health Workforce Development Training Program	71.00	Do Not Fund
Charitable Ventures dba Start Well	Expanding Access to Infant/Early Childhood Mental Health Consultation in Home Visiting	70.17	Do Not Fund
Health Career Connection	Health Career Connection and Partners Advancing a Diverse Behavioral Health Workforce in OC 2025-2029	69.33	Do Not Fund
Charitable Ventures of Orange County dba Thrive Together OC	Thrive Together OC Training Hub	69.00	Do Not Fund
Unlimited Possibilities (UP)	Provider Workforce Development for UP's Access to Care Program	67.00	Do Not Fund
Illumination Institute	Orange County Disability Collective Workforce Development Initiative	64.33	Do Not Fund
Families Together of Orange County	Provider Empowerment Pathways	62.67	Do Not Fund
Livingstone Community Development Corporation	Provider Connection Program	61.67	Do Not Fund
CARTSS, A Licensed Professional Clinical Counseling Corporation	Taking Flight Network, Inc	59.83	Do Not Fund
Celebrating Life CHC	Kristina Sergeyeva VIP Pre-Health Student Program/SunFlowers Strong Scholarship	59.33	Do Not Fund
360 Behavioral Health	Board Certified Behavior Analyst (BCBA) Development Fellowship	58.83	Do Not Fund
CEO Leadership Alliance Orange County	"Thriving OC for All: Strengthening the Healthcare Talent Pipeline to Boost Economic Mobility and Build Holistic Healthy Communities	57.33	Do Not Fund

Scoring of All Applications (cont.)

Organization Name	Proposed Program Title	Score	Recommendation
Big Brothers Big Sisters of Orange County and the Inland Empire	Behavioral Health Workforce Mentorship and Job Placement Program	57.00	Do Not Fund
The Purpose of Recovery	BH Intern Program	56.00	Do Not Fund
Olive Community Services, Inc.	Care Champions: Developing a behavioral and preventive healthcare workforce for the SAMENA community	54.33	Do Not Fund
Access California Services	AccessCal's Health Care Workforce Program	52.67	Do Not Fund
Go RN	Orange County Healthcare Fast Track	52.67	Do Not Fund
Serve the People Community Health Center	Care Team Development Program	52.33	Do Not Fund
The Lukes Network	Goodwill Industries of Orange County (GIOC) Healthcare Career Pathways Program	51.67	Do Not Fund
PHYSICIAN PARTNERS MEDICAL GROUP	Provider Workforce Development - Round 2 Workforce Training and Development Innovation Fund	49.17	Do Not Fund
Laguna Beach Community Clinic	Comprehensive Care Program: Personnel Retention Plan	48.33	Do Not Fund
UCI Health	Leadership Success Program for Senior Leaders	48.00	Do Not Fund
Be Well OC/Mind OC	Be Well OC Irvine Crisis Stabilization Unit	0.00	Do Not Fund
Krista Care LLC	Krista Care Workforce Expansion and Retention Program	0.00	Do Not Fund
Wellness & Prevention Foundation	Mental Health Workforce Development	0.00	Do Not Fund
Center for Family Health Initiative (CFHI)	Advancing Black Care Providers (ABC) Initiative	0.00	Do Not Fund
Right at Home Central OC	Serving Underrepresented Patients with Excellent Resources (SUPER)	0.00	Do Not Fund

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CalOptima Health Board Action Agenda Referral

Action To Be Taken November 07, 2024
Regular Meeting of the CalOptima Health Board of Directors

Report Item

14. Adopt Resolution No. 24-1107-01 Approving the Revised 2025 CalOptima Health Compliance Plan, 2025 CalOptima Health Code of Conduct, 2025 CalOptima Health Anti-Fraud, Waste and Abuse (FWA) Plan, 2025 CalOptima Health HIPAA Privacy and Security Program, and Revised CalOptima Health Office of Compliance Policies and Procedures.

Contact

John Tanner, Chief Compliance Officer, (657) 235-6997

Recommended Actions

1. Adopt Resolution No. 24-1107-01 approving:
    a. The revised 2025 CalOptima Health Compliance Plan; 2025 CalOptima Health Code of Conduct; 2025 CalOptima Health Anti-Fraud, Waste and Abuse (FWA) Plan; and the 2025 CalOptima Health HIPAA Privacy and Security Program; and
    b. Revised CalOptima Health Office of Compliance policies and procedures.

Background

CalOptima Health is committed to conducting its operations in compliance with ethical standards and all applicable laws, regulations, and rules, including federal and state health care program requirements. As part of that commitment, the CalOptima Health Board of Directors (Board) is annually presented with CalOptima Health's Compliance Program and associated documents (Compliance Program) for review and approval. The 2025 CalOptima Health Compliance Plan; 2025 CalOptima Health Code of Conduct; 2025 CalOptima Health Anti-Fraud, Waste and Abuse (FWA) Plan; and the 2025 CalOptima Health HIPAA Privacy and Security Program, comprehensively address the fundamental elements necessary for an effective compliance program, including those elements identified by the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services and the Centers for Medicare & Medicaid Services (CMS).

Compliance Program Elements

Federal laws and regulations (including the CMS Medicare Advantage regulations) and OIG compliance guidance require that compliance programs be reasonably designed, implemented, and enforced to ensure the programs are effective in preventing, detecting, and correcting violations of standards or laws. The Compliance Program addresses each of the seven fundamental elements of an effective compliance program, in addition to FWA prevention, detection, and remediation.

Written Standards

As part of its Compliance Program, CalOptima Health develops, maintains, and distributes to its Board, employees, and first tier, downstream or related entities (FDRs) written standards in the form of the 2025 CalOptima Health Compliance Plan, 2025 CalOptima Health Code of Conduct, 2025 CalOptima Health Anti-Fraud, Waste and Abuse Plan, the 2025 CalOptima Health HIPAA Privacy and Security Program, and written policies and procedures, as further detailed in the 2025 CalOptima Health Compliance Plan. The 2025 CalOptima Health Compliance Plan incorporates all the elements of an effective compliance program, as recommended by the OIG and required by CMS regulations. The

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Compliance Program also includes a comprehensive anti-FWA plan, which establishes guidelines and procedures designed to prevent, detect, and remediate FWA in CalOptima Health programs.

Oversight
As CalOptima Health's governing body, the Board is responsible for ensuring and overseeing the implementation, effectiveness, and continued operation of the Compliance Program. The Board delegates to the Chief Executive Officer, who then delegates to the Chief Compliance Officer, the administration of the Compliance Program's development, maintenance, implementation, monitoring, and enforcement activities. The Chief Compliance Officer, in conjunction with the Compliance Committee, are accountable for the oversight and reporting roles and responsibilities set forth in the 2025 CalOptima Health Compliance Plan. The Delegation Oversight Committee, a subcommittee of the Compliance Committee, is responsible for overseeing delegated activities.

Training and Education
Utilizing web-based courses, as well as distribution of guidelines and publications, the Compliance Program incorporates training and education regarding CalOptima Health's compliance standards and requirements, as well as specialized educational courses assigned to individuals based on their respective roles within CalOptima Health's departments and programs. Upon appointment, hiring, or commencement of a contract, and annually thereafter, the Board, employees, and FDRs receive CalOptima Health's Code of Conduct and are required to complete comprehensive training covering compliance obligations and applicable laws, FWA (where applicable), Health Insurance Portability and Accountability Act (HIPAA) privacy and security requirements, Health Information Technology for Economic and Clinical Health Act, and Confidentiality of Medical Information Act.

Effective Lines of Communication and Reporting
CalOptima Health utilizes various methods to communicate general information, regulatory updates, and process changes from the Chief Compliance Officer to the Board, employees, FDRs, and members, including, but not limited to, presentations at meetings and updates in print and/or electronic form about how to identify, report, and prevent compliance issues and FWA. The Board, employees, FDRs, and/or members receive information and reminders to report compliance concerns, questionable conduct or practices, suspected or actual non-compliance issues, and FWA incidents through one of CalOptima Health's multiple reporting mechanisms. These reporting options provide for anonymity and confidentiality (to the extent permitted by applicable law and circumstances). CalOptima Health maintains and supports a non-retaliation policy governing good-faith reports of suspected or actual non-compliance and/or FWA.

Enforcement and Disciplinary Standards
The Board, employees, and FDRs are subject to appropriate disciplinary and/or corrective actions for non-compliance with CalOptima Health's standards, requirements, or applicable laws, as specified in the Compliance Program documents and related policies and procedures, including, but not limited to, CalOptima Health's policies and procedures on performance and behavior standards, corrective action plans, and/or sanctions. CalOptima Health implements consistent, timely, and effective enforcement of

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standards when non-compliance or unethical behavior is determined, including any appropriate disciplinary action, to address improper conduct, activity, and/or behavior.

Monitoring, Auditing and Identification of Risks
CalOptima Health has implemented and continues to implement comprehensive monitoring and auditing activities, which are performed by the Delegation Oversight Department and Internal Audit Department in conjunction with CalOptima Health contract owners and functional business owners responsible for ongoing monitoring. The purpose of CalOptima Health's monitoring and auditing activities is to test and confirm compliance with all applicable regulations, contractual agreements, and federal and state laws, as well as applicable policies and procedures established to protect against non-compliance and potential FWA in CalOptima Health's programs. The 2025 CalOptima Health Compliance Plan and related policies and procedures address the monitoring and auditing processes carried out by CalOptima Health.

Response and Remediation
Once a violation or offense has been detected or reported, CalOptima Health initiates all necessary steps to investigate, identify, and respond appropriately to the violation or offense and to prevent similar violations and offenses from occurring. As described in the 2025 CalOptima Health Compliance Plan, CalOptima Health will conduct a timely and documented investigation and undertake appropriate corrective actions where appropriate, including, but not limited to, modifying its Compliance Program and its policies and procedures, to prevent the same or similar violation or offense from occurring in the future.

Discussion
CalOptima Health regularly reviews its Compliance Plan, Code of Conduct, Anti-Fraud, Waste & Abuse (FWA) Plan, and CalOptima Health HIPAA Privacy and Security Program to ensure current alignment with federal and state health care program requirements and laws, as well as CalOptima Health operations. CalOptima Health's Chief Compliance Officer has reviewed the 2025 CalOptima Health Compliance Plan, 2025 CalOptima Health Code of Conduct, 2025 CalOptima Health Anti-Fraud, Waste & Abuse (FWA) Plan, 2025 CalOptima Health HIPAA Privacy and Security Program and Office of Compliance policies and procedures to ensure consistency with applicable federal and state health care program laws, regulations, and/or guidance.

Summary of Changes
The 2025 CalOptima Health Compliance Plan, 2025 CalOptima Health Code of Conduct, 2025 CalOptima Health Anti-Fraud, Waste and Abuse (FWA) Plan, and 2025 CalOptima Health HIPAA Privacy and Security Program have been updated and revised as follows:

- The **2025 CalOptima Health Compliance Plan** was revised to reflect timing for updates to the Compliance Plan to occur no less than annually and Board reviews and approvals to occur annually. Supporting language was added for both the Compliance Program and the role of the Chief Compliance Officer to act independently of operational and program areas without fear of repercussions for uncovering deficiencies or noncompliance. The Compliance Committee duties were enhanced to add the annual maintenance of the Compliance Plan to be consistent with

regulatory and operational changes, subject to Board approval. The Director of FWA title was updated to remove Privacy in alignment with the staffing update to two separate director roles.

- The **2025 CalOptima Health Code of Conduct** was updated to add the expectation for employees, contractors, officers, Board members, network providers, subcontractors, and downstream contractors, to act ethically and ensure compliance with the Code of Conduct. The Principles of the Code of Conduct were reorganized and updated to include regulatory agency standards and clarify requirements. Health equity prioritization was added to the design and implementation of CalOptima Health strategies and programs. Reinforcement of federal and state laws was added to ensure transparent, legal, and ethical business practices. Conflicts of Interest were enhanced to reference pertinent CalOptima Health policies, include forms, and update processes. Compliance Program Reporting was updated to reflect process clarification, and contractors were added to the list of responsible parties throughout.

- The **2025 CalOptima Health Anti-Fraud, Waste and Abuse (FWA) Plan** contains edits to add prepayment claim reviews and clarifying language to the FWA investigative process and align definitions with the 2024 Department of Health Care Services Contract. Minor grammatical edits and additions to the list of CalOptima Health policies and procedures were made to support and enhance the FWA Plan.

- The **2025 CalOptima Health HIPAA Privacy and Security Program** was updated to include controls implemented to protect member information and reflect current HIPAA violation fines.

Policies and Procedures
Consistent with applicable federal and state health care program laws, regulations, and/or guidance, the Chief Compliance Officer, with the support of the Office of Compliance staff, has updated the related policies and procedures. The summary of changes is included in Attachment 6. This summary contains a list of policies with substantive changes reflected Attachment 7, as well as policies with non-substantive changes (*i.e.*, formatting, spelling, punctuation, capitalization, minor clarifying language and/or grammatical changes).

Fiscal Impact
The recommended actions have no anticipated fiscal impact. To the extent that there are any fiscal impacts due to increases in Compliance Program resources, such impact will be addressed in separate Board actions or in future operating budgets.

Rationale for Recommendation
To ensure CalOptima Health's continuing commitment to conducting its operations in compliance with ethical and legal standards and all applicable laws, regulations, and rules, CalOptima Health staff recommends that the Board adopt Resolution No. 24-1107-07 approving the updated CalOptima Health 2025 Compliance Plan, 2025 Code of Conduct, 2025 Anti-Fraud, Waste & Abuse (FWA) Plan, the 2025 HIPAA Privacy and Security Program, and related policies and procedures. These updated documents will supersede CalOptima Health's 2024 Compliance Plan, 2024 Code of Conduct, 2024 Health Anti-

Fraud, Waste and Abuse (FWA) Plan, and 2024 HIPAA Privacy and Security Program approved by the Board on October 5, 2023.

Concurrence
James Novello, Outside General Counsel Kennaday Leavitt

Attachments
1. Resolution No. 24-1107-01, Resolution Approving the 2025 CalOptima Health Compliance Plan, 2025 CalOptima Health Code of Conduct, 2025 CalOptima Health Anti-Fraud, Waste & Abuse (FWA) Plan, 2025 CalOptima Health HIPAA Privacy and Security Program and revised Policies and Procedures
2. 2025 CalOptima Health Compliance Plan_Final
3. 2025 CalOptima Health Code of Conduct_Final
4. 2025 CalOptima Health Anti-Fraud, Waste & Abuse (FWA) Plan_Final
5. 2025 CalOptima Health HIPAA Privacy and Security Program_Final
6. Summary of Proposed Actions to CalOptima Health Office of Compliance Policies and Procedures
7. Revised Office of Compliance Policies and Procedures (redlined and clean versions)

/s/ Michael Hunn *11/01/2024*
Authorized Signature **Date**

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RESOLUTION NO. 24-1107-01

RESOLUTION OF THE BOARD OF DIRECTORS OF ORANGE COUNTY HEALTH AUTHORITY dba CalOptima Health

APPROVING THE 2025 CALOPTIMA HEALTH COMPLIANCE PLAN, 2025 CALOPTIMA HEALTH CODE OF CONDUCT, 2025 CALOPTIMA HEALTH ANTI-FRAUD, WASTE AND ABUSE (FWA) PLAN, 2025 CALOPTIMA HEALTH HIPAA PRIVACY AND SECURITY PROGRAM AND REVISED OFFICE OF COMPLIANCE POLICIES AND PROCEDURES

WHEREAS, Section 4.1 of the Bylaws of the Orange County Health Authority, dba CalOptima Health, provides that the Board of Directors is the governing body of CalOptima Health, and except as otherwise provided by the Bylaws or by Ordinance, the powers of CalOptima Health shall be exercised, its property controlled, and its business and affairs conducted by or under the direction of the Board of Directors; and

WHEREAS, the Board of Directors has responsibility for approving, implementing, and monitoring a Compliance Program governing CalOptima Health's operations consistent with all applicable laws, regulations, and guidelines; and

WHEREAS, the Board of Directors supports CalOptima Health's commitment to compliant, lawful, and ethical conduct, and values the importance of compliance and ethics in CalOptima Health's operations; and

WHEREAS, the Board of Directors last reviewed and approved the CalOptima Health Compliance Program on October 5, 2023, including the Compliance Plan, Code of Conduct, Anti-Fraud, Waste, and Abuse (FWA) Plan, and related Office of Compliance policies and procedures; and

WHEREAS, the Board of Directors reviews the CalOptima Health Compliance Program documents on a periodic basis to ensure the CalOptima Health Compliance Program is consistent with and updated to reflect applicable laws, regulations, and guidelines and to demonstrate the Board of Director's commitment to an effective Compliance Program.

NOW THEREFORE, BE IT RESOLVED:

Section 1. The Board of Directors hereby approves the 2025 CalOptima Health Compliance Plan, 2025 CalOptima Health Code of Conduct, 2025 CalOptima Health Anti-Fraud, Waste and Abuse (FWA) Plan and the 2025 CalOptima Health HIPAA Privacy and Security Program.

Section 2. The Board of Directors hereby approves and adopts the revised Office of Compliance policies and procedures contained in the attached Summary of Proposed Actions to CalOptima Health Office of Compliance Policies and Procedures attached to this Resolution.

Section 3. The Chief Executive Officer or his/her designee is hereby authorized and directed to implement, monitor, and enforce the 2025 CalOptima Health Compliance Plan, 2025 CalOptima Health Code of Conduct, 2025 CalOptima Health Anti-Fraud, Waste and Abuse (FWA) Plan and the 2025 CalOptima Health HIPAA Privacy and Security Program.

Section 4. These actions are effective upon the date of adoption of this Resolution.

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APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, dba CalOptima Health, this 7th day of November 2024.

AYES:
NOES:
ABSENT:
ABSTAIN:

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Isabel Becerra, Chair, CalOptima Health Board of Directors

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

Attachment 6: Summary of Proposed Actions for Office of Compliance Policies and Procedures

Table 1: Revisions to the Office of Compliance Policies and Procedures

The following table lists the proposed revisions to the CalOptima Office of Compliance policies and procedures, by department.

POLICY & DEPARTMENT	REVISION & PROGRAM	A – NEW B – REVISED C – RETIREMENT D – REVISED [MINOR EDITS]: E – ANNUAL REVIEW [NO EDITS]:
HH.3024: Confidentiality of Medical Information Act Compliance *Privacy*	**A – NEW:** This new policy was developed to support requirements of the Confidentiality of Medical Information Act (CMIA). **Program(s):** Medi-Cal; OneCare; PACE Department Point(s) of Contact: Tamekia Mosley; Eric Royal; John Tanner	
AA.1270: Certification of Document and Data Submissions *Regulatory Affairs & Compliance*	**B – REVISED:** This policy was revised to add terms and references to appropriate regulations to ensure compliance with regulatory and interoperability requirements related to data, information, and documentation submitted to DHCS, to which a DHCS-approved certification statement applies. Additional updates involve the inclusion of language to clarify the responsibility of CalOptima Health's Provider Relations department to collect monthly data attestations from each delegated Health Network for data, information, and documentation submitted to CalOptima Health. Reference and glossary updates were also made to align with current contractual and regulatory guidelines. **Program(s):** Medi-Cal; OneCare Department Point(s) of Contact: Annabel Vaughn; John Tanner	

POLICY & DEPARTMENT	REVISION & PROGRAM	A – NEW B – REVISED C – RETIREMENT D – REVISED [MINOR EDITS]: E – ANNUAL REVIEW [NO EDITS]:
AA.1275: Department of Health Care Services (DHCS) File and Use Submission Process *Regulatory Affairs & Compliance*	**B – REVISED:** This policy was updated to clarify procedures performed by CalOptima Health's Regulatory Affairs & Compliance Medi-Cal (RAC Medi-Cal) department to verify readiness of and submit revised deliverables/submissions and policies, including the signed DHCS Medi-Cal Managed Care Plan File and Use Attestation Form to DHCS as File and Use. Glossary updates were also made to align with current contractual and regulatory guidelines. **Program(s):** Medi-Cal Department Point(s) of Contact: Annabel Vaughn; John Tanner	
GA.7505: Regulatory Liaison Responsibilities *Regulatory Affairs & Compliance*	**B – REVISED:** This policy was updated to clarify CalOptima Health's submission timeframe for revised Corrective Action Plans (CAPs) to DHCS for DHCS approval as being within 15 calendar days after receipt of DHCS's request for CAP revisions. Glossary updates were also made to align with current contractual and regulatory guidelines. **Program(s):** Administrative Department Point(s) of Contact: Annabel Vaughn; John Tanner	
HH.1105: Fraud, Waste, and Abuse Detection *Fraud, Waste & Abuse*	**B – REVISED:** This policy was updated to add additional sources in which CalOptima Health may receive complaints of suspected fraud, waste, and abuse (FWA), which include memorandums and resources from the Centers for Medicare and Medicaid Services (CMS) and referrals from the Department of Health Care Services (DHCS). Reference and glossary updates were also made to align with current contractual and regulatory guidelines. **Program(s):** Medi-Cal; OneCare; PACE Department Point(s) of Contact: Cynthia Valencia; Fay Ho; John Tanner	

POLICY & DEPARTMENT	REVISION & PROGRAM	A – NEW B – REVISED C – RETIREMENT D – REVISED [MINOR EDITS]: E – ANNUAL REVIEW [NO EDITS]:
HH.2005: Corrective Action Plan *Regulatory Affairs & Compliance*	**B – REVISED:** This policy was revised to provide additional elements to be included in an Immediate Corrective Action Plan (ICAP) and Corrective Action Plan (CAP) response, and the provision to make a publicly available report containing CAP status and action taken to close out findings by CalOptima Health's Office of Compliance on a quarterly basis to align with the 2024 DHCS MCP Contract. Attachment A, ICAP/CAP Request Template was also updated for formatting and language changes to align with the 2024 DHCS MCP Contract. Glossary updates were also made to align with current contractual and regulatory guidelines. **Program(s):** Medi-Cal; OneCare; PACE Department Point(s) of Contact: Annabel Vaughn; John Tanner	
HH.2007: Compliance Committee *Office of Compliance*	**B – REVISED:** This policy was updated to clarify the role of CalOptima Health's Compliance Committee, including procedures regarding designation and/or selection of its members, review of the Compliance Plan and responsibilities within CalOptima Health to align with the 2024 Department of Health Care Services (DHCS) Contract. Glossary updates were also made to align with current contractual and regulatory guidelines. **Program(s):** Medi-Cal; OneCare; PACE Department Point(s) of Contact: Annie Phillips; Annabel Vaughn; John Tanner	
HH.2014: Compliance Program *Office of Compliance*	**B – REVISED:** This policy was updated to clarify the review of CalOptima Health's Compliance Program will occur no less than annually, the roles of CalOptima Health's Board of Directors and Compliance Officer regarding the review, approval, and development of the Compliance Program, and requirements to publicly post the Compliance Plan on CalOptima Health's website. Glossary updates were also made to align with current contractual and regulatory guidelines. **Program(s):** Medi-Cal; OneCare; PACE; Administrative Department Point(s) of Contact: Annie Phillips; Annabel Vaughn; John Tanner	

POLICY & DEPARTMENT	REVISION & PROGRAM	A – NEW B – REVISED C – RETIREMENT D – REVISED [MINOR EDITS]: E – ANNUAL REVIEW [NO EDITS]:
HH.2022: Record Retention and Access *Regulatory Affairs & Compliance*	**B – REVISED:** This policy was updated for the addition of documentation of disciplinary actions for a period of at least ten (10) years to be included in CalOptima Health's and its First Tier, Downstream, and Related Entities (FDR's) requirements to retain and make available contracts, books, documents, records, and financial statements and reference CalOptima Health's Document Retention Schedule. Reference and glossary updates were also made to align with current contractual and regulatory guidelines. **Program(s):** Medi-Cal; OneCare; PACE Department Point(s) of Contact: Annie Phillips; Annabel Vaughn; John Tanner	
HH.2023: Compliance Training *Regulatory Affairs & Compliance*	**B – REVISED:** Language and grammatical revisions were made throughout this policy to provide clarity and improve readability. Attachment A, First Tier, Downstream, and Related Entities (FDR) Compliance Attestation was also updated to remove language regarding mail-in options. Glossary updates were also made to align with current contractual and regulatory guidelines. **Program(s):** Medi-Cal; OneCare; PACE Department Point(s) of Contact: Annie Phillips; Annabel Vaughn; John Tanner	
HH.2028: Code of Conduct *Regulatory Affairs & Compliance*	**B – REVISED:** This policy was updated to include language to ensure approval of the Code of Conduct by CalOptima Health's Board of Directors and clarify availability of the Code of Conduct on CalOptima Health's public website to align with the 2024 Department of Health Care Services (DHCS) Contract. Attachment A, CalOptima Health Code of Conduct was also added to this policy. Glossary updates were also made to align with current contractual and regulatory guidelines. **Program(s):** Medi-Cal; OneCare; PACE Department Point(s) of Contact: Annie Phillips; Annabel Vaughn; John Tanner	

POLICY & DEPARTMENT	REVISION & PROGRAM	A – NEW B – REVISED C – RETIREMENT D – REVISED [MINOR EDITS]: E – ANNUAL REVIEW [NO EDITS]:
HH.3000: Notice of Privacy Practices *Privacy*	**B – REVISED:** This policy was updated to clarify controls for physical/electronic access and impermissible/permissible uses of member data including Protected Health Information (PHI) and Personally Identifiable Information (PII). Language revisions were also applied for clarity in directives and procedural clarifications were made to outline elements that must be included in the content of the Notice of Privacy Practice (NPP) to align with the Health Insurance Portability and Accountability Act (HIPAA) Final Privacy Rule and Title 42 Code of Federal Regulations (C.F.R.) Part 2. The content throughout Attachment A, NPP was also updated to align with Title 42 C.F.R. Part 2, Health Equity (HE) Accreditation Standards, and Section 1157 Final Rule. Reference and glossary updates were also made to align with current contractual and regulatory guidelines. **Program(s):** Medi-Cal; OneCare; PACE Department Point(s) of Contact: Tamekia Mosley; Eric Royal; John Tanner	
HH.3002: Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls *Privacy*	**B – REVISED:** This policy was revised to add language referencing Personally Identifiable Information (PII) and to add reproductive health care as minimum necessary data. Procedures were also updated regarding the minimum disclosure of Protected Health Information (PHI), requests for PHI/PII and federal and state law criteria for determinations of requests for the release of PHI/PII by CalOptima Health's Privacy Officer or designee. Reference and glossary updates were also made to align with current contractual and regulatory guidelines and CalOptima Health policies. **Program(s):** Medi-Cal; OneCare; PACE Department Point(s) of Contact: Tamekia Mosley; Eric Royal; John Tanner	
HH.3008: Member Right to Request Confidential Communications *Privacy*	**B – REVISED:** This policy was revised to clarify processes for CalOptima Health's Customer Service department to route Request for Restriction on Manner/Method of Confidential Communications Forms to the Privacy department when completed and submitted by a member. Glossary updates were also made to align with current contractual and regulatory guidelines. **Program(s):** Medi-Cal; OneCare; PACE Department Point(s) of Contact: Tamekia Mosley; Eric Royal; John Tanner	

POLICY & DEPARTMENT	REVISION & PROGRAM	A – NEW B – REVISED C – RETIREMENT D – REVISED [MINOR EDITS]: E – ANNUAL REVIEW [NO EDITS]:
New Title **HH.3010:** Protected Health Information Disclosures Permitted and Required by Law *Privacy*	**B – REVISED:** This policy was updated to include language clarifying CalOptima Health's responsibility not to use or disclose PHI related to lawful Reproductive Health Care and procedures for attestation requirements for a use or disclosure of Reproductive Health Care related PHI for non-prohibited purposes to align with requirements of the HIPAA Privacy Final Rule and advisory by Legal. Attachment A, Attestation Regarding Requested Use or Disclosure of Protected Health Information Potentially Related to Reproductive Health Care was also added to this policy. Reference and glossary updates were also made to align with current contractual and regulatory guidelines. **Program(s):** Medi-Cal; OneCare; PACE Department Point(s) of Contact: Tamekia Mosley; Eric Royal; John Tanner	
Title Revision **HH.3014:** Use of Electronic Mail with Protected Health Information (PHI) and Personally Identifiable Information (PII) *Privacy*	**B – REVISED:** This policy was updated to include language referencing PHI/PII to align with the National Committee of Quality Assurance (NCQA) requirements and clarify references to CalOptima Health policies. Reference and glossary updates were also made to align with current contractual and regulatory guidelines and CalOptima Health policies. **Program(s):** Medi-Cal; OneCare; PACE Department Point(s) of Contact: Tamekia Mosley; Eric Royal; John Tanner	
HH.3016: Guidelines for Handling Protected Health Information (PHI) Offsite *Privacy*	**B – REVISED:** General guidelines within this policy were updated to clarify that CalOptima Health staff shall not access, use, or disclose any member Protected Health Information (PHI) via CalOptima Health's system without a business need. **Program(s):** Medi-Cal; OneCare; PACE Department Point(s) of Contact: Tamekia Mosley; Eric Royal; John Tanner	

POLICY & DEPARTMENT	REVISION & PROGRAM	A – NEW B – REVISED C – RETIREMENT D – REVISED [MINOR EDITS]: E – ANNUAL REVIEW [NO EDITS]:
Title Revision **HH.3020:** Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PII or other Unauthorized Use or Disclosure of PHI/PII *Privacy*	**B – REVISED:** This policy was updated to include language referencing PII throughout to align with the Health Plan Management System (HPMS) Memorandum: Update on Security and Privacy Breach Reporting Procedures. Updates were also made to include procedures regarding Centers for Medicare and Medicaid (CMS) reporting related to Health Information and Technology for Economic and Clinical Health (HITECH) breach notification regulations, notifications to the CMS Account Manager if there is potential for significant member harm, monthly breach reports by CalOptima Health's Privacy department, and notifications to PACE Account Managers regarding security and privacy breaches involving PACE participants. Attachment C, PACE Privacy Breach Notification Timeline and Summary Form was added to this policy. Reference and glossary updates were also made to align with current contractual and regulatory guidelines. **Program(s):** Medi-Cal; OneCare; PACE Department Point(s) of Contact: Tamekia Mosley; Eric Royal; John Tanner	
HH.3022: Business Associate Agreements *Privacy*	**B – REVISED:** This policy was revised to include language and directives regarding CalOptima Health's monitoring of its business associates. Procedural updates were also made to include regulatory amendments to Business Associate Agreements (BAAs) and compliance requirements for business associates via BAAs to provide more protections to member medical information. Provisional updates were made to Attachment C, CalOptima Health Business Associate Agreement Template, to ensure member medical information protection. Glossary updates were also made to align with current contractual and regulatory guidelines. **Program(s):** Medi-Cal; OneCare; PACE; Administrative Department Point(s) of Contact: Tamekia Mosley; Eric Royal; John Tanner	

POLICY & DEPARTMENT	REVISION & PROGRAM	A – NEW B – REVISED C – RETIREMENT D – REVISED [MINOR EDITS]: E – ANNUAL REVIEW [NO EDITS]:
HH.5000: Provider Overpayment Investigation and Determination *Fraud, Waste & Abuse*	**B – REVISED:** This policy was revised to include appropriate cross-reference to CalOptima Health policy(s) for maintaining medical records, update reference to former title 'Audit & Oversight Committee' to current title 'Delegation Oversight Committee (DOC),' add rendering provider NPI as an additional required detail to include in the "Overpayment Spreadsheet" to adequately review, investigate, and determine if claims were overpaid, and clarify timelines and procedures for notifying DHCS and/or CMS of overpayment determinations after the date CalOptima Health identified the overpayment. Reference and glossary updates were also made to align with current contractual and regulatory guidelines. **Program(s):** Medi-Cal; OneCare; PACE Department Point(s) of Contact: Cynthia Valencia; Fay Ho; John Tanner	

Table 2: Office of Compliance Policies and Procedures: Non-substantive Revisions

The following table contains the proposed list of policies without substantive revisions for the CalOptima Office of Compliance, by department.

POLICY	DEPARTMENT
HH.1107: Fraud, Waste, and Abuse Investigation and Reporting	*Fraud, Waste, and Abuse*
HH.5004: False Claims Act Education	*Fraud, Waste, and Abuse*
HH.4003: Annual Risk Assessment	*Internal Audit*
HH.3004: Member Request to Amend Records	*Privacy*
HH.3005: Member Request for Accounting of Disclosures	*Privacy*
HH.3006: Tracking and Reporting Disclosures of Protected Health Information (PHI)	*Privacy*
HH.3007: Member Rights to Request Restrictions on Use and Disclosure of Protected Health Information (PHI)	*Privacy*
HH.3009: Access by Member's Personal Representative	*Privacy*
HH.3011: Use and Disclosure of PHI for Treatment, Payment, and Health Care Operations	*Privacy*
HH.3019: De-identification of Protected Health Information (PHI)	*Privacy*
HH.3023: Information Sharing	*Privacy*
GA.7501: Regulatory Communications	*Regulatory Affairs & Compliance*
GA.7508: CalOptima Health Policy and Procedure Review Process	*Regulatory Affairs & Compliance*
HH.2002: Sanctions	*Regulatory Affairs & Compliance*
HH.2018: Compliance and Ethics Hotline	*Regulatory Affairs & Compliance*
HH.2019: Reporting Suspected or Actual Fraud, Waste, or Abuse (FWA) and Violations of Applicable Laws and Regulations and/or CalOptima Health Policies	*Regulatory Affairs & Compliance*
HH.2020: Conducting Compliance Investigations	*Regulatory Affairs & Compliance*
HH.2021: Exclusion and Preclusion Monitoring	*Regulatory Affairs & Compliance*

POLICY	DEPARTMENT
MA.9124: CMS Self-Disclosure	*Regulatory Affairs & Compliance*

Orange County Health Authority
dba CalOptima Health

~~2024~~ 2025 Compliance Plan

(Revised September ~~2023~~2024)

Document maintained by: John Tanner
CalOptima Health Chief Compliance Officer

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Introduction

At the Orange County Health Authority, dba CalOptima Health, we are committed to conducting our operations in compliance with ethical standards, contractual obligations, and all applicable statutes, regulations, and rules, including those pertaining to Medi-Cal, Medicare Advantage Prescription Drug plan (MAPD), Program of All-Inclusive Care for the Elderly (PACE), and other CalOptima Health Programs.

A key aspect of fulfilling the mission of CalOptima Health is serving our member's health with excellence and dignity, respecting the value and needs of each person in compliance with the rules and regulations applicable to CalOptima Health's programs. We realize health plan compliance can be complicated with its many regulatory requirements. CalOptima Health maintains up to date Policies and Procedures to help staff understand and comply with all required regulations. Additionally, the CalOptima Health Office of Compliance is here to help and support staff in understanding the regulations.

You, the CalOptima Health Board of Directors (hereafter, "Board") Member, Employee, Contractor, or First Tier, Downstream, and Related Entity (FDR), are the most important elements of the Compliance Program. It is important to understand that compliance is everyone's responsibility. If you become aware of a potential non-compliant or unethical matter, we are relying on you to raise your concerns without any fear of intimidation or retaliation. We encourage you to discuss your concerns with your leadership. If for any reason you do not feel comfortable discussing an issue with your leadership, please contact the Office of Compliance by reaching out directly to the Chief Compliance Officer (CCO) or another member of the compliance team.

You also have the option to anonymously report issues to the:

Compliance and Ethics Hotline at 1-855-507-1805

This is a service that is operated by an independent third party. Issues reported to the Hotline will be confidentially routed to the CalOptima Health Office of Compliance for investigation. You can choose to report anonymously and no identifying information will be forwarded to CalOptima Health. **CalOptima Health maintains a non-retaliation policy to protect individuals who report suspected non-compliance or Fraud, Waste, and Abuse (FWA) issues in good faith.** CalOptima Health takes violations of CalOptima Health's non-retaliation policy seriously, and the Chief Compliance Officer will review and enforce disciplinary and/or other appropriate action for violations, as appropriate, with the approval of the Compliance Committee.

This Compliance Plan is a key aspect of our overall Compliance Program. Review the Compliance Plan and consider it as the framework for compliance in your work at or with CalOptima Health.

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THE COMPLIANCE PROGRAM

CalOptima Health has developed a comprehensive Compliance Plan applicable to all of CalOptima Health's programs, including, but not limited to, its Medi-Cal, MAPD, PACE, and other CalOptima Health Programs. The Compliance Plan in conjunction with our Code of Conduct and Policies and Procedures constitutes our Compliance Program and incorporates the seven elements of an effective Compliance Program as recommended by the Department of Health and Human Services (DHHS) Office of Inspector General (OIG) to meet the Medicare and Medi-Cal regulations.

SEVEN ELEMENTS

1. **Code of Conduct, Written Policies and Procedures**

2. **Compliance Officer, Compliance Committee, High-Level Oversight**

3. **Effective Training and Education**

4. **Effective Lines of Communication**

5. **Well-Publicized Disciplinary Standards**

6. **Effective System for Routine Monitoring. Auditing, and Identification of Compliance Risks**

7. **Procedures and Systems for Prompt Response to Compliance Issues**

The Compliance Plan is continually evolving and may be modified and enhanced based on compliance monitoring and identification of new areas of operational, regulatory, or legal risk, but not less than annually. CalOptima Health makes this Compliance Plan available to the Board, employees, contractors, and FDRs. All Board Members, employees, and contractors are required to read the Compliance Plan including the Code of Conduct and conduct themselves in accordance with the requirements of the Compliance Program. FDRs have the option to adopt CalOptima Health's Compliance Plan, Code of Conduct, and Compliance Policies and Procedures, or with the approval of CalOptima Health, the FDR may follow their own Compliance Plan, Code of Conduct, and Compliance Policies and Procedures. In those instances, the FDRs must either attest to receipt and review of the CalOptima Health program documents, or equivalent materials. Throughout this document, when referencing these materials and FDRs, it means CalOptima Health materials or the FDR equivalent.

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Compliance Program Seven Elements

I. CODE OF CONDUCT, WRITTEN POLICIES AND PROCEDURES

a. Code of Conduct

The Code of Conduct is CalOptima Health's foundational document detailing fundamental principles, values, and the framework for business practices within and applicable to CalOptima Health. The objective of the Code of Conduct is to provide guiding principles to Board Members, employees, contractors, and FDRs in conducting their business activities in a professional, ethical, and lawful manner.

Reporting Non-Compliance: One of the most fundamental aspects of the Code of Conduct is the **requirement** that all Board Members, employees, contractors, and FDRs **promptly report** any suspected FWA or noncompliance with applicable regulations or CalOptima Health policies. This can be accomplished by reporting directly to your supervisor or management, the Compliance Department, or the CalOptima Health Chief Compliance Officer. If requested, a reported issue will be treated in a confidential manner, to the extent possible. If the individual reporting the issue wants to remain anonymous, they can call the Compliance and Ethics Hotline at **1-855-507-1805**, seven days a week, 24 hours a day**.** This service is managed by an independent third party.

Non-Retaliation: CalOptima Health maintains a strict non-retaliation policy to protect individuals who report suspected non-compliance or FWA issues in good faith. CalOptima Health takes violations of CalOptima Health's non-retaliation policy seriously, and the Chief Compliance Officer will review and enforce disciplinary and/or other appropriate action for violations, as appropriate, with the approval of the Compliance Committee.

The Code of Conduct is a separate document from the Compliance Plan and can be found on the CalOptima Health's InfoNet at *https://caloptima.sharepoint.com/sites/OfficeofCompliance* or on the CalOptima Health website at *https://www.caloptima.org/en/About/GeneralCompliance/GeneralComplianceResourceLinks*. The Code of Conduct is approved by the Board and distributed to Board Members, employees, contractors, and FDRs upon appointment, hire, or the commencement of the contract, and annually thereafter. New Board Members, employees, contractors, and FDRs are required to sign an attestation acknowledging receipt and review of the Code of Conduct within ninety (90) calendar days of the appointment, hire, or commencement of the contract, and annually thereafter.

b. Compliance Plan

As noted above, this Compliance Plan outlines how contractual and legal standards are reviewed and implemented throughout the organization and communicated to the Board, employees, contractors, and FDRs. This Compliance Plan also includes a comprehensive

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section articulating CalOptima Health's commitment to preventing FWA, and setting forth guidelines and procedures designed to detect, prevent, and remediate FWA in the administration of CalOptima Health Programs. This Compliance Plan allows the Compliance Program to act independently of operational and program areas without fear of repercussions for uncovering deficiencies or noncompliance.

The Compliance Plan is available on CalOptima Health's external website for Board Members and FDRs, as well as on CalOptima Health's intranet site, which is accessible to all employees (InfoNet).

c. Policies and Procedures

CalOptima Health has developed written Policies and Procedures to address specific areas of CalOptima Health's operations, compliance activities, and FWA prevention, detection, and remediation to ensure CalOptima Health can effectively adhere to all applicable laws, regulations, and guidelines. These Policies and Procedures are designed to provide guidance to Board Members, employees, contractors, and FDRs concerning compliance expectations and outline processes on how to identify, report, investigate, and/or resolve suspected, detected, or reported compliance issues. Board Members, employees, contractors, and FDRs are expected to be familiar with the Policies and Procedures pertinent to their respective roles and responsibilities and are expected to perform their responsibilities in compliance with ethical standards, contractual obligations, and applicable law. The Chief Compliance Officer, or his/her designee, will ensure that Board Members, employees, contractors, and FDRs are informed of applicable policy requirements, and that such dissemination of information is documented and retained, in accordance with applicable record retention standards.

CalOptima Health Policies and Procedures are reviewed annually and updated, as needed, depending on state and federal regulatory changes and/or operational improvements to address identified risk factors. Changes to CalOptima Health's Policies and Procedures are reviewed and approved by CalOptima Health's Policy Review Committee. The Policy Review Committee, comprised of executive officers and key management staff, regularly reviews, and approves proposed changes to CalOptima Health's Policies and Procedures. Board Members, employees, contractors, and FDRs receive notice when Policies and Procedures are updated via a monthly memorandum. All CalOptima Health Policies and Procedures are available to Board Members, employees, contractors and FDRs on the InfoNet and the CalOptima Health website.

II. COMPLIANCE OFFICER, COMPLIANCE COMMITTEE, HIGH LEVEL OVERSIGHT

a. Governing Body

The Board, as the Governing authority, is responsible for approving, implementing, and Monitoring the Compliance Program governing CalOptima Health's operations. The Board delegates the Compliance Program oversight and day-to-day compliance activities to the Chief Executive Officer (CEO), who then delegates such oversight and activities to the Chief Compliance Officer. The Chief Compliance Officer is an employee of CalOptima Health, who

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handles compliance oversight and activities full-time. The Chief Compliance Officer, in conjunction with the Compliance Committee, are both accountable for the oversight and reporting roles and responsibilities as set forth in this Compliance Plan. However, the Board remains accountable for ensuring the effectiveness of the Compliance Program within CalOptima Health and Monitoring the status of the Compliance Program to ensure its efficient and successful implementation. The Board reviews and approves the Compliance Plan, Code of Conduct and Compliance Policies and Procedures annually.

b. Compliance Officer

The Chief Compliance Officer is a full-time employee of CalOptima Health and coordinates and communicates all assigned compliance activities and programs. This includes but is not limited to, developing, implementing, and monitoring the day-to-day activities of the Compliance Program. The Chief Compliance Officer reports directly to the CEO and the Compliance Committee and to the Board and is Chair of the Compliance Committee. In this capacity the Chief Compliance officer reports on the activities and status of the Compliance Program. The Chief Compliance Officer has the authority to escalate issues of concern directly to the Board and acts independently of operational and program areas without fear of repercussions for uncovering deficiencies or noncompliance. Furthermore, the Chief Compliance Officer oversees that CalOptima Health meets all state and federal regulatory and contractual requirements. The Chief Compliance Officer, or his or her designee, shall also act as the Fraud Prevention Officer.

The Chief Compliance Officer interacts with the Board, CEO, CalOptima Health's executive staff and departmental management, FDRs, legal counsel, state and federal representatives, and others as required. In addition, the Chief Compliance Officer supervises the Office of Compliance, which includes compliance professionals with expertise and responsibilities for the following areas: Medi-Cal and Medicare Regulatory Affairs & Compliance, FWA, Privacy, Internal Auditing and Monitoring, Policies and Procedures, and training on compliance activities.

c. Compliance Committee

The Compliance Committee, chaired by the Chief Compliance Officer, is composed of CalOptima Health's executive staff including but not limited to the Chief Executive Officer, Chief Operating Officer, Chief Information Officer, Chief Medical Officer, and Chief Financial Officer. The role of the Compliance Committee is to oversee and ensure the implementation of the Compliance Program and to participate in carrying out the provisions of this Compliance Plan. The Compliance Committee meets at least on a quarterly basis, or more frequently as necessary, to ensure reasonable oversight of the Compliance Program.

The Board delegates the following responsibilities to the Compliance Committee:

- Maintain and update the Code of Conduct consistent with regulatory requirements and/or operational changes, subject to the ultimate approval by the Board.
- Maintain and update the Compliance Plan, on an annual basis, consistent with regulatory requirements and/or operational changes, subject to the ultimate approval by the Board

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- ► Maintain written notes, records, correspondence, or minutes (as appropriate) of Compliance Committee meetings reflecting reports made to the Compliance Committee and the Compliance Committee's decisions on the issues raised (subject to all applicable privileges).
- ► Review and monitor the effectiveness of the Compliance Program, including Monitoring key performance reports and metrics, evaluating business and administrative operations, and overseeing the creation, implementation, and development of corrective and preventive action(s) to ensure they are prompt and effective.
- ► Recommend and monitor the development of internal systems and controls to implement CalOptima Health's standards and Policies and Procedures as part of its daily operations.
- ► Determine the appropriate strategy and/or approach to promote compliance and detect potential violations and advise the Chief Compliance Officer accordingly.
- ► Review and address reports of monitoring and auditing of areas in which CalOptima Health is at risk of program non-compliance and/or potential FWA and ensure Corrective Action Plans (CAPs) and Immediate Corrective Action Plans (ICAPs) are implemented and monitored for effectiveness.

III. EFFECTIVE TRAINING AND EDUCATION

Training and education are important elements in CalOptima Health's overall Compliance Program. The following trainings must be completed by Board Members, employees, contractors, and FDRs within ninety (90) calendar days of hire, appointment, or commencement of the contract, as applicable, and annually thereafter:

- **Code of Conduct**
- **General Compliance**
- **FWA**
- **HIPAA Privacy Compliance**

Adherence to the Compliance Program requirements, including training requirements, shall be a condition of employment and a factor in the annual performance evaluation of each Employee.

Specialized education courses are assigned to individuals based on their respective roles or positions within or with CalOptima Health's departments and its programs. Examples include, but are not limited to, the fundamentals of managing Seniors and People with Disabilities (SPD) and cultural competency.

a. Compliance Training for FDRs

All FDRs that provide services to Medi-Cal and Medicare Advantage Part D members, are to complete compliance and FWA training through their own internal compliance program or by using training materials supplied by CalOptima Health.

b. Tracking Required Compliance Training

The Chief Compliance Officer, or his/her designee, is responsible for coordinating compliance education and training programs, and ensuring that records evidencing an individual's/FDR's completion of the training requirements are documented and maintained, such as sign-in sheets,

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attestations, or electronic certifications, as required by law. The Chief Compliance Officer, CalOptima Health executive staff, management, and the Clerk of the Board are responsible for ensuring that Board Members, employees, contractors, and FDRs complete training on an annual basis.

CalOptima Health's Human Resources Department utilizes state of the art web-based training courses that emphasize CalOptima Health's commitment to the Compliance Program, and updates courses regularly to ensure that employees are kept fully informed about any changes in procedures, regulations, and requirements.

IV. EFFECTIVE LINES OF COMMUNICATION – REPORTING NON-COMPLIANCE

CalOptima Health works diligently to foster a culture of compliance throughout the organization by regularly communicating the importance of regulatory requirements and reinforcement of company expectations for ethical and lawful behavior.

CalOptima Health shall maintain and communicate that systems are in place to receive, record, and respond to reports of potential or actual non-compliance from employees, contractors, members, providers, vendors, FDRs, and subcontractors.

a. Compliance and Ethics Hotline, Website and Email

The CalOptima Health's hotline is a confidential, toll-free resource available to employees, contractors, members, providers, vendors, FDRs, and the general public 24 hours a day, seven days a week to report violations of, or raise questions or concerns relating to, non-compliance, unethical behavior, and/or suspected FWA. These reporting mechanisms may be used by all stakeholders of CalOptima Health.

Reporting mechanisms include the following:

Compliance and Ethics Hotline

1-855-507-1805

- Website: caloptima.org
- Email: Compliance@caloptima.org

The hotline and the online "Compliance and Fraud, Waste and Abuse Reporting Form" may be completed anonymously. These communications are never traced. **Anyone can make a report without fear of intimidation or retaliation.**

b. Report Directly to Management and Executive Staff

CalOptima Health employees are encouraged to contact their immediate management or executive staff when non-compliant activity is suspected or observed. In other words, **if you see something, say something.** A report should be made immediately upon suspecting or identifying the potential or suspected unethical behavior, non-compliance, or violation. Executive staff or management will promptly escalate the report to the Chief Compliance Officer for further investigation and reporting to the CalOptima Health Compliance Committee. If an Employee is concerned that his/her management or executive staff did not adequately address his/her report or complaint, the Employee may go directly to the Chief Compliance Officer, or the Office of the CEO. If for any reason an employee does not feel comfortable discussing an issue with leadership, they may contact Compliance by reaching out directly to the Chief Compliance Officer (CCO) or another member of the compliance team. Employees also always have the **option to anonymously** report issues to the:

Compliance and Ethics Hotline

1-855-507-1805

CalOptima Health educates Board Members, employees and FDRs about CalOptima Health's hotline and online form through:

1) Compliance/FWA training
2) CalOptima Health's intranet (referred to as InfoNet)
3) Posters displayed in common work areas
4) CalOptima Health's Policies and Procedures
5) Newsletters, emails, and other means of communication

c. Confidentiality and Non-Retaliation

CalOptima Health maintains and supports a non-retaliation policy governing good faith reports of suspected, or actual, non-compliance and/or FWA. Every effort will be made to keep reports confidential to the extent permitted by applicable law and circumstances, but there may be some instances where the identity of the individual making the report will have to be disclosed. As a result, CalOptima Health has implemented and enforces a non-retaliation policy to protect individuals who report suspected or actual non-compliance, or FWA, issues in good faith. This non-retaliation policy extends to reports received from FDRs and members. CalOptima Health's non-retaliation policy is communicated along with reporting instructions by posting information on the CalOptima Health InfoNet and website, as well as sending periodic member notifications.

CalOptima Health also takes violations of CalOptima Health's non-retaliation policy seriously, and the Chief Compliance Officer will review and enforce disciplinary and/or other CAPs for violations, as appropriate, with the approval of the Compliance Committee.

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V. ENFORCEMENT AND DISCIPLINARY STANDARDS

a. Conduct Subject to Enforcement and Discipline

Board Members, employees, contractors, and FDRs are subject to appropriate disciplinary and/or corrective actions if they have violated CalOptima Health's standards, requirements, or applicable laws as specified and detailed in the Compliance Program documents and related Policies and Procedures. Board Members, employees, contractors, and FDRs may be disciplined or sanctioned, as applicable, for failing to adhere to CalOptima Health's Compliance Program and/or violating standards, regulatory requirements, and/or applicable laws, including, but not limited to:

- Conduct that leads to the filing of a false or improper claim in violation of federal or state laws and/or contractual requirements.
- Conduct resulting in a violation of any other federal or state laws or contractual requirements relating to participation in Federal and/or State Health Care Programs.
- Failure to perform any required obligation relating to compliance with the Compliance Program, applicable laws, Policies and Procedures, and/or contracts.
- Failure to report violations or suspected violations of the Compliance Program, or applicable laws, or to report suspected or actual FWA issues to an appropriate person through one of the reporting mechanisms.
- Conduct that violates HIPAA and other privacy laws and/or CalOptima Health's HIPAA Privacy and Security Program and policies, including actions that harm the privacy of members, or the CalOptima Health information systems that store member data.

b. Enforcement and Discipline

CalOptima Health maintains a "zero tolerance" policy towards any illegal, or unethical, conduct that impacts the operation, mission, or image of CalOptima Health. The standards established in the Compliance Program shall be enforced consistently through appropriate disciplinary actions. Individuals, or entities, may be disciplined by way of reprimand, suspension, financial penalties, sanctions, and/or termination, depending on the nature and severity of the conduct, or behavior. Board Members may be subject to removal, employees and contractors are subject to discipline, up to and including termination, and FDRs may be Sanctioned, or contracts may be terminated, where permitted. Violations of applicable laws and regulations, even unintentional, could potentially subject individuals, entities, or CalOptima Health to civil, criminal, or administrative sanctions and/or penalties. Further violations could lead to suspension, Preclusion, or Exclusion, from participation in Federal and/or State Health Care Programs.

CalOptima Health employees shall be evaluated annually based on their compliance with CalOptima Health's Compliance Program. Where appropriate, CalOptima Health shall promptly initiate education and training to correct identified problems, or behaviors.

VI. EFFECTIVE SYSTEM FOR ROUTINE MONITORING, AUDITING, AND IDENTIFICATION OF COMPLIANCE RISKS

Monitoring and Auditing can help prevent, detect, and correct non-compliance with applicable federal and/or state requirements. A risk assessment serves as a tool for determining levels of risk and serves as a guide for which monitoring and auditing activities are performed to assess ongoing levels of compliance.

Routine Monitoring and Auditing of CalOptima Health Operations

The routine monitoring and auditing of CalOptima Health's operations is conducted by the Internal Audit Department under the Office of Compliance.

a. Risk Assessment

A Compliance Risk Assessment will be performed no less than annually to evaluate the current status of CalOptima Health's operational areas.

Operations and processes will be evaluated based on:

1) Deficiencies found by regulatory agencies
2) Deficiencies found by internal and external audit and monitoring reports
3) Institution of new or updated Policies and Procedures and/or regulations/guidance.
4) Cross departmental interdependencies
5) Significant management or organizational changes and/or significant systems changes
6) The OIG Work Plan
7) Monitoring dashboard trends

The Director of the Internal Audit Department, or his/her designee, will work with the operational areas, to identify and assess compliance risks. The risk assessment process will be managed by the Director of the Internal Audit Department , or his/her designee, and presented to the Compliance Committee, for review and approval. The risk assessment shall also be updated as processes change or are identified as being deficient.

b. Monitoring and Auditing

The Audit Work Plan (AWP) is developed based on the results of the risk assessment. Internal auditing and monitoring activities are employed to test and verify compliance with all applicable regulations, guidance, contractual agreements, and federal and state laws, as well as CalOptima Health Policies and Procedures. The AWP includes:

1. Audits to be performed including estimated time frames
2. Audit methodologies
3. Necessary resources
4. Person(s) responsible
5. Final audit reports
6. Follow-up activities from findings including CAPs (when applicable)

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The Internal Audit Department manages a dashboard of key compliance metrics that serves as a monitoring tool to track performance compliance for such items as coverage determinations, complaints, appeals, grievances, regulatory communications, credentialing, customer service, transition of coverage (TOC), and claims. The Internal Audit Department performs audits based on the AWP. The monitoring and auditing results are communicated to executive staff, the Compliance Committee, and the Board.

In addition, an Audit of the Compliance Program and its effectiveness is conducted by an independent third party annually, and the results are reported to the Compliance Committee, and the Board.

Routine Monitoring and Auditing of First-tier, Downstream, and Related party entities (FDRs)

c. FDR Annual Risk Assessment

The Director, Delegation Oversight, or his/her designee will conduct an annual comprehensive risk assessment to determine an FDR's vulnerabilities and high-risk areas. High-risk FDRs are those that are continually non-compliant or at risk of non-compliance based on identified gaps in processes with regulatory and CalOptima Health requirements. Any previously identified issues, which include any corrective actions, low service level performance, reported detected offenses, and/or complaints and appeals from the previous year will be factors that are included in the risk assessment. Any FDR deemed high risk or vulnerable is presented to the Chief Compliance Officer to collaborate in determining appropriate follow-up. FDRs determined to be high-risk may be subjected to a more frequent monitoring and auditing schedule, as well as additional reporting requirements. The risk assessment process, along with reports from FDRs, will be managed by the Director, Delegation Oversight, or his/her designee, and presented to the Compliance Committee for review and discussion.

d. FDR Monitoring and Auditing

An FDR AWP is developed based on the results of the FDR risk assessment. Auditing and Monitoring Activities are employed to test and verify compliance with all applicable regulations, guidance, contractual agreements, and federal and state laws, as well as applicable CalOptima Health Policies and Procedures or equivalent. The FDR AWP includes:

1. Audits to be performed including estimated time frames
2. Audit methodologies
3. Necessary resources
4. Person(s) responsible
5. Final audit reports
6. Follow-up activities from findings including CAPs (when applicable)

The Delegation Oversight Department manages a dashboard of key compliance metrics that serves as a monitoring tool to track compliant performance of FDRs' case management, credentialling, claims, and utilization management. Delegation Oversight performs audits as

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per the FDR AWP. The monitoring and auditing results are communicated to executive staff, the Compliance Committee, and the Board.

e. Regular Exclusion and Preclusion Screening

CalOptima Health performs Participation Status Reviews by searching the OIG–LEIE, the GSA–SAM, the DHCS Medi-Cal Suspended & Ineligible Provider Lists, Medi-Cal Restricted Provider Database (RPD), Medi-Cal Procedure/Drug Code Limitation List, and the CMS Preclusion List upon appointment, hire, or commencement of a contract, as applicable, and monthly thereafter, to ensure Board Members, employees, contractors, Providers and/or FDRs are not suspended, excluded, or do not become excluded or precluded from participating in Federal and/or State Health Care Programs. Board Members, employees, contractors, Providers, and FDRs are required to disclose their participation status as part of their initial appointment, employment, commencement of the contract and registration/application processes and if they receive a notice of a suspension, Preclusion, Exclusion, or debarment during the period of appointment, employment, or contract term. CalOptima Health also requires that its First Tier Entities comply with Participation Status Review requirements with respect to their relationships with Downstream Entities, including without limitation, the delegated credentialing and re-credentialing processes.

VII. PROCEDURES AND SYSTEMS FOR PROMPT REPONSE TO COMPLIANCE ISSUES

CalOptima Health takes corrective actions when there is a confirmed incident of non-compliance. CalOptima Health may identify the incident of non-compliance through a variety of sources, such as self-reporting, governmental audits, internal audits, hotline calls, external audits, or member complaints, either directly to CalOptima Health or through governmental units. Whenever CalOptima Health identifies an issue of non-compliance or potential FWA, it is investigated and resolved.

The Chief Compliance Officer and/or ~~Director of FWA/Privacy~~Director of FWA, in conjunction with the Office of Compliance, FWA~~/Privacy~~ Department and other key staff, are responsible for reviewing cases of non-compliance and suspected activity, and for disclosing such issues to the appropriate authority, when applicable. Because of the complex nature of some issues that may be reported or identified, the investigation may be delegated to the appropriate internal expert.

When a material issue of non-compliance is discovered or a department's process or system results in non-compliance with regulatory requirements, the business area may be required to implement a formal CAP which is overseen by the Office of Compliance. The CAP promotes the correction of the identified issue in a timely manner. Corrective actions may include revising processes, updating policies or procedures, retraining staff, reviewing systems edits and/or addressing other root causes. The CAP must achieve sustained compliance with the overall requirements for that specific operational department.

The status of open CAPs is reviewed by the Office of Compliance on a monthly basis, or at a

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frequency determined by the Chief Compliance Officer. The Office of Compliance monitors CAP implementation and requires that business departments regularly report the completion of all interim actions. The Office of Compliance tracks the duration of open CAPs and intervenes as appropriate to promote timely completion. Once a CAP is complete, the Office of Compliance may validate the corrective actions by auditing individual action items over a period of time to confirm compliance and the effectiveness of the implemented corrective actions. A summary of CAP activity is periodically reported to executive staff and the Compliance Committee.

CalOptima Health's oversight of FDRs includes a requirement that FDRs submit a CAP when material deficiencies are identified through Delegation Oversight audits, ongoing monitoring and/or self-reporting. CalOptima Health takes appropriate action against any contracted organization that does not comply with a CAP or does not meet its regulatory obligations, up to and including termination of its agreement. FDRs are bound contractually through written agreements with CalOptima Health that stipulate compliance with governmental requirements and include provisions for termination for failure to cure performance deficiencies.

CalOptima Health's Compliance Plan is effective in promoting compliance and controlling FWA at both the sponsor and FDR/Subcontractor levels in managing the Medi-Cal and Medicare programs. Policies and procedures associated with this Compliance Plan further expand the activities and oversight of the program.

a. Referral to Enforcement Agencies

In appropriate circumstances, CalOptima Health shall report violations of Medi-Cal Program requirements to DHCS Audits and Investigations, violations of Medicare Program requirements to the Medicare Drug Integrity Contractor (MEDIC), and violations of other state and federal laws to the appropriate law enforcement agencies, in accordance with the applicable reporting procedures adopted by such enforcement agencies.

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FRAUD, WASTE, AND ABUSE (FWA) PREVENTION AND DETECTION

The detection, prevention, and remediation of FWA are components of CalOptima Health's Compliance Program. FWA activities are implemented and overseen by CalOptima Health's Chief Compliance Officer in conjunction with the Director, FWA ~~& Privacy~~ or his/her designee, in conjunction with other compliance activities. Investigations are performed, or overseen, by the Special Investigations Unit (SIU), an internal investigative unit within CalOptima Health's Office of Compliance, responsible for FWA investigations. The Chief Compliance Officer, and/or his/her designee, shall attend the quarterly DHCS Program Integrity meetings, as scheduled. The Chief Compliance Officer, or his/her designee, reports FWA activities to the CalOptima Health Compliance Committee, the Office of the CEO, the Board, and Regulatory Agencies.

CalOptima Health utilizes various resources to detect, prevent, and remediate FWA. In addition, CalOptima Health promptly investigates suspected FWA issues and may implement disciplinary or corrective action to avoid recurrence of FWA issues. The objective of the Anti-Fraud, Waste, Abuse (FWA) Plan is to ensure that the scope of benefits covered by CalOptima Health Programs are appropriately delivered to members and resources are effectively utilized in accordance with federal and state guidelines. CalOptima Health incorporates a system of internal assessments which are organized to identify FWA and promptly respond appropriately to such incidents of FWA. See the CalOptima Health 2024 Anti-Fraud, Waste and Abuse (FWA) Plan for further details.

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Orange County Health Authority
dba CalOptima Health

2025 Compliance Plan

(Revised September 2024)

Document maintained by: John Tanner
CalOptima Health Chief Compliance Officer

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Introduction

At the Orange County Health Authority, dba CalOptima Health, we are committed to conducting our operations in compliance with ethical standards, contractual obligations, and all applicable statutes, regulations, and rules, including those pertaining to Medi-Cal, Medicare Advantage Prescription Drug plan (MAPD), Program of All-Inclusive Care for the Elderly (PACE), and other CalOptima Health Programs.

A key aspect of fulfilling the mission of CalOptima Health is serving our member's health with excellence and dignity, respecting the value and needs of each person in compliance with the rules and regulations applicable to CalOptima Health's programs. We realize health plan compliance can be complicated with its many regulatory requirements. CalOptima Health maintains up to date Policies and Procedures to help staff understand and comply with all required regulations. Additionally, the CalOptima Health Office of Compliance is here to help and support staff in understanding the regulations.

You, the CalOptima Health Board of Directors (hereafter, "Board") Member, Employee, Contractor, or First Tier, Downstream, and Related Entity (FDR), are the most important elements of the Compliance Program. It is important to understand that compliance is everyone's responsibility. If you become aware of a potential non-compliant or unethical matter, we are relying on you to raise your concerns without any fear of intimidation or retaliation. We encourage you to discuss your concerns with your leadership. If for any reason you do not feel comfortable discussing an issue with your leadership, please contact the Office of Compliance by reaching out directly to the Chief Compliance Officer (CCO) or another member of the compliance team.

You also have the option to anonymously report issues to the:

Compliance and Ethics Hotline at 1-855-507-1805

This is a service that is operated by an independent third party. Issues reported to the Hotline will be confidentially routed to the CalOptima Health Office of Compliance for investigation. You can choose to report anonymously and no identifying information will be forwarded to CalOptima Health. **CalOptima Health maintains a non-retaliation policy to protect individuals who report suspected non-compliance or Fraud, Waste, and Abuse (FWA) issues in good faith.** CalOptima Health takes violations of CalOptima Health's non-retaliation policy seriously, and the Chief Compliance Officer will review and enforce disciplinary and/or other appropriate action for violations, as appropriate, with the approval of the Compliance Committee.

This Compliance Plan is a key aspect of our overall Compliance Program. Review the Compliance Plan and consider it as the framework for compliance in your work at or with CalOptima Health.

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THE COMPLIANCE PROGRAM

CalOptima Health has developed a comprehensive Compliance Plan applicable to all of CalOptima Health's programs, including, but not limited to, its Medi-Cal, MAPD, PACE, and other CalOptima Health Programs. The Compliance Plan in conjunction with our Code of Conduct and Policies and Procedures constitutes our Compliance Program and incorporates the seven elements of an effective Compliance Program as recommended by the Department of Health and Human Services (DHHS) Office of Inspector General (OIG) to meet the Medicare and Medi-Cal regulations.

SEVEN ELEMENTS

1. **Code of Conduct, Written Policies and Procedures**

2. **Compliance Officer, Compliance Committee, High-Level Oversight**

3. **Effective Training and Education**

4. **Effective Lines of Communication**

5. **Well-Publicized Disciplinary Standards**

6. **Effective System for Routine Monitoring. Auditing, and Identification of Compliance Risks**

7. **Procedures and Systems for Prompt Response to Compliance Issues**

The Compliance Plan is continually evolving and may be modified and enhanced based on compliance monitoring and identification of new areas of operational, regulatory, or legal risk, but not less than annually. CalOptima Health makes this Compliance Plan available to the Board, employees, contractors, and FDRs. All Board Members, employees, and contractors are required to read the Compliance Plan including the Code of Conduct and conduct themselves in accordance with the requirements of the Compliance Program. FDRs have the option to adopt CalOptima Health's Compliance Plan, Code of Conduct, and Compliance Policies and Procedures, or with the approval of CalOptima Health, the FDR may follow their own Compliance Plan, Code of Conduct, and Compliance Policies and Procedures. In those instances, the FDRs must either attest to receipt and review of the CalOptima Health program documents, or equivalent materials. Throughout this document, when referencing these materials and FDRs, it means CalOptima Health materials or the FDR equivalent.

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Compliance Program Seven Elements

I. CODE OF CONDUCT, WRITTEN POLICIES AND PROCEDURES

a. Code of Conduct

The Code of Conduct is CalOptima Health's foundational document detailing fundamental principles, values, and the framework for business practices within and applicable to CalOptima Health. The objective of the Code of Conduct is to provide guiding principles to Board Members, employees, contractors, and FDRs in conducting their business activities in a professional, ethical, and lawful manner.

Reporting Non-Compliance: One of the most fundamental aspects of the Code of Conduct is the **requirement** that all Board Members, employees, contractors, and FDRs **promptly report** any suspected FWA or noncompliance with applicable regulations or CalOptima Health policies. This can be accomplished by reporting directly to your supervisor or management, the Compliance Department, or the CalOptima Health Chief Compliance Officer. If requested, a reported issue will be treated in a confidential manner, to the extent possible. If the individual reporting the issue wants to remain anonymous, they can call the Compliance and Ethics Hotline at **1-855-507-1805**, seven days a week, 24 hours a day**.** This service is managed by an independent third party.

Non-Retaliation: CalOptima Health maintains a strict non-retaliation policy to protect individuals who report suspected non-compliance or FWA issues in good faith. CalOptima Health takes violations of CalOptima Health's non-retaliation policy seriously, and the Chief Compliance Officer will review and enforce disciplinary and/or other appropriate action for violations, as appropriate, with the approval of the Compliance Committee.

The Code of Conduct is a separate document from the Compliance Plan and can be found on the CalOptima Health's InfoNet at *https://caloptima.sharepoint.com/sites/OfficeofCompliance* or on the CalOptima Health website at *https://www.caloptima.org/en/About/GeneralCompliance/GeneralComplianceResourceLinks*. The Code of Conduct is approved by the Board and distributed to Board Members, employees, contractors, and FDRs upon appointment, hire, or the commencement of the contract, and annually thereafter. New Board Members, employees, contractors, and FDRs are required to sign an attestation acknowledging receipt and review of the Code of Conduct within ninety (90) calendar days of the appointment, hire, or commencement of the contract, and annually thereafter.

b. Compliance Plan

As noted above, this Compliance Plan outlines how contractual and legal standards are reviewed and implemented throughout the organization and communicated to the Board, employees, contractors, and FDRs. This Compliance Plan also includes a comprehensive

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section articulating CalOptima Health's commitment to preventing FWA, and setting forth guidelines and procedures designed to detect, prevent, and remediate FWA in the administration of CalOptima Health Programs. This Compliance Plan allows the Compliance Program to act independently of operational and program areas without fear of repercussions for uncovering deficiencies or noncompliance.

The Compliance Plan is available on CalOptima Health's external website for Board Members and FDRs, as well as on CalOptima Health's intranet site, which is accessible to all employees (InfoNet).

c. Policies and Procedures

CalOptima Health has developed written Policies and Procedures to address specific areas of CalOptima Health's operations, compliance activities, and FWA prevention, detection, and remediation to ensure CalOptima Health can effectively adhere to all applicable laws, regulations, and guidelines. These Policies and Procedures are designed to provide guidance to Board Members, employees, contractors, and FDRs concerning compliance expectations and outline processes on how to identify, report, investigate, and/or resolve suspected, detected, or reported compliance issues. Board Members, employees, contractors, and FDRs are expected to be familiar with the Policies and Procedures pertinent to their respective roles and responsibilities and are expected to perform their responsibilities in compliance with ethical standards, contractual obligations, and applicable law. The Chief Compliance Officer, or his/her designee, will ensure that Board Members, employees, contractors, and FDRs are informed of applicable policy requirements, and that such dissemination of information is documented and retained, in accordance with applicable record retention standards.

CalOptima Health Policies and Procedures are reviewed annually and updated, as needed, depending on state and federal regulatory changes and/or operational improvements to address identified risk factors. Changes to CalOptima Health's Policies and Procedures are reviewed and approved by CalOptima Health's Policy Review Committee. The Policy Review Committee, comprised of executive officers and key management staff, regularly reviews, and approves proposed changes to CalOptima Health's Policies and Procedures. Board Members, employees, contractors, and FDRs receive notice when Policies and Procedures are updated via a monthly memorandum. All CalOptima Health Policies and Procedures are available to Board Members, employees, contractors and FDRs on the InfoNet and the CalOptima Health website.

II. COMPLIANCE OFFICER, COMPLIANCE COMMITTEE, HIGH LEVEL OVERSIGHT

a. Governing Body

The Board, as the Governing authority, is responsible for approving, implementing, and Monitoring the Compliance Program governing CalOptima Health's operations. The Board delegates the Compliance Program oversight and day-to-day compliance activities to the Chief Executive Officer (CEO), who then delegates such oversight and activities to the Chief Compliance Officer. The Chief Compliance Officer is an employee of CalOptima Health, who

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handles compliance oversight and activities full-time. The Chief Compliance Officer, in conjunction with the Compliance Committee, are both accountable for the oversight and reporting roles and responsibilities as set forth in this Compliance Plan. However, the Board remains accountable for ensuring the effectiveness of the Compliance Program within CalOptima Health and Monitoring the status of the Compliance Program to ensure its efficient and successful implementation. The Board reviews and approves the Compliance Plan, Code of Conduct and Compliance Policies and Procedures annually.

b. Compliance Officer

The Chief Compliance Officer is a full-time employee of CalOptima Health and coordinates and communicates all assigned compliance activities and programs. This includes but is not limited to, developing, implementing, and monitoring the day-to-day activities of the Compliance Program. The Chief Compliance Officer reports directly to the CEO and the Compliance Committee and to the Board and is Chair of the Compliance Committee. In this capacity the Chief Compliance officer reports on the activities and status of the Compliance Program. The Chief Compliance Officer has the authority to escalate issues of concern directly to the Board and acts independently of operational and program areas without fear of repercussions for uncovering deficiencies or noncompliance. Furthermore, the Chief Compliance Officer oversees that CalOptima Health meets all state and federal regulatory and contractual requirements. The Chief Compliance Officer, or his or her designee, shall also act as the Fraud Prevention Officer.

The Chief Compliance Officer interacts with the Board, CEO, CalOptima Health's executive staff and departmental management, FDRs, legal counsel, state and federal representatives, and others as required. In addition, the Chief Compliance Officer supervises the Office of Compliance, which includes compliance professionals with expertise and responsibilities for the following areas: Medi-Cal and Medicare Regulatory Affairs & Compliance, FWA, Privacy, Internal Auditing and Monitoring, Policies and Procedures, and training on compliance activities.

c. Compliance Committee

The Compliance Committee, chaired by the Chief Compliance Officer, is composed of CalOptima Health's executive staff including but not limited to the Chief Executive Officer, Chief Operating Officer, Chief Information Officer, Chief Medical Officer, and Chief Financial Officer. The role of the Compliance Committee is to oversee and ensure the implementation of the Compliance Program and to participate in carrying out the provisions of this Compliance Plan. The Compliance Committee meets at least on a quarterly basis, or more frequently as necessary, to ensure reasonable oversight of the Compliance Program.

The Board delegates the following responsibilities to the Compliance Committee:

- Maintain and update the Code of Conduct consistent with regulatory requirements and/or operational changes, subject to the ultimate approval by the Board.
- Maintain and update the Compliance Plan, on an annual basis, consistent with regulatory requirements and/or operational changes, subject to the ultimate approval by the Board

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- ► Maintain written notes, records, correspondence, or minutes (as appropriate) of Compliance Committee meetings reflecting reports made to the Compliance Committee and the Compliance Committee's decisions on the issues raised (subject to all applicable privileges).
- ► Review and monitor the effectiveness of the Compliance Program, including Monitoring key performance reports and metrics, evaluating business and administrative operations, and overseeing the creation, implementation, and development of corrective and preventive action(s) to ensure they are prompt and effective.
- ► Recommend and monitor the development of internal systems and controls to implement CalOptima Health's standards and Policies and Procedures as part of its daily operations.
- ► Determine the appropriate strategy and/or approach to promote compliance and detect potential violations and advise the Chief Compliance Officer accordingly.
- ► Review and address reports of monitoring and auditing of areas in which CalOptima Health is at risk of program non-compliance and/or potential FWA and ensure Corrective Action Plans (CAPs) and Immediate Corrective Action Plans (ICAPs) are implemented and monitored for effectiveness.

III. EFFECTIVE TRAINING AND EDUCATION

Training and education are important elements in CalOptima Health's overall Compliance Program. The following trainings must be completed by Board Members, employees, contractors, and FDRs within ninety (90) calendar days of hire, appointment, or commencement of the contract, as applicable, and annually thereafter:

- **Code of Conduct**
- **General Compliance**
- **FWA**
- **HIPAA Privacy Compliance**

Adherence to the Compliance Program requirements, including training requirements, shall be a condition of employment and a factor in the annual performance evaluation of each Employee.

Specialized education courses are assigned to individuals based on their respective roles or positions within or with CalOptima Health's departments and its programs. Examples include, but are not limited to, the fundamentals of managing Seniors and People with Disabilities (SPD) and cultural competency.

a. Compliance Training for FDRs

All FDRs that provide services to Medi-Cal and Medicare Advantage Part D members, are to complete compliance and FWA training through their own internal compliance program or by using training materials supplied by CalOptima Health.

b. Tracking Required Compliance Training

The Chief Compliance Officer, or his/her designee, is responsible for coordinating compliance education and training programs, and ensuring that records evidencing an individual's/FDR's completion of the training requirements are documented and maintained, such as sign-in sheets,

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attestations, or electronic certifications, as required by law. The Chief Compliance Officer, CalOptima Health executive staff, management, and the Clerk of the Board are responsible for ensuring that Board Members, employees, contractors, and FDRs complete training on an annual basis.

CalOptima Health's Human Resources Department utilizes state of the art web-based training courses that emphasize CalOptima Health's commitment to the Compliance Program, and updates courses regularly to ensure that employees are kept fully informed about any changes in procedures, regulations, and requirements.

IV. EFFECTIVE LINES OF COMMUNICATION – REPORTING NON-COMPLIANCE

CalOptima Health works diligently to foster a culture of compliance throughout the organization by regularly communicating the importance of regulatory requirements and reinforcement of company expectations for ethical and lawful behavior.

CalOptima Health shall maintain and communicate that systems are in place to receive, record, and respond to reports of potential or actual non-compliance from employees, contractors, members, providers, vendors, FDRs, and subcontractors.

a. Compliance and Ethics Hotline, Website and Email

The CalOptima Health's hotline is a confidential, toll-free resource available to employees, contractors, members, providers, vendors, FDRs, and the general public 24 hours a day, seven days a week to report violations of, or raise questions or concerns relating to, non-compliance, unethical behavior, and/or suspected FWA. These reporting mechanisms may be used by all stakeholders of CalOptima Health.

Reporting mechanisms include the following:

Compliance and Ethics Hotline

1-855-507-1805

- Website: caloptima.org
- Email: Compliance@caloptima.org

The hotline and the online "Compliance and Fraud, Waste and Abuse Reporting Form" may be completed anonymously. These communications are never traced. **Anyone can make a report without fear of intimidation or retaliation.**

b. Report Directly to Management and Executive Staff

CalOptima Health employees are encouraged to contact their immediate management or executive staff when non-compliant activity is suspected or observed. In other words, **if you see something, say something.** A report should be made immediately upon suspecting or identifying the potential or suspected unethical behavior, non-compliance, or violation. Executive staff or management will promptly escalate the report to the Chief Compliance Officer for further investigation and reporting to the CalOptima Health Compliance Committee. If an Employee is concerned that his/her management or executive staff did not adequately address his/her report or complaint, the Employee may go directly to the Chief Compliance Officer, or the Office of the CEO. If for any reason an employee does not feel comfortable discussing an issue with leadership, they may contact Compliance by reaching out directly to the Chief Compliance Officer (CCO) or another member of the compliance team. Employees also always have the **option to anonymously** report issues to the:

Compliance and Ethics Hotline

1-855-507-1805

CalOptima Health educates Board Members, employees and FDRs about CalOptima Health's hotline and online form through:

1) Compliance/FWA training
2) CalOptima Health's intranet (referred to as InfoNet)
3) Posters displayed in common work areas
4) CalOptima Health's Policies and Procedures
5) Newsletters, emails, and other means of communication

c. Confidentiality and Non-Retaliation

CalOptima Health maintains and supports a non-retaliation policy governing good faith reports of suspected, or actual, non-compliance and/or FWA. Every effort will be made to keep reports confidential to the extent permitted by applicable law and circumstances, but there may be some instances where the identity of the individual making the report will have to be disclosed. As a result, CalOptima Health has implemented and enforces a non-retaliation policy to protect individuals who report suspected or actual non-compliance, or FWA, issues in good faith. This non-retaliation policy extends to reports received from FDRs and members. CalOptima Health's non-retaliation policy is communicated along with reporting instructions by posting information on the CalOptima Health InfoNet and website, as well as sending periodic member notifications.

CalOptima Health also takes violations of CalOptima Health's non-retaliation policy seriously, and the Chief Compliance Officer will review and enforce disciplinary and/or other CAPs for violations, as appropriate, with the approval of the Compliance Committee.

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V. ENFORCEMENT AND DISCIPLINARY STANDARDS

a. Conduct Subject to Enforcement and Discipline

Board Members, employees, contractors, and FDRs are subject to appropriate disciplinary and/or corrective actions if they have violated CalOptima Health's standards, requirements, or applicable laws as specified and detailed in the Compliance Program documents and related Policies and Procedures. Board Members, employees, contractors, and FDRs may be disciplined or sanctioned, as applicable, for failing to adhere to CalOptima Health's Compliance Program and/or violating standards, regulatory requirements, and/or applicable laws, including, but not limited to:

- Conduct that leads to the filing of a false or improper claim in violation of federal or state laws and/or contractual requirements.
- Conduct resulting in a violation of any other federal or state laws or contractual requirements relating to participation in Federal and/or State Health Care Programs.
- Failure to perform any required obligation relating to compliance with the Compliance Program, applicable laws, Policies and Procedures, and/or contracts.
- Failure to report violations or suspected violations of the Compliance Program, or applicable laws, or to report suspected or actual FWA issues to an appropriate person through one of the reporting mechanisms.
- Conduct that violates HIPAA and other privacy laws and/or CalOptima Health's HIPAA Privacy and Security Program and policies, including actions that harm the privacy of members, or the CalOptima Health information systems that store member data.

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6) The OIG Work Plan
7) Monitoring dashboard trends

The Director of the Internal Audit Department, or his/her designee, will work with the operational areas, to identify and assess compliance risks. The risk assessment process will be managed by the Director of the Internal Audit Department , or his/her designee, and presented to the Compliance Committee, for review and approval. The risk assessment shall also be updated as processes change or are identified as being deficient.

b. Monitoring and Auditing

The Audit Work Plan (AWP) is developed based on the results of the risk assessment. Internal auditing and monitoring activities are employed to test and verify compliance with all applicable regulations, guidance, contractual agreements, and federal and state laws, as well as CalOptima Health Policies and Procedures. The AWP includes:

1. Audits to be performed including estimated time frames
2. Audit methodologies
3. Necessary resources
4. Person(s) responsible
5. Final audit reports
6. Follow-up activities from findings including CAPs (when applicable)

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The Internal Audit Department manages a dashboard of key compliance metrics that serves as a monitoring tool to track performance compliance for such items as coverage determinations, complaints, appeals, grievances, regulatory communications, credentialing, customer service, transition of coverage (TOC), and claims. The Internal Audit Department performs audits based on the AWP. The monitoring and auditing results are communicated to executive staff, the Compliance Committee, and the Board.

In addition, an Audit of the Compliance Program and its effectiveness is conducted by an independent third party annually, and the results are reported to the Compliance Committee, and the Board.

Routine Monitoring and Auditing of First-tier, Downstream, and Related party entities (FDRs)

c. FDR Annual Risk Assessment

The Director, Delegation Oversight, or his/her designee will conduct an annual comprehensive risk assessment to determine an FDR's vulnerabilities and high-risk areas. High-risk FDRs are those that are continually non-compliant or at risk of non-compliance based on identified gaps in processes with regulatory and CalOptima Health requirements. Any previously identified issues, which include any corrective actions, low service level performance, reported detected offenses, and/or complaints and appeals from the previous year will be factors that are included in the risk assessment. Any FDR deemed high risk or vulnerable is presented to the Chief Compliance Officer to collaborate in determining appropriate follow-up. FDRs determined to be high-risk may be subjected to a more frequent monitoring and auditing schedule, as well as additional reporting requirements. The risk assessment process, along with reports from FDRs, will be managed by the Director, Delegation Oversight, or his/her designee, and presented to the Compliance Committee for review and discussion.

d. FDR Monitoring and Auditing

An FDR AWP is developed based on the results of the FDR risk assessment. Auditing and Monitoring Activities are employed to test and verify compliance with all applicable regulations, guidance, contractual agreements, and federal and state laws, as well as applicable CalOptima Health Policies and Procedures or equivalent. The FDR AWP includes:

1. Audits to be performed including estimated time frames
2. Audit methodologies
3. Necessary resources
4. Person(s) responsible
5. Final audit reports
6. Follow-up activities from findings including CAPs (when applicable)

The Delegation Oversight Department manages a dashboard of key compliance metrics that serves as a monitoring tool to track compliant performance of FDRs' case management, credentialing, claims, and utilization management. Delegation Oversight performs audits as per

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the FDR AWP. The monitoring and auditing results are communicated to executive staff, the Compliance Committee, and the Board.

e. Regular Exclusion and Preclusion Screening

CalOptima Health performs Participation Status Reviews by searching the OIG–LEIE, the GSA–SAM, the DHCS Medi-Cal Suspended & Ineligible Provider Lists, Medi-Cal Restricted Provider Database (RPD), Medi-Cal Procedure/Drug Code Limitation List, and the CMS Preclusion List upon appointment, hire, or commencement of a contract, as applicable, and monthly thereafter, to ensure Board Members, employees, contractors, Providers and/or FDRs are not suspended, excluded, or do not become excluded or precluded from participating in Federal and/or State Health Care Programs. Board Members, employees, contractors, Providers, and FDRs are required to disclose their participation status as part of their initial appointment, employment, commencement of the contract and registration/application processes and if they receive a notice of a suspension, Preclusion, Exclusion, or debarment during the period of appointment, employment, or contract term. CalOptima Health also requires that its First Tier Entities comply with Participation Status Review requirements with respect to their relationships with Downstream Entities, including without limitation, the delegated credentialing and re-credentialing processes.

VII. PROCEDURES AND SYSTEMS FOR PROMPT REPONSE TO COMPLIANCE ISSUES

CalOptima Health takes corrective actions when there is a confirmed incident of non-compliance. CalOptima Health may identify the incident of non-compliance through a variety of sources, such as self-reporting, governmental audits, internal audits, hotline calls, external audits, or member complaints, either directly to CalOptima Health or through governmental units. Whenever CalOptima Health identifies an issue of non-compliance or potential FWA, it is investigated and resolved.

The Chief Compliance Officer and/or Director of FWA, in conjunction with the Office of Compliance, FWA Department and other key staff, are responsible for reviewing cases of non-compliance and suspected activity, and for disclosing such issues to the appropriate authority, when applicable. Because of the complex nature of some issues that may be reported or identified, the investigation may be delegated to the appropriate internal expert.

When a material issue of non-compliance is discovered or a department's process or system results in non-compliance with regulatory requirements, the business area may be required to implement a formal CAP which is overseen by the Office of Compliance. The CAP promotes the correction of the identified issue in a timely manner. Corrective actions may include revising processes, updating policies or procedures, retraining staff, reviewing systems edits and/or addressing other root causes. The CAP must achieve sustained compliance with the overall requirements for that specific operational department.

The status of open CAPs is reviewed by the Office of Compliance on a monthly basis, or at a frequency determined by the Chief Compliance Officer. The Office of Compliance monitors

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CAP implementation and requires that business departments regularly report the completion of all interim actions. The Office of Compliance tracks the duration of open CAPs and intervenes as appropriate to promote timely completion. Once a CAP is complete, the Office of Compliance may validate the corrective actions by auditing individual action items over a period of time to confirm compliance and the effectiveness of the implemented corrective actions. A summary of CAP activity is periodically reported to executive staff and the Compliance Committee.

CalOptima Health's oversight of FDRs includes a requirement that FDRs submit a CAP when material deficiencies are identified through Delegation Oversight audits, ongoing monitoring and/or self-reporting. CalOptima Health takes appropriate action against any contracted organization that does not comply with a CAP or does not meet its regulatory obligations, up to and including termination of its agreement. FDRs are bound contractually through written agreements with CalOptima Health that stipulate compliance with governmental requirements and include provisions for termination for failure to cure performance deficiencies.

CalOptima Health's Compliance Plan is effective in promoting compliance and controlling FWA at both the sponsor and FDR/Subcontractor levels in managing the Medi-Cal and Medicare programs. Policies and procedures associated with this Compliance Plan further expand the activities and oversight of the program.

a. Referral to Enforcement Agencies

In appropriate circumstances, CalOptima Health shall report violations of Medi-Cal Program requirements to DHCS Audits and Investigations, violations of Medicare Program requirements to the Medicare Drug Integrity Contractor (MEDIC), and violations of other state and federal laws to the appropriate law enforcement agencies, in accordance with the applicable reporting procedures adopted by such enforcement agencies.

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FRAUD, WASTE, AND ABUSE (FWA) PREVENTION AND DETECTION

The detection, prevention, and remediation of FWA are components of CalOptima Health's Compliance Program. FWA activities are implemented and overseen by CalOptima Health's Chief Compliance Officer in conjunction with the Director, FWA or his/her designee, in conjunction with other compliance activities. Investigations are performed, or overseen, by the Special Investigations Unit (SIU), an internal investigative unit within CalOptima Health's Office of Compliance, responsible for FWA investigations. The Chief Compliance Officer, and/or his/her designee, shall attend the quarterly DHCS Program Integrity meetings, as scheduled. The Chief Compliance Officer, or his/her designee, reports FWA activities to the CalOptima Health Compliance Committee, the Office of the CEO, the Board, and Regulatory Agencies.

CalOptima Health utilizes various resources to detect, prevent, and remediate FWA. In addition, CalOptima Health promptly investigates suspected FWA issues and may implement disciplinary or corrective action to avoid recurrence of FWA issues. The objective of the Anti-Fraud, Waste, Abuse (FWA) Plan is to ensure that the scope of benefits covered by CalOptima Health Programs are appropriately delivered to members and resources are effectively utilized in accordance with federal and state guidelines. CalOptima Health incorporates a system of internal assessments which are organized to identify FWA and promptly respond appropriately to such incidents of FWA. See the CalOptima Health 2024 Anti-Fraud, Waste and Abuse (FWA) Plan for further details.

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~~2024~~ 2025 Code of Conduct

(Revised September 2024~~3~~)

Document maintained by: John Tanner
CalOptima Health Chief Compliance Officer

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Message from Chief Compliance Officer (CCO)

CalOptima Health is committed to its mission "to serve member health with excellence and dignity, respecting the value and needs of each person." Foundational to fulfilling this commitment is conducting ourselves in an ethical and compliant manner in the course of our daily activities and interactions. CalOptima Health expects all employees, contractors, officers, board members, network providers, subcontractors and downstream contractors act ethically and have a responsibility in ensuring compliance.

This document is a guide with 112 principles and related standards to provide a framework for CalOptima Health's Code of Conduct and how we are to conduct ourselves in serving our members. Please review this Code of Conduct and reach out to the Chief Compliance Officer or a representative from the Office of Compliance if you have any questions regarding this information.

It is incumbent upon all Board members, employees, providers and contractors to report any potential issues of non-compliance or misconduct. Reporting can be done online via the InfoNet or the CalOptima Health website, email, or phone.

You also have the option to anonymously report issues to the:

Compliance and Ethics Hotline at 1-855-507-1805

If you are unsure of a particular matter or situation, talk to your supervisor or a representative from the Office of Compliance to discuss your concerns and get guidance. Conducting our business compliantly and ethically is key to sustaining our business and maintaining our focus in serving our members.

Thank you for your dedication to serving our members and to following this Code of Conduct.

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Code of Conduct 11~~2~~ Principles

1. Mission, Vision, and Values:
CalOptima Health is committed to its Mission, Vision, and Values

2. Member Rights:
CalOptima Health is committed to meeting the health care needs of its members by providing access to quality health care services.

3. Compliance with the Law and Applicable Program Requirements:
CalOptima Health is committed to conducting all activities and operations in compliance with all applicable requirements and standards under its contract with DHCS and all ~~law~~ and federal and state ~~applicable program~~ requirements including CMS requirements.

4. Business Ethics:
In furtherance of CalOptima Health's commitment to the highest standards of business ethics, employees and contractors shall accurately and honestly represent CalOptima Health and shall not engage in any activity or scheme intended to defraud anyone of money, property, or honest services.

5. Conflicts of Interests:
Board members, ~~and~~ employees, and contractors owe a duty of undivided and unqualified loyalty to CalOptima Health.

~~**Business Relationships:**~~

~~**6.** Business transactions with vendors, contractors, and other third parties shall be conducted at arm's length in fact and in appearance, transacted free from improper inducements and in accordance with applicable law and ethical standards.~~**Public Integrity:**
CalOptima Health and its Board members, employees, and contractors shall comply with laws and regulations governing public agencies.

7. Confidentiality:
Board members, employees, and contractors shall maintain the confidentiality of all confidential information in accordance with applicable law and shall not disclose such confidential information except as specifically authorized by CalOptima Health policies, procedures, and applicable laws.

~~6.~~8. Compliance Program Reporting:
Board members, employees, and contractors have a duty to comply with CalOptima Health's Compliance Program and such duty shall be a condition of their respective appointment, employment, or engagement.

~~**7.1. Confidentiality:**~~
~~Board members, employees, and contractors shall maintain the confidentiality of all confidential information in accordance with applicable law and shall not disclose such confidential information except as specifically authorized by CalOptima Health policies, procedures, and applicable laws.~~

~~**8. Public Integrity:**~~
~~CalOptima Health and its Board members and employees shall comply with laws and regulations governing public agencies.~~

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~~9.1. Business Relationships:~~

~~Business transactions with vendors, contractors, and other third parties shall be conducted at arm's length in fact and in appearance, transacted free from improper inducements and in accordance with applicable law and ethical standards.~~

~~10.~~9. **Discrimination:**

CalOptima Health acknowledges that fair and equitable treatment of employees, contractors, members, providers, and other persons is fundamental to fulfilling its mission and goals.

~~11.~~10. **Participation Status:**

CalOptima Health requires that employees, contractors, providers, and suppliers meet Government requirements for participation in CalOptima Health's programs.

~~12.~~11. **Government Inquiries/Legal Disputes:**

Employees and contractors shall notify CalOptima Health upon receipt of Government inquiries and shall not destroy or alter documents in response to a government request for documents or information.

Code of Conduct Principles and Standards

Principle	Standard
1. **Mission, Vision, and Values** CalOptima Health is committed to its Mission, Vision, and Values	**Mission** To serve member health with excellence and dignity, respecting the value and needs of each person. **Vision by 2027** • CalOptima Health Same-Day Treatment Authorizations • Real-Time Claims Payments • Annual Assessments of Member's Social Determinants of Health. **Values = CalOptima Health CARES** **C**ollaboration; **A**ccountability; **R**espect; **E**xcellence; **S**tewardship
2. **Member Rights** CalOptima Health is committed to meeting the health care needs of its members by providing access to quality health care services.	**Member Choice, Access to Health Care Services, Continuity of Care** Employees and contractors shall comply with CalOptima Health policies and procedures and applicable law governing member choice, access to health care services, and continuity of member care. Employees and contractors shall comply with all requirements for coordination of medical and support services for persons with special needs. Health Equity Employees and contractors shall endeavor to address and prioritize health equity in the design and implementation of CalOptima Health strategies and programs.

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Principle	Standard
	Cultural and Linguistic Services CalOptima Health and contractors shall provide culturally, linguistically, and sensory appropriate services to CalOptima Health members to ensure effective communication regarding diagnosis, medical history, and treatment, and health education. **Disabled Member Access** CalOptima Health's facilities shall adhere to the requirements of Title III of the Americans with Disabilities Act of 1990 by providing access for disabled members. **Emergency Treatment** Employees and contractors shall comply with all applicable guidelines, policies and procedures, and laws governing CalOptima Health member access and payment of emergency services including, without limitation, the Emergency Medical Treatment and Active Labor Act ("EMTALA") and state patient "anti-dumping" laws, prior authorization limitations, and payment standards. **Grievance and Appeals Processes** CalOptima Health, its physician groups, its Health Networks, and third-party administrators (TPA) shall ensure that CalOptima Health members are informed of their grievance and appeal rights including, the state hearing process, through member handbooks and other communications in accordance with CalOptima Health policies and procedures and applicable laws. Employees and contractors shall address, investigate, and resolve CalOptima Health member complaints and grievances in a prompt and nondiscriminatory manner in accordance with CalOptima Health policies and applicable laws.
3. Compliance with the Law and Applicable Program Requirements CalOptima Health is committed to conducting all activities and operations in compliance with applicable law and program requirements.	**Transparent, Legal, and Ethical Business Conduct** CalOptima Health is committed to conducting its business with integrity, honesty, and fairness and in compliance with all federal and state laws and~~laws and~~ regulations,~~.~~ and applicable requirements and standards under its Contract with DHCS. CalOptima Health expects all employees, contractors, officers, board of directors members, network providers, subcontractors, and downstream contractors to act ethically and are responsible for ensuring CalOptima Health compliance.~~that apply to its operations. CalOptima Health depends on its Board members, employees, and those who do business with it to help fulfill this commitment.~~ **Obeying the Law**

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Principle	Standard
	Board members, employees, and contractors (including First Tier and Downstream Entities included in the term "FDRs") shall not lie, steal, cheat, or violate any law in connection with their employment and/or engagement with CalOptima Health. **Fraud, Waste, & Abuse (FWA)** CalOptima Health shall refrain from conduct which would violate the Fraud, Waste, and Abuse laws. CalOptima Health is committed to the detection, prevention, and reporting of Fraud, Waste, and Abuse. CalOptima Health is also responsible for ensuring that Board members, employees, contractors, and FDRs receive appropriate FWA training as described in regulatory guidance. CalOptima Health's Compliance Plan, Anti-Fraud, Waste, and Abuse Plan and policies describe examples of Potential Fraud, Waste, and Abuse and discuss employee and contractor FWA obligations and potential Sanctions arising from relevant federal and state FWA laws. CalOptima Health expects and requires that its Board members, employees, and contractors do not participate in any conduct that may violate the FWA laws including federal and state anti-kickback laws, false claims acts, and civil monetary penalty laws. **Political Activities** CalOptima Health's political participation is limited by law. CalOptima Health funds, property, and resources are not to be used to contribute to political campaigns, political parties, and/or organizations. Board members, employees and contractors may participate in the political process on their own time and at their own expense but shall not give the impression that they are speaking on behalf of or representing CalOptima Health in these activities. **Anti-Trust** All Board members, employees, and contractors must comply with applicable antitrust, unfair competition, and similar laws which regulate competition. Such persons shall seek advice from legal counsel if they encounter any business decisions involving a risk of violation of antitrust laws. The types of activities that potentially implicate antitrust laws include, without limitation, agreements to fix prices, bid rigging, and related activities; boycotts, certain exclusive dealings, and price discrimination agreements; unfair trade practices; sales or purchases conditioned on reciprocal purchases or sales; and discussion of factors determinative of prices at trade association meetings.
4. Business Ethics	**Candor & Honesty**

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Principle	Standard
In furtherance of CalOptima Health's commitment to the highest standards of business ethics, employees and contractors shall accurately and honestly represent CalOptima Health and shall not engage in any activity or scheme intended to defraud anyone of money, property, or honest services.	CalOptima Health requires candor and honesty from individuals in the performance of their responsibilities and in communications including, communications with CalOptima Health's Board of Directors, supervisory employees, attorneys, and auditors. No Board member, employee, or contractor shall make false or misleading statements to any members and/or persons, or entities, doing business with CalOptima Health about products or services of CalOptima Health. **Financial and Data Reporting** All financial reports, accounting records, research reports, expense accounts, data submissions, attestations, timesheets, and other documents must accurately and clearly represent the relevant facts and the true nature of a transaction. CalOptima Health maintains a system of internal controls to ensure that all transactions are executed in accordance with Management's authorization and recorded in a proper manner to maintain accountability of the agency's assets. Improper or fraudulent accounting documentation or financial reporting or false or misleading encounter, claims, cost, or other required regulatory data submissions is contrary to the policy of CalOptima Health and may be in violation of applicable laws and regulatory obligations. **Regulatory Agencies and Accrediting Bodies** CalOptima Health will deal with all Regulatory Agencies and accrediting bodies in a direct, open, and honest manner. Employees and contractors shall not take action with Regulatory Agencies and accrediting bodies that is false or misleading.

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Principle	Standard
5. Conflicts of Interests Board members, ~~and~~ employees, and contractors owe a duty of undivided and unqualified loyalty to CalOptima Health.	**Conflicts of Interest ~~Code~~** Designated employees and contractors~~, including Board members,~~ shall comply with the requirements of GA.8012: Conflicts of Interest (policy), ~~the CalOptima Health Conflict of Interest Code~~ and applicable laws. Board members~~, and~~ employees, and contractors are expected to conduct their activities to avoid impropriety and/or the appearance of impropriety, which might arise from the influence of those activities on business decisions of CalOptima Health, or from disclosure of CalOptima Health's business operations. In addition to these provisions, designated employees are also subject to the provisions of the Conflict of Interest Code adopted by the CalOptima Health Board of Directors in compliance with the California Government Code. Designated employees must complete a Form 700 Statement of Economic Interests and a CalOptima Health Supplement to Form 700 upon hire, annually, and upon separation of employment. The HR department coordinates this activity with the CalOptima Health Clerk of the Board. See CalOptima Health Policies GA.8012: Conflicts of Interest, AA.1204: Gifts, Honoraria, and Travel Payments, and AA.1216: Solicitation and Receipts of Gifts to CalOptima Health. ~~**Outside Services and Interests**~~ ~~Without the prior written approval of the Chief Executive Officer (or in the case of the Chief Executive Officer, the Chair of the CalOptima Health Board of Directors), no employee shall (1) perform work or render services for any contractor, association of contractors or other organizations with which CalOptima Health does business or which seek to do business with CalOptima Health; (2) be a director, officer, or consultant of any such contractor or association of contractors; or (3) permit his or her name to be used in any fashion that would tend to indicate a business connection with any such contractor or association of contractors.~~
6. Public Integrity CalOptima Health and its Board members, employees, and contractors shall comply with laws and regulations governing public agencies.	**Public Records** CalOptima Health shall provide access to CalOptima Health Public Records to any person, corporation, partnership, firm, or association requesting to inspect and copy them in accordance with the California Public Records Act, California Government Code Sections 6250 et seq. and CalOptima Health policies. **Public Funds** CalOptima Health, its Board members, employees, and contractors shall not make gifts of public funds or assets or lend credit to private persons without

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Principle	Standard
	adequate consideration unless such actions clearly serve a public purpose within the authority of the agency and are otherwise approved by legal counsel. CalOptima Health, its Board members, employees, and contractors shall comply with applicable law and CalOptima Health policies governing the investment of public funds and expenditure limitations. **Public Meetings** CalOptima Health, its Board members, employees, and contractors shall comply with requirements relating to the notice and operation of public meetings in accordance with the Ralph M. Brown Act, California Government Code Sections 54950 et seq.
7. Confidentiality Board members, employees, and contractors shall maintain the confidentiality of all confidential information in accordance with applicable law and shall not disclose such confidential information except as specifically authorized by CalOptima Health policies, procedures, and applicable laws.	**No Personal Benefit** Board members, employees and contractors shall not use confidential or proprietary CalOptima Health information for their own personal benefit or for the benefit of any other person or entity, while employed at, or engaged by, CalOptima Health, or at any time thereafter. **Duty to Safeguard Member Confidential Information** CalOptima Health recognizes the importance of its members' right to confidentiality and implements policies and procedures to ensure its members' confidentiality rights and the protection of medical and other confidential information. Board members, employees and contractors shall safeguard CalOptima Health member identity, eligibility, social security, medical information and other confidential information in accordance with applicable laws including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH Act) and implementing regulations, the California Security Breach Notification Law, the California Confidentiality of Medical Information Act, other applicable federal and state privacy laws, and CalOptima Health's policies and procedures. **Personnel Files** Personal information contained in employee personnel files shall be maintained in a manner designed to ensure confidentiality in accordance with applicable laws. **Proprietary Information** Subject to its obligations under the Public Records Act, CalOptima Health shall safeguard confidential proprietary information including, without limitation, contractor information and proprietary computer software, in accordance with and, to the extent required by contract or law. CalOptima

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Principle	Standard
	Health shall safeguard provider identification numbers including, without limitation, Medi-Cal license, Medicare numbers, social security numbers, and other identifying numbers.
~~6.~~8.**Compliance Program Reporting** Board members, employees, and contractors have a duty to comply with CalOptima Health's Compliance Program and such duty shall be a condition of their respective appointment, employment, or engagement.	**Reporting Requirements** In alignment with CalOptima Health's reporting policies, all Board members, employees and contractors are expected and required to promptly report suspected violations of any statute, regulation, or guideline applicable to Federal and/or State health care programs or of CalOptima Health's policies and Compliance Plan.~~All Board members, employees and contractors are expected and required to promptly report suspected violations of any statute, regulation, or guideline applicable to Federal and/or State health care programs or of CalOptima Health's own policies in accordance with CalOptima Health's reporting policies and its Compliance Plan~~. Such reports may be made to a Supervisor ~~or,~~ the Chief Compliance Officer~~. Reports can~~ or may also be made to CalOptima Health's Compliance and Ethics H~~h~~otline number below. Persons making reports to the hotline can do so on an anonymous basis. **Compliance and Ethics Hotline: 1-855-507-1805** **Disciplinary Action** Failure to comply with the Compliance Program, including the Code of Conduct, policies, and/or applicable statutes, regulations and guidelines may lead to disciplinary action. Discipline for failure to abide by the Code of Conduct may, in CalOptima Health's discretion, range from oral correction to termination in accordance with CalOptima Health's policies. In addition, failure to comply may result in the imposition of civil, criminal, or administrative fines on the individual, or entity, and CalOptima Health or Exclusion or Preclusion from participation in Federal and/or State health care programs. **Training and Education** CalOptima Health provides training and education to Board members, employees, contractors, and FDRs. Timely completion of compliance and HIPAA training is mandatory for all CalOptima Health employees and contractors. **Non-Retaliation Policy** CalOptima Health prohibits retaliation against any individual who reports discrimination, harassment, or compliance concerns, or participates in an investigation of such reports, in good faith. Employees and contractors

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Principle	Standard
	involved in any retaliatory acts may be subject to discipline, up to and including termination of employment. **Referrals of FWA to Government Agencies** CalOptima Health is obligated to coordinate compliance activities with federal and state regulators. Employees and contractors shall comply with CalOptima Health policies related to FWA referral requirements to federal and state regulators, delegated program integrity contractors, and law enforcement agencies. **Certification** All Board members, employees, and contractors are required to certify, in writing, that they have received, read, understand, and will abide by the Code of Conduct and applicable policies.
~~**7. Confidentiality**~~ ~~Board members, employees, and contractors shall maintain the confidentiality of all confidential information in accordance with applicable law and shall not disclose such confidential information except as specifically authorized by CalOptima Health policies, procedures, and applicable laws.~~	~~**No Personal Benefit**~~ ~~Board members, employees and contractors shall not use confidential or proprietary CalOptima Health information for their own personal benefit or for the benefit of any other person or entity, while employed at, or engaged by, CalOptima Health, or at any time thereafter.~~ ~~**Duty to Safeguard Member Confidential Information**~~ ~~CalOptima Health recognizes the importance of its members' right to confidentiality and implements policies and procedures to ensure its members' confidentiality rights and the protection of medical and other confidential information. Board members, employees and contractors shall safeguard CalOptima Health member identity, eligibility, social security, medical information and other confidential information in accordance with applicable laws including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH Act) and implementing regulations, the California Security Breach Notification Law, the California Confidentiality of Medical Information Act, other applicable federal and state privacy laws, and CalOptima Health's policies and procedures.~~ ~~**Personnel Files**~~ ~~Personal information contained in Employee employee personnel files shall be maintained in a manner designed to ensure confidentiality in accordance with applicable laws.~~ ~~**Proprietary Information**~~

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Principle	Standard
	Subject to its obligations under the Public Records Act, CalOptima Health shall safeguard confidential proprietary information including, without limitation, contractor information and proprietary computer software, in accordance with and, to the extent required by contract or law. CalOptima Health shall safeguard provider identification numbers including, without limitation, Medi-Cal license, Medicare numbers, social security numbers, and other identifying numbers.
8. Public Integrity CalOptima Health and its Board members and employees shall comply with laws and regulations governing public agencies.	**Public Records** CalOptima Health shall provide access to CalOptima Health Public Records to any person, corporation, partnership, firm, or association requesting to inspect and copy them in accordance with the California Public Records Act, California Government Code Sections 6250 et seq. and CalOptima Health policies. **Public Funds** CalOptima Health, its Board members, and employees shall not make gifts of public funds or assets or lend credit to private persons without adequate consideration unless such actions clearly serve a public purpose within the authority of the agency and are otherwise approved by legal counsel. CalOptima Health, its Board members, and employees shall comply with applicable law and CalOptima Health policies governing the investment of public funds and expenditure limitations. **Public Meetings** CalOptima Health, and its Board members, and employees shall comply with requirements relating to the notice and operation of public meetings in accordance with the Ralph M. Brown Act, California Government Code Sections 54950 et seq.
9. Business Relationships Business transactions with vendors, contractors, and other third parties shall be conducted at arm's length in fact and in appearance, transacted free from improper inducements and in accordance with	**Business Inducements** Board members, employees, and contractors shall not seek to gain advantage through improper use of payments, business courtesies, or other inducements. The offering, giving, soliciting, or receiving of any form of bribe or other improper payment is prohibited. Board members, employees, contractors, and providers shall not use their positions to personally profit or assist others in profiting in any way at the expense of Federal and/or State health care programs, CalOptima Health, or CalOptima Health members. **Gifts to CalOptima Health** Board members and employees are specifically prohibited from soliciting and accepting personal gratuities, gifts, favors, services, entertainment, or

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Principle	Standard
applicable law and ethical standards.	any other things of value from any person or entity that furnishes items or services used, or that may be used, in CalOptima Health and its programs unless specifically permitted under CalOptima Health policies. Employees may not accept cash or cash equivalents. Perishable or consumable gifts given to a department or group are not subject to any specific limitation and business meetings at which a meal is served is not considered a prohibited business courtesy. **Provision of Gifts by CalOptima Health** Employees may provide gifts, entertainment, or meals of nominal value to CalOptima Health's current and prospective business partners and other persons when such activities have a legitimate business purpose, are reasonable, and are otherwise consistent with applicable law and CalOptima Health policies on this subject. In addition to complying with statutory and regulatory requirements, it is critical to even avoid the appearance of impropriety when giving gifts to persons and entities that do business or are seeking to do business with CalOptima Health. **Third-Party Sponsored Events** CalOptima Health's joint participation in contractor, vendor, or other third-party sponsored events, educational programs and workshops is subject to compliance with applicable law, including gift of public fund requirements and fraud and abuse prohibitions, and must be approved in accordance with CalOptima Health policies on this subject. In no event, shall CalOptima Health participate in any joint contractor, vendor, or third party sponsored event where the intent of the other participant is to improperly influence, or gain unfair advantage from, CalOptima Health or its operations. Employees' attendance at contractor, vendor, or other third-party sponsored events, educational programs and workshops is generally permitted where there is a legitimate business purpose but is subject to prior approval in accordance with CalOptima Health policies. **Provision of Gifts to Government Agencies** Board members, employees, and contractors shall not offer or provide any money, gifts, or other things of value to any government entity or its representatives, except campaign contributions to elected officials in accordance with applicable campaign contribution laws. **Broad Application of Standards** CalOptima Health intends that these standards be construed broadly to avoid even the appearance of improper activity.

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Principle	Standard
~~10.~~9. **Discrimination** CalOptima Health acknowledges that fair and equitable treatment of employees, contractors, members, providers, and other persons is fundamental to fulfilling its mission and goals.	**No Discrimination** CalOptima Health is committed to compliance with applicable anti-discrimination laws including Title VI of the Civil Right Act of 1964. Board members, employees and contractors shall not unlawfully discriminate on the basis of race, color, national origin, creed, ancestry, religion, language, age, marital status, gender (which includes sex, gender identity, gender transition status and gender expression), sexual orientation, health status, pregnancy, physical or mental disability, military status or any other classification protected by law. CalOptima Health is committed to providing a work environment free from discrimination and harassment based on any classification noted above. **Reassignment** CalOptima Health, physician groups, and Health Networks shall not reassign members in a discriminatory manner, including based on the enrollee's health status.
~~11.~~10. **Participation Status** CalOptima Health requires that employees, contractors, providers, and suppliers meet Government requirements for participation in CalOptima Health's programs.	**Federal and State Health Care Program Participation Status** Board members, employees, and contractors shall not be currently suspended, terminated, debarred, or otherwise ineligible to participate in any Federal or State health care program, including the Medi-Cal program and Medicare programs. **CalOptima Health Screening** CalOptima Health will Monitor the participation status of employees, individuals and entities doing business with CalOptima Health by conducting regular Exclusion and Preclusion screening reviews in accordance with CalOptima Health policies. **Disclosure of Participation Status** Board members, employees and contractors shall disclose to CalOptima Health whether they are currently suspended, terminated, debarred, or otherwise ineligible to participate in any Federal and/or State health care program. Employees, individuals, and entities that do business with CalOptima Health shall disclose to CalOptima Health any pending investigation, disciplinary action, or other matter that could potentially result in their ~~Exclusion~~ exclusion or ~~Preclusion~~ preclusion from participation in any Federal or State health care program. **Delegated Third Party Administrator Review** CalOptima Health requires that its Health Networks, physician groups, and third-party administrators review participating providers and suppliers for

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Principle	Standard
	licensure and participation status as part of the delegated credentialing and recredentialing processes when such obligations have been delegated to them. **Licensure** CalOptima Health requires that all employees, contractors, Health Networks, participating providers, and suppliers who are required to be licensed, credentialed, certified, and/or registered in order to furnish items or services to CalOptima Health and its members have valid and current licensure, credentials, certification and/or registration, as applicable.
~~12.~~11. **Government Inquiries/Legal Disputes** Employees and contractors shall notify CalOptima Health upon receipt of ~~Government~~ government inquiries and shall not destroy or alter documents in response to a government request for documents or information.	**Notification of Government Inquiry** Employees and contractors shall notify the Chief Compliance Officer and/or their supervisor immediately upon the receipt (at work or at home) of an inquiry, subpoena, or other agency or government requests for information regarding CalOptima Health. **No Destruction of Documents** Employees and contractors shall not destroy or alter CalOptima Health information or documents in anticipation of, or in response to, a request for documents by any governmental agency or from a court of competent jurisdiction. **Preservation of Documents Including Electronically Stored Information** Board members~~, and~~ employees, and contractors shall comply with all obligations to preserve documents, data, and records including, electronically stored information in accordance with CalOptima Health policies and shall comply with instructions on preservation of information and prohibitions and destruction of information issued by legal counsel.

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2025 Code of Conduct

(Revised September 2024)

Document maintained by: John Tanner
CalOptima Health Chief Compliance Officer

CalOptima Health - A Public Agency
505 City Parkway West | Orange, CA 92868 | www.CalOptimaHealth.org
Main: 714-246-8400 | TTY: 711

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Message from Chief Compliance Officer (CCO)

CalOptima Health is committed to its mission "to serve member health with excellence and dignity, respecting the value and needs of each person." Foundational to fulfilling this commitment is conducting ourselves in an ethical and compliant manner in the course of our daily activities and interactions. CalOptima Health expects all employees, contractors, officers, board members, network providers, subcontractors and downstream contractors act ethically and have a responsibility in ensuring compliance.

This document is a guide with 11 principles and related standards to provide a framework for CalOptima Health's Code of Conduct and how we are to conduct ourselves in serving our members. Please review this Code of Conduct and reach out to the Chief Compliance Officer or a representative from the Office of Compliance if you have any questions regarding this information.

It is incumbent upon all Board members, employees, providers and contractors to report any potential issues of non-compliance or misconduct. Reporting can be done online via the InfoNet or the CalOptima Health website, email, or phone.

You also have the option to anonymously report issues to the:

Compliance and Ethics Hotline at 1-855-507-1805

If you are unsure of a particular matter or situation, talk to your supervisor or a representative from the Office of Compliance to discuss your concerns and get guidance. Conducting our business compliantly and ethically is key to sustaining our business and maintaining our focus in serving our members.

Thank you for your dedication to serving our members and to following this Code of Conduct.

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Code of Conduct 11 Principles

1. **Mission, Vision, and Values:**
   CalOptima Health is committed to its Mission, Vision, and Values

2. **Member Rights:**
   CalOptima Health is committed to meeting the health care needs of its members by providing access to quality health care services.

3. **Compliance with the Law and Applicable Program Requirements:**
   CalOptima Health is committed to conducting all activities and operations in compliance with all applicable requirements and standards under its contract with DHCS and all and federal and state requirements including CMS requirements.

4. **Business Ethics:**
   In furtherance of CalOptima Health's commitment to the highest standards of business ethics, employees and contractors shall accurately and honestly represent CalOptima Health and shall not engage in any activity or scheme intended to defraud anyone of money, property, or honest services.

5. **Conflicts of Interests:**
   Board members, employees, and contractors owe a duty of undivided and unqualified loyalty to CalOptima Health.

6. **Public Integrity:**
   CalOptima Health and its Board members, employees, and contractors shall comply with laws and regulations governing public agencies.

7. **Confidentiality:**
   Board members, employees, and contractors shall maintain the confidentiality of all confidential information in accordance with applicable law and shall not disclose such confidential information except as specifically authorized by CalOptima Health policies, procedures, and applicable laws.

8. **Compliance Program Reporting:**
   Board members, employees, and contractors have a duty to comply with CalOptima Health's Compliance Program and such duty shall be a condition of their respective appointment, employment, or engagement.

9. **Discrimination:**
   CalOptima Health acknowledges that fair and equitable treatment of employees, contractors, members, providers, and other persons is fundamental to fulfilling its mission and goals.

10. **Participation Status:**
    CalOptima Health requires that employees, contractors, providers, and suppliers meet Government requirements for participation in CalOptima Health's programs.

11. **Government Inquiries/Legal Disputes:**
    Employees and contractors shall notify CalOptima Health upon receipt of Government inquiries and shall not destroy or alter documents in response to a government request for documents or information.

Code of Conduct Principles and Standards

Principle	Standard
1. Mission, Vision, and Values CalOptima Health is committed to its Mission, Vision, and Values	**Mission** To serve member health with excellence and dignity, respecting the value and needs of each person. **Vision by 2027** • CalOptima Health Same-Day Treatment Authorizations • Real-Time Claims Payments • Annual Assessments of Member's Social Determinants of Health. **Values = CalOptima Health CARES** **C**ollaboration; **A**ccountability; **R**espect; **E**xcellence; **S**tewardship
2. Member Rights CalOptima Health is committed to meeting the health care needs of its members by providing access to quality health care services.	**Member Choice, Access to Health Care Services, Continuity of Care** Employees and contractors shall comply with CalOptima Health policies and procedures and applicable law governing member choice, access to health care services, and continuity of member care. Employees and contractors shall comply with all requirements for coordination of medical and support services for persons with special needs. **Health Equity** Employees and contractors shall endeavor to address and prioritize health equity in the design and implementation of CalOptima Health strategies and programs. **Cultural and Linguistic Services** CalOptima Health and contractors shall provide culturally, linguistically, and sensory appropriate services to CalOptima Health members to ensure effective communication regarding diagnosis, medical history, and treatment, and health education. **Disabled Member Access** CalOptima Health's facilities shall adhere to the requirements of Title III of the Americans with Disabilities Act of 1990 by providing access for disabled members. **Emergency Treatment** Employees and contractors shall comply with all applicable guidelines, policies and procedures, and laws governing CalOptima Health member access and payment of emergency services including, without limitation, the Emergency Medical Treatment and Active Labor Act ("EMTALA") and

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Principle	Standard
	state patient "anti-dumping" laws, prior authorization limitations, and payment standards. **Grievance and Appeals Processes** CalOptima Health, its physician groups, its Health Networks, and third-party administrators (TPA) shall ensure that CalOptima Health members are informed of their grievance and appeal rights including, the state hearing process, through member handbooks and other communications in accordance with CalOptima Health policies and procedures and applicable laws. Employees and contractors shall address, investigate, and resolve CalOptima Health member complaints and grievances in a prompt and nondiscriminatory manner in accordance with CalOptima Health policies and applicable laws.
3. Compliance with the Law and Applicable Program Requirements CalOptima Health is committed to conducting all activities and operations in compliance with applicable law and program requirements.	**Transparent, Legal, and Ethical Business Conduct** CalOptima Health is committed to conducting its business with integrity, honesty, and fairness and in compliance with all federal and state laws and regulations**,** and applicable requirements and standards under its Contract with DHCS. CalOptima Health expects all employees, contractors, officers, board of directors members, network providers, subcontractors, and downstream contractors to act ethically and are responsible for ensuring CalOptima Health compliance. **Obeying the Law** Board members, employees, and contractors (including First Tier and Downstream Entities included in the term "FDRs") shall not lie, steal, cheat, or violate any law in connection with their employment and/or engagement with CalOptima Health. **Fraud, Waste, & Abuse (FWA)** CalOptima Health shall refrain from conduct which would violate the Fraud, Waste, and Abuse laws. CalOptima Health is committed to the detection, prevention, and reporting of Fraud, Waste, and Abuse. CalOptima Health is also responsible for ensuring that Board members, employees, contractors, and FDRs receive appropriate FWA training as described in regulatory guidance. CalOptima Health's Compliance Plan, Anti-Fraud, Waste, and Abuse Plan and policies describe examples of Potential Fraud, Waste, and Abuse and discuss employee and contractor FWA obligations and potential Sanctions arising from relevant federal and state FWA laws. CalOptima Health expects and requires that its Board members, employees, and contractors do not participate in any conduct that may violate the FWA laws including federal and state anti-kickback laws, false claims acts, and civil monetary penalty laws.

Principle	Standard
	Political Activities CalOptima Health's political participation is limited by law. CalOptima Health funds, property, and resources are not to be used to contribute to political campaigns, political parties, and/or organizations. Board members, employees and contractors may participate in the political process on their own time and at their own expense but shall not give the impression that they are speaking on behalf of or representing CalOptima Health in these activities. **Anti-Trust** All Board members, employees, and contractors must comply with applicable antitrust, unfair competition, and similar laws which regulate competition. Such persons shall seek advice from legal counsel if they encounter any business decisions involving a risk of violation of antitrust laws. The types of activities that potentially implicate antitrust laws include, without limitation, agreements to fix prices, bid rigging, and related activities; boycotts, certain exclusive dealings, and price discrimination agreements; unfair trade practices; sales or purchases conditioned on reciprocal purchases or sales; and discussion of factors determinative of prices at trade association meetings.
4. Business Ethics In furtherance of CalOptima Health's commitment to the highest standards of business ethics, employees and contractors shall accurately and honestly represent CalOptima Health and shall not engage in any activity or scheme intended to defraud anyone of money, property, or honest services.	**Candor & Honesty** CalOptima Health requires candor and honesty from individuals in the performance of their responsibilities and in communications including, communications with CalOptima Health's Board of Directors, supervisory employees, attorneys, and auditors. No Board member, employee, or contractor shall make false or misleading statements to any members and/or persons, or entities, doing business with CalOptima Health about products or services of CalOptima Health. **Financial and Data Reporting** All financial reports, accounting records, research reports, expense accounts, data submissions, attestations, timesheets, and other documents must accurately and clearly represent the relevant facts and the true nature of a transaction. CalOptima Health maintains a system of internal controls to ensure that all transactions are executed in accordance with Management's authorization and recorded in a proper manner to maintain accountability of the agency's assets. Improper or fraudulent accounting documentation or financial reporting or false or misleading encounter, claims, cost, or other required regulatory data submissions is contrary to the

Principle	Standard
	policy of CalOptima Health and may be in violation of applicable laws and regulatory obligations. **Regulatory Agencies and Accrediting Bodies** CalOptima Health will deal with all Regulatory Agencies and accrediting bodies in a direct, open, and honest manner. Employees and contractors shall not take action with Regulatory Agencies and accrediting bodies that is false or misleading.

5. Conflicts of Interests Board members, employees, and contractors owe a duty of undivided and unqualified loyalty to CalOptima Health.	**Conflicts of Interest** Designated employees and contractors shall comply with the requirements of GA.8012: Conflicts of Interest (policy), and applicable laws. Board members, employees, and contractors are expected to conduct their activities to avoid impropriety and/or the appearance of impropriety, which might arise from the influence of those activities on business decisions of CalOptima Health, or from disclosure of CalOptima Health's business operations. In addition to these provisions, designated employees are also subject to the provisions of the Conflict of Interest Code adopted by the CalOptima Health Board of Directors in compliance with the California Government Code. Designated employees must complete a Form 700 Statement of Economic Interests and a CalOptima Health Supplement to Form 700 upon hire, annually, and upon separation of employment. The HR department coordinates this activity with the CalOptima Health Clerk of the Board. CalOptima Health Policy GA.8012: Conflicts of Interest describes in detail prohibited conflicts of interest relative to your employment with CalOptima Health. One aspect of particular interest are conflicts related to family members. As noted in CalOptima Health Policy GA.8012: Conflicts of Interest: • If an employee or an employee's immediate family member, as defined in the Political Reform Act, has a financial or employment relationship with a current or potential provider, supplier, vendor, consultant or member, the employee must disclose this fact in writing to HR. ○ For example, if CalOptima Health is considering contracting with a vendor for which your brother is an employee, you must disclose this in writing to HR. • CalOptima Health Employees shall not handle member or provider issues, applications, requests, or cases on behalf of CalOptima Health for member(s) of the employee's own family or for personal friends. For further specific information on Conflicts of Interest; Gifts, Honoraria, and Travel Payments; and Solicitation and Receipts of Gifts see CalOptima Health Policies GA.8012: Conflicts of Interest, AA.1204: Gifts, Honoraria, and Travel Payments, and AA.1216: Solicitation and Receipt of Gifts to CalOptima Health. If you have any questions regarding these policies, you may reach out to the Chief Human Resources Officer or the Chief Compliance Officer.

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Principle	Standard
6. Public Integrity CalOptima Health and its Board members, employees, and contractors shall comply with laws and regulations governing public agencies.	**Public Records** CalOptima Health shall provide access to CalOptima Health Public Records to any person, corporation, partnership, firm, or association requesting to inspect and copy them in accordance with the California Public Records Act, California Government Code Sections 6250 et seq. and CalOptima Health policies. **Public Funds** CalOptima Health, its Board members, employees, and contractors shall not make gifts of public funds or assets or lend credit to private persons without adequate consideration unless such actions clearly serve a public purpose within the authority of the agency and are otherwise approved by legal counsel. CalOptima Health, its Board members, employees, and contractors shall comply with applicable law and CalOptima Health policies governing the investment of public funds and expenditure limitations. **Public Meetings** CalOptima Health, its Board members, employees, and contractors shall comply with requirements relating to the notice and operation of public meetings in accordance with the Ralph M. Brown Act, California Government Code Sections 54950 et seq.
7. Confidentiality Board members, employees, and contractors shall maintain the confidentiality of all confidential information in accordance with applicable law and shall not disclose such confidential information except as specifically authorized by CalOptima Health policies, procedures, and applicable laws.	**No Personal Benefit** Board members, employees and contractors shall not use confidential or proprietary CalOptima Health information for their own personal benefit or for the benefit of any other person or entity, while employed at, or engaged by, CalOptima Health, or at any time thereafter. **Duty to Safeguard Member Confidential Information** CalOptima Health recognizes the importance of its members' right to confidentiality and implements policies and procedures to ensure its members' confidentiality rights and the protection of medical and other confidential information. Board members, employees and contractors shall safeguard CalOptima Health member identity, eligibility, social security, medical information and other confidential information in accordance with applicable laws including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH Act) and implementing regulations, the California Security Breach Notification Law, the California Confidentiality of Medical Information Act, other applicable federal and state privacy laws, and CalOptima Health's policies and procedures.

Principle	Standard
	Personnel Files Personal information contained in employee personnel files shall be maintained in a manner designed to ensure confidentiality in accordance with applicable laws. **Proprietary Information** Subject to its obligations under the Public Records Act, CalOptima Health shall safeguard confidential proprietary information including, without limitation, contractor information and proprietary computer software, in accordance with and, to the extent required by contract or law. CalOptima Health shall safeguard provider identification numbers including, without limitation, Medi-Cal license, Medicare numbers, social security numbers, and other identifying numbers.
8. Compliance Program Reporting Board members, employees, and contractors have a duty to comply with CalOptima Health's Compliance Program and such duty shall be a condition of their respective appointment, employment, or engagement.	**Reporting Requirements** In alignment with CalOptima Health's reporting policies, all Board members, employees and contractors are expected and required to promptly report suspected violations of any statute, regulation, or guideline applicable to Federal and/or State health care programs or of CalOptima Health's policies and Compliance Plan.. Such reports may be made to a Supervisor, the Chief Compliance Officer or may also be made to CalOptima Health's Compliance and Ethics Hotline number below. Persons making reports to the hotline can do so on an anonymous basis. **Compliance and Ethics Hotline: 1-855-507-1805** **Disciplinary Action** Failure to comply with the Compliance Program, including the Code of Conduct, policies, and/or applicable statutes, regulations and guidelines may lead to disciplinary action. Discipline for failure to abide by the Code of Conduct may, in CalOptima Health's discretion, range from oral correction to termination in accordance with CalOptima Health's policies. In addition, failure to comply may result in the imposition of civil, criminal, or administrative fines on the individual, or entity, and CalOptima Health or Exclusion or Preclusion from participation in Federal and/or State health care programs. **Training and Education** CalOptima Health provides training and education to Board members, employees, contractors, and FDRs. Timely completion of compliance and

Principle	Standard
	HIPAA training is mandatory for all CalOptima Health employees and contractors. **Non-Retaliation Policy** CalOptima Health prohibits retaliation against any individual who reports discrimination, harassment, or compliance concerns, or participates in an investigation of such reports, in good faith. Employees and contractors involved in any retaliatory acts may be subject to discipline, up to and including termination of employment. **Referrals of FWA to Government Agencies** CalOptima Health is obligated to coordinate compliance activities with federal and state regulators. Employees and contractors shall comply with CalOptima Health policies related to FWA referral requirements to federal and state regulators, delegated program integrity contractors, and law enforcement agencies. **Certification** All Board members, employees, and contractors are required to certify, in writing, that they have received, read, understand, and will abide by the Code of Conduct and applicable policies.
9. Discrimination CalOptima Health acknowledges that fair and equitable treatment of employees, contractors, members, providers, and other persons is fundamental to fulfilling its mission and goals.	**No Discrimination** CalOptima Health is committed to compliance with applicable anti-discrimination laws including Title VI of the Civil Right Act of 1964. Board members, employees and contractors shall not unlawfully discriminate on the basis of race, color, national origin, creed, ancestry, religion, language, age, marital status, gender (which includes sex, gender identity, gender transition status and gender expression), sexual orientation, health status, pregnancy, physical or mental disability, military status or any other classification protected by law. CalOptima Health is committed to providing a work environment free from discrimination and harassment based on any classification noted above. **Reassignment** CalOptima Health, physician groups, and Health Networks shall not reassign members in a discriminatory manner, including based on the enrollee's health status.
10. Participation Status CalOptima Health requires that employees,	**Federal and State Health Care Program Participation Status** Board members, employees, and contractors shall not be currently suspended, terminated, debarred, or otherwise ineligible to participate in any

Principle	Standard
contractors, providers, and suppliers meet Government requirements for participation in CalOptima Health's programs.	Federal or State health care program, including the Medi-Cal program and Medicare programs. **CalOptima Health Screening** CalOptima Health will Monitor the participation status of employees, individuals and entities doing business with CalOptima Health by conducting regular Exclusion and Preclusion screening reviews in accordance with CalOptima Health policies. **Disclosure of Participation Status** Board members, employees and contractors shall disclose to CalOptima Health whether they are currently suspended, terminated, debarred, or otherwise ineligible to participate in any Federal and/or State health care program. Employees, individuals, and entities that do business with CalOptima Health shall disclose to CalOptima Health any pending investigation, disciplinary action, or other matter that could potentially result in their exclusion or preclusion from participation in any Federal or State health care program. **Delegated Third Party Administrator Review** CalOptima Health requires that its Health Networks, physician groups, and third-party administrators review participating providers and suppliers for licensure and participation status as part of the delegated credentialing and recredentialing processes when such obligations have been delegated to them. **Licensure** CalOptima Health requires that all employees, contractors, Health Networks, participating providers, and suppliers who are required to be licensed, credentialed, certified, and/or registered in order to furnish items or services to CalOptima Health and its members have valid and current licensure, credentials, certification and/or registration, as applicable.
11. Government Inquiries/Legal Disputes Employees and contractors shall notify CalOptima Health upon receipt of government inquiries and shall not destroy or alter	**Notification of Government Inquiry** Employees and contractors shall notify the Chief Compliance Officer and/or their supervisor immediately upon the receipt (at work or at home) of an inquiry, subpoena, or other agency or government requests for information regarding CalOptima Health. **No Destruction of Documents** Employees and contractors shall not destroy or alter CalOptima Health information or documents in anticipation of, or in response to, a request for

Principle	Standard
documents in response to a government request for documents or information.	documents by any governmental agency or from a court of competent jurisdiction. **Preservation of Documents Including Electronically Stored Information** Board members, employees, and contractors shall comply with all obligations to preserve documents, data, and records including, electronically stored information in accordance with CalOptima Health policies and shall comply with instructions on preservation of information and prohibitions and destruction of information issued by legal counsel.

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Orange County Health Authority
dba CalOptima Health

~~2024~~ 2025 Anti-Fraud, Waste, and Abuse (FWA) Plan

(Revised September 202~~3~~4)

Document maintained by: Fay Ho
CalOptima Health Director FWA ~~and Privacy Officer~~

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I. FRAUD, WASTE, AND ABUSE (FWA) PREVENTION AND DETECTION

The detection, prevention, and remediation of FWA are components of CalOptima Health's Compliance Program. FWA activities are implemented and overseen by CalOptima Health's Chief Compliance Officer, or his/her Designee. The Chief Compliance Officer, or his or her designee, shall also act as the Fraud Prevention Officer. Investigations are performed, or overseen, in conjunction with other compliance activities by the Special Investigations Unit (SIU), an internal investigative unit within CalOptima Health's Office of Compliance, responsible for FWA investigations.

The Chief Compliance Officer, or his/her Designee, reports FWA activities to the CalOptima Health Compliance Committee, Chief Executive Officer, the CalOptima Health Board, and Regulatory Agencies. The Anti-Fraud, Waste, and Abuse (FWA) Plan has been developed in accordance with the following federal and state statutes, regulations, and guidelines:

- Applicable state laws and contractual requirements
- Civil False Claims Act, 31 U.S.C. §§3729-3733
- Criminal False Claims Act, 18 U.S.C. §287
- Anti-Kickback Statute, 42 U.S.C. §1320a-7b
- 42 C.F.R. 422 and 423
- 42 C.F.R. 438.608
- Applicable regulatory guidance

CalOptima Health utilizes various resources to detect, prevent, and remediate FWA. In addition, CalOptima Health promptly investigates suspected FWA issues and may implement disciplinary, or corrective, action to avoid recurrence of FWA issues. The objective of the FWA program is to ensure that the scope of benefits covered by the CalOptima Health Programs is appropriately delivered to members and resources are effectively utilized in accordance with federal and state guidelines. CalOptima Health incorporates a system of internal assessments which are organized to identify FWA and promptly respond appropriately to such incidents of FWA.

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II. DEFINITIONS

Abuse ("Abuse") means practices that are inconsistent with sound fiscal and business practices or medical standards, and result in an unnecessary cost to a CalOptima Health Program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to the CalOptima Health Programs.~~actions that may, directly or indirectly, result in unnecessary costs to a CalOptima Health program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.~~

Fraud ("Fraud") means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with Title 42 Code of Federal Regulations section 455.2, Welfare and Institutions Code section 14043.1(i).~~knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. § 1347).~~

Waste ("Waste") means the overutilization or inappropriate utilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Health Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.~~the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Health program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.~~

III. FWA TRAINING

FWA training is provided to all Board Members, contractors, and employees as part of the overall compliance training courses in order to help detect, prevent, and remediate FWA in accordance with CalOptima Health Policy HH.2023: Compliance Training. First-tier, downstream and related ~~parties~~ entities (FDRs) are also required to complete FWA training. CalOptima Health's FWA training provides guidance to Board Members, employees, contractors, and FDRs on how to identify activities and behaviors that would constitute FWA and how to report suspected, or actual, FWA activities. Training materials are retained for a period of at least ten (10) years, and such training includes, but is not limited to:

- ► The process for detection, prevention, and reporting of suspected or actual FWA;
- ► Common types of member FWA and FDR FWA as well as common local and national schemes relevant to managed care organization operations;
- ► Information on how to identify FWA in CalOptima Health Programs (e.g., suspicious activities suggesting CalOptima Health members, or their family members, may be engaged in improper drug utilization or drug-seeking behavior, conduct suggesting improper utilization, persons offering kickbacks for referring, etc.);

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- Information on how to identify potential prescription drug FWA (e.g., identification of significant outliers whose drug utilization patterns far exceed those of the average member in terms of cost or quantity, disproportionate utilization of controlled substances, use of prescription medications for excessive periods of time, misrepresenting the type of drug that was actually dispensed, excessive prescriptions by a particular physician, etc.);
- How to report potential FWA using CalOptima Health's reporting options, including CalOptima Health's Compliance and Ethics Hotline;
- CalOptima Health's policy of non-retaliation and non-retribution toward individuals who make such reports in good faith; and
- Information on the False Claims Act and CalOptima Health's requirement to train employees and FDRs on the False Claims Act and other applicable FWA laws.

CalOptima Health shall provide Board Members, employees, contractors, FDRs, and members with reminders and additional training and educational materials through print and electronic communications, including, but not limited to, newsletters, alerts, and/or applicable meetings.

IV. DETECTION OF FWA

a. Data Sources

In partnership with CalOptima Health internal departments, CalOptima Health's SIU utilizes different sources and analyzes various data in an effort to detect patterns of FWA. Members, FDRs, employees, contractors, law enforcement and Regulatory Agencies, and others may contact CalOptima Health by phone, mail, and email if they suspect any individual, or entity, is engaged in inappropriate practices. Furthermore, the sources identified below can be used to identify problem areas within CalOptima Health, such as enrollment, finance, or other relevant data.

Sources used to detect FWA include, but are not limited to:

- CalOptima Health's Compliance and Ethics Hotline or other reporting mechanisms;
- Claims data history;
- Encounter data;
- Medical record audits;
- Member and provider complaints, appeals, and grievance reviews;
- Utilization Management reports;
- Provider utilization profiles;
- Pharmacy data;
- Auditing and monitoring activities;
- Monitoring external health care FWA cases and determining if CalOptima Health's FWA Program can be strengthened with information gleaned from the case activity; and/or
- Internal and external surveys, reviews, and audits.

b. Data Analytics

CalOptima Health uses technology and data analyses to reduce FWA externally. Using a combination of industry standard edits and CalOptima Health-specific edits, CalOptima Health identifies claims for which procedures have been unbundled or upcoded. CalOptima Health also identifies suspect FDRs based on billing patterns.

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CalOptima Health also uses the services of an external Medicare Secondary Payer (MSP) Vendor to reduce costs associated with its Medicare-Medicaid programs, such as the OneCare, and/or PACE programs, by ensuring that federal and state funds are not used where certain health insurance, or coverage, is primarily responsible.

c. Analysis and Identification of Risk Areas Using Claims Data

Claims data are analyzed in numerous ways to uncover fraudulent billing schemes. Routine review of claims data will be conducted in order to identify unusual patterns, outliers in billing and utilization, and identify the population of providers and pharmacies that will be further investigated and/or audited. Any medical claim can be pended and reviewed, in accordance with applicable state or federal law if they meet certain criteria that warrant additional review. Payments for pharmacy claims may also be pended and reviewed in accordance with applicable state or federal law based on criteria focused on the types of drugs (e.g., narcotics), provider patterns, and suspicious activities reported pertaining to pharmacies. CalOptima Health along with the Pharmacy Benefit Manager (PBM) will conduct data mining activities in order to identify potential issues of prescription or pharmacy FWA.

The following trends are reviewed and flagged for potential FWA, including:

- Overutilized services;
- Aberrant provider billing practices;
- Abnormal billing in relation to peers;
- Manipulation of modifiers;
- Unusual coding practices such as excessive procedures per day, or excessive surgeries per patient;
- Unbundling of services;
- Unusual Durable Medical Equipment (DME) billing; and/or
- Unusual utilization patterns by members and providers.

The following claims data may be utilized to evaluate and uncover fraudulent billing schemes:

- Average dollars paid per medical procedure;
- Average medical procedures per office visit;
- Average visits per member;
- Average distance a member travels to see a provider/pharmacy;
- Excessive patient levels of high-risk diagnoses;
- Peer to peer comparisons within specialties;
- Analysis of provider medical billing activity within their own peer group;
- Analysis of pharmacy billing and provider prescribing practices;
- Controlled drug prescribing exceeds two (2) standard deviations of the provider's peer group; and/or
- Number of times a provider bills a CPT code in relation to all providers, or within their own peer group.

The claims data from the PBM go through the same risk assessment process. The analysis may be focused on the following characteristics:

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- Prescription drug shorting, which occurs when pharmacy staff provides less than the prescribed quantity and intentionally does not inform the member or arranges to provide the balance but bills for the prescribed amount.
- Bait and switch pricing, which occurs when a member is led to believe that a drug will cost one (1) price, but at the point of sale, they are charged a higher amount. An example of this type of scheme is when the pharmacy switches the prescribed medication to a form that increases the pharmacy's reimbursement.
- Prescription forging, or altering, which occurs when existing prescriptions are altered to increase the quantity or the number of refills, without the prescriber's authorization. Usually, the medications are diverted after being billed to the Medicare Part D program.
- Dispensing expired, or adulterated, prescription drugs, which occurs when pharmacies dispense drugs after the expiration date on the package. This also includes drugs that are intended as samples not for sale or have not been stored or handled in accordance with manufacturer and FDA requirements.
- Prescription refill errors, which occur when pharmacy staff deliberately provides several refills different from the number prescribed by the provider.
- Failure to offer negotiated prices, which occurs when a pharmacy charges a member the wrong amount.

d. Sample Indicators

No single indicator is evidence of FWA. The presence of several indicators may suggest FWA, but further investigation is needed to determine if a suspicion of FWA exists. The following list below highlights common industry indicators and red flags that are used to determine whether to investigate an FDR or their claim disposition:

- Claims that show any altered information (dates, codes, names).
- Photocopies of claim forms and bills, or handwritten claims and bills.
- Provider's last name is the same as the member/patient's last name.
- The insured's address is the same as the servicing provider.
- Same provider submits multiple claims for the same treatment for multiple family members or group members of provider's practice.
- Provider resubmitting claim with changed diagnosis code for a date of service already denied.

Cases identified through these data sources and risk assessments are entered into the FWA case management system and a reports are routinely generated and shared with the Chief Compliance Officer and Compliance Committee. In addition, the Chief Compliance Officer, and/or his/her Designee, shall attend the quarterly DHCS Program Integrity meetings, as scheduled.

V. FWA INVESTIGATIVE PROCESS

Once the SIU receives an allegation of suspected FWA or detects FWA through an evaluation of the data sources identified above, the SIU utilizes the following steps as a guide to investigate and document the case:

- The allegation is logged into the case management system;

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- The allegation is assigned an investigation number (sequentially by year of receipt) and an electronic file is assigned on the internal drive by investigation number and name;
- SIU develops an investigative plan;
- SIU obtains a legal opinion from legal counsel on specific cases or issues, as necessary;
- Quality of care issues are referred to CalOptima Health's Quality Improvement Department;
- Where appropriate, SIU will submit a Request for Information (RFI) directly to an FDR to obtain relevant information;
- SIU interviews the individual who reported the FWA, affected members and/or FDRs, or any other potential witnesses, as appropriate;
- SIU conducts a data analytics review of the allegation for overall patterns, trends, and errors using applicable data sources and reports;
- Review of FDR enrollment applications, history, and ownership~~, as necessary;~~
- Review of member enrollment applications and other documents, as necessary;
- Review of applicable contracts and/or All Plan Letters (APLs);
- Discuss allegation and evidence collected with subject matter experts~~, as necessary~~;
- All supporting documentation is scanned and saved in the assigned electronic file. Any pertinent information, gathered during the SIU review/investigation, is placed into the electronic file;
- After an allegation is logged into the case management system, the investigation is tracked to its ultimate conclusion;
- The FWA case report shall reflect all information gathered and documentation received to ensure timely receipt, review, and resolution, and report may be made to applicable state or federal agencies within mandated/required time periods~~, if appropriate~~;
- If a referral to another investigative agency is warranted, the information is collected, and a referral is made to the appropriate agency; and/or
- If the investigation results in recommendations for disciplinary or corrective actions, the results of the investigation may be reported to the Chief Compliance Officer, CEO, and Compliance Committee. If a CalOptima Health internal department or FDR has repeat disciplinary or corrective actions, SIU may report the issue(s) to the Compliance Committee for further action.

a. Referral to Enforcement Agencies

CalOptima Health's SIU shall coordinate timely referrals of potential FWA to appropriate Regulatory Agencies, or their designated program integrity contractors, including the CMS MEDIC, DHCS Audits and Investigations, and/or other enforcement agencies, in accordance with the applicable reporting procedures adopted by such enforcement agencies. FDRs shall report FWA to CalOptima Health within the time frames required by the applicable contract and in sufficient time for CalOptima Health to timely report to applicable enforcement agencies. Significant program non-compliance, or suspected FWA, should be reported to CMS and/or DHCS, as soon as possible after discovery, but no later than ten (10) business days to DHCS after CalOptima Health first becomes aware of and is on notice of such activity, and within thirty (30) calendar days to CMS MEDIC after a potential fraudulent or abusive activity is identified for a case impacting the OneCare or PACE programs.

Potential cases that should be referred include, but are not limited to:

- Suspected, detected, or reported criminal, civil, or administrative law violations;

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- ► Allegations that extend beyond CalOptima Health and involve multiple health plans, multiple states, or widespread schemes;
- ► Allegations involving known patterns of FWA;
- ► Patterns of FWA threatening the life, or well-being, of CalOptima Health members; and/or
- ► Schemes with large financial risk to CalOptima Health, or its members.

b. Findings, Response, and Remediation

Outcomes and findings of the investigation may include, but are not limited to, confirmation of violations, insufficient evidence of FWA, need for contract amendment, education and training requirement, recommendation of focused audits, additional investigation, continued monitoring, prepayment claim review, new policy implementation, and/or criminal or civil action. As appropriate, claims will be denied or reversed, chargebacks against future claims will be employed, and other payment recovery actions will be taken. ~~When the root cause of the potential FWA issue has been identified, the~~ The SIU will track and trend the FWA allegation and investigation, including, ~~but not limited to,~~ the data analysis performed, which shall be reported to the Compliance Committee on a quarterly basis. Investigation findings can be used to determine whether disciplinary, or corrective, action is appropriate, whether there is a need for a change in CalOptima Health's Policies and Procedures~~, and/or whether the matter should be reported to applicable state and federal agencies.~~.

In accordance with applicable CalOptima Health Policies and Procedures, CalOptima Health shall take appropriate disciplinary, or corrective, action against Board Members, employees, and/or FDRs related to validated instances of FWA. CalOptima Health will also assess FDRs for potential overpayments when reviewing and undertaking corrective actions. Corrective actions will be monitored by the Compliance Committee, and progressive discipline will be monitored by the Department of Human Resources, as appropriate. Corrective actions may include, but are not limited to, financial sanctions, regulatory reporting, CAPs, or termination of the delegation agreement, when permitted by the contract terms. Should such disciplinary, or corrective, action need to be issued, CalOptima Health's Office of Compliance will initiate review and discussion at the first Compliance Committee following the date of identification of the suspected FWA, the date of report to DHCS, or the date of FWA substantiation by DHCS subsequent to the report. If vulnerability is identified through a single FWA incident, the corrective action may be applied universally.

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Should there be any investigation or prosecution conducted by the Office of the Attorney General, Division of Medi-Cal Fraud and Elder Abuse (DMFEA), or the U.S. DOJ, CalOptima Health shall cooperate with the investigation, which may include, but is not limited to, providing information and access to records upon request.

VI. ANNUAL FWA EVALUATION

CalOptima Health's Compliance Committee shall periodically review and evaluate the FWA work plan, FWA activities, and its effectiveness as part of the overall Compliance Program Audit and Monitoring Activities. Revisions should be made based on industry changes, trends in FWA activities (locally and nationally), the OIG Work Plan, the CalOptima Health Compliance Plan, and other input from applicable sources.

VII. POLICIES AND PROCEDURES (P&Ps)

The CalOptima Health Policies and Procedures listed below are the primary means by which the Anti-Fraud, Waste and Abuse Plan is effectuated at CalOptima Health.

- GA.8022: Performance and Behavior Standards
- GG.1428: Pharmacy Management Medi-Cal Rx Responsibilities
- GG.1615: Corrective Action Plan for Practitioners and Organizational Providers
- HH.1105: Fraud, Waste, and Abuse Detection
- HH.1107: Fraud, Waste, and Abuse Investigation and Reporting
- HH.2002: Sanctions
- HH.2005: Corrective Action Plan
- HH.2007: Compliance Committee
- HH.2014: Compliance Program
- HH.2018: Compliance and Ethics Hotline
- HH.2019: Reporting Suspected or Actual FWA, Violations of Applicable Laws, and/or CalOptima Health Policies
- HH.2020: Conducting Compliance Investigations
- HH.2023: Compliance and FWA Training Programs
- HH.2028: Code of Conduct
- HH.3012: Non-retaliation for Reporting Violations
- HH.5000: Provider Overpayment Investigation and Determination

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- HH.5004: False Claims Act Education
- MA.5013: Pharmacy Audits and Reviews
- MA.6104: Opioid Medication Utilization Management

Orange County Health Authority
dba CalOptima Health

2025 Anti-Fraud, Waste, and Abuse (FWA) Plan

(Revised September 2024)

Document maintained by: Fay Ho
CalOptima Health Director FWA

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I. FRAUD, WASTE, AND ABUSE (FWA) PREVENTION AND DETECTION

The detection, prevention, and remediation of FWA are components of CalOptima Health's Compliance Program. FWA activities are implemented and overseen by CalOptima Health's Chief Compliance Officer, or his/her Designee. The Chief Compliance Officer, or his or her designee, shall also act as the Fraud Prevention Officer. Investigations are performed, or overseen, in conjunction with other compliance activities by the Special Investigations Unit (SIU), an internal investigative unit within CalOptima Health's Office of Compliance, responsible for FWA investigations.

The Chief Compliance Officer, or his/her Designee, reports FWA activities to the CalOptima Health Compliance Committee, Chief Executive Officer, the CalOptima Health Board, and Regulatory Agencies. The Anti-Fraud, Waste, and Abuse (FWA) Plan has been developed in accordance with the following federal and state statutes, regulations, and guidelines:

- Applicable state laws and contractual requirements
- Civil False Claims Act, 31 U.S.C. §§3729-3733
- Criminal False Claims Act, 18 U.S.C. §287
- Anti-Kickback Statute, 42 U.S.C. §1320a-7b
- 42 C.F.R. 422 and 423
- 42 C.F.R. 438.608
- Applicable regulatory guidance

CalOptima Health utilizes various resources to detect, prevent, and remediate FWA. In addition, CalOptima Health promptly investigates suspected FWA issues and may implement disciplinary, or corrective, action to avoid recurrence of FWA issues. The objective of the FWA program is to ensure that the scope of benefits covered by the CalOptima Health Programs is appropriately delivered to members and resources are effectively utilized in accordance with federal and state guidelines. CalOptima Health incorporates a system of internal assessments which are organized to identify FWA and promptly respond appropriately to such incidents of FWA.

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II. DEFINITIONS

Abuse ("Abuse") means practices that are inconsistent with sound fiscal and business practices or medical standards, and result in an unnecessary cost to a CalOptima Health Program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to the CalOptima Health Programs.

Fraud ("Fraud") means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with Title 42 Code of Federal Regulations section 455.2, Welfare and Institutions Code section 14043.1(i).

Waste ("Waste") means the overutilization or inappropriate utilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Health Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

III. FWA TRAINING

FWA training is provided to all Board Members, contractors, and employees as part of the overall compliance training courses in order to help detect, prevent, and remediate FWA in accordance with CalOptima Health Policy HH.2023: Compliance Training. First-tier, downstream and related entities (FDRs) are also required to complete FWA training. CalOptima Health's FWA training provides guidance to Board Members, employees, contractors, and FDRs on how to identify activities and behaviors that would constitute FWA and how to report suspected, or actual, FWA activities. Training materials are retained for a period of at least ten (10) years, and such training includes, but is not limited to:

- The process for detection, prevention, and reporting of suspected or actual FWA;
- Common types of member FWA and FDR FWA as well as common local and national schemes relevant to managed care organization operations;
- Information on how to identify FWA in CalOptima Health Programs (e.g., suspicious activities suggesting CalOptima Health members, or their family members, may be engaged in improper drug utilization or drug-seeking behavior, conduct suggesting improper utilization, persons offering kickbacks for referring, etc.);
- Information on how to identify potential prescription drug FWA (e.g., identification of significant outliers whose drug utilization patterns far exceed those of the average member in terms of cost or quantity, disproportionate utilization of controlled substances, use of prescription medications for excessive periods of time, misrepresenting the type of drug that was actually dispensed, excessive prescriptions by a particular physician, etc.);
- How to report potential FWA using CalOptima Health's reporting options, including CalOptima Health's Compliance and Ethics Hotline;
- CalOptima Health's policy of non-retaliation and non-retribution toward individuals who make such reports in good faith; and
- Information on the False Claims Act and CalOptima Health's requirement to train employees and FDRs on the False Claims Act and other applicable FWA laws.

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CalOptima Health shall provide Board Members, employees, contractors, FDRs, and members with reminders and additional training and educational materials through print and electronic communications, including, but not limited to, newsletters, alerts, and/or applicable meetings.

IV. DETECTION OF FWA

a. Data Sources

In partnership with CalOptima Health internal departments, CalOptima Health's SIU utilizes different sources and analyzes various data in an effort to detect patterns of FWA. Members, FDRs, employees, contractors, law enforcement and Regulatory Agencies, and others may contact CalOptima Health by phone, mail, and email if they suspect any individual, or entity, is engaged in inappropriate practices. Furthermore, the sources identified below can be used to identify problem areas within CalOptima Health, such as enrollment, finance, or other relevant data.

Sources used to detect FWA include, but are not limited to:

- CalOptima Health's Compliance and Ethics Hotline or other reporting mechanisms;
- Claims data history;
- Encounter data;
- Medical record audits;
- Member and provider complaints, appeals, and grievance reviews;
- Utilization Management reports;
- Provider utilization profiles;
- Pharmacy data;
- Auditing and monitoring activities;
- Monitoring external health care FWA cases and determining if CalOptima Health's FWA Program can be strengthened with information gleaned from the case activity; and/or
- Internal and external surveys, reviews, and audits.

b. Data Analytics

CalOptima Health uses technology and data analyses to reduce FWA externally. Using a combination of industry standard edits and CalOptima Health-specific edits, CalOptima Health identifies claims for which procedures have been unbundled or upcoded. CalOptima Health also identifies suspect FDRs based on billing patterns.

CalOptima Health also uses the services of an external Medicare Secondary Payer (MSP) Vendor to reduce costs associated with its Medicare-Medicaid programs, such as the OneCare, and/or PACE programs, by ensuring that federal and state funds are not used where certain health insurance, or coverage, is primarily responsible.

c. Analysis and Identification of Risk Areas Using Claims Data

Claims data are analyzed in numerous ways to uncover fraudulent billing schemes. Routine review of claims data will be conducted in order to identify unusual patterns, outliers in billing and utilization, and identify the population of providers and pharmacies that will be further investigated and/or audited. Any medical claim can be pended and reviewed, in accordance

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with applicable state or federal law if they meet certain criteria that warrant additional review. Payments for pharmacy claims may also be pended and reviewed in accordance with applicable state or federal law based on criteria focused on the types of drugs (e.g., narcotics), provider patterns, and suspicious activities reported pertaining to pharmacies. CalOptima Health along with the Pharmacy Benefit Manager (PBM) will conduct data mining activities in order to identify potential issues of prescription or pharmacy FWA.

The following trends are reviewed and flagged for potential FWA, including:

- Overutilized services;
- Aberrant provider billing practices;
- Abnormal billing in relation to peers;
- Manipulation of modifiers;
- Unusual coding practices such as excessive procedures per day, or excessive surgeries per patient;
- Unbundling of services;
- Unusual Durable Medical Equipment (DME) billing; and/or
- Unusual utilization patterns by members and providers.

The following claims data may be utilized to evaluate and uncover fraudulent billing schemes:

- Average dollars paid per medical procedure;
- Average medical procedures per office visit;
- Average visits per member;
- Average distance a member travels to see a provider/pharmacy;
- Excessive patient levels of high-risk diagnoses;
- Peer to peer comparisons within specialties;
- Analysis of provider medical billing activity within their own peer group;
- Analysis of pharmacy billing and provider prescribing practices;
- Controlled drug prescribing exceeds two (2) standard deviations of the provider's peer group; and/or
- Number of times a provider bills a CPT code in relation to all providers, or within their own peer group.

The claims data from the PBM go through the same risk assessment process. The analysis may be focused on the following characteristics:

- Prescription drug shorting, which occurs when pharmacy staff provides less than the prescribed quantity and intentionally does not inform the member or arranges to provide the balance but bills for the prescribed amount.
- Bait and switch pricing, which occurs when a member is led to believe that a drug will cost one (1) price, but at the point of sale, they are charged a higher amount. An example of this type of scheme is when the pharmacy switches the prescribed medication to a form that increases the pharmacy's reimbursement.
- Prescription forging, or altering, which occurs when existing prescriptions are altered to increase the quantity or the number of refills, without the prescriber's authorization. Usually, the medications are diverted after being billed to the Medicare Part D program.
- Dispensing expired, or adulterated, prescription drugs, which occurs when pharmacies dispense drugs after the expiration date on the package. This also includes drugs that are

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intended as samples not for sale or have not been stored or handled in accordance with manufacturer and FDA requirements.

- ► Prescription refill errors, which occur when pharmacy staff deliberately provides several refills different from the number prescribed by the provider.
- ► Failure to offer negotiated prices, which occurs when a pharmacy charges a member the wrong amount.

d. Sample Indicators

No single indicator is evidence of FWA. The presence of several indicators may suggest FWA, but further investigation is needed to determine if a suspicion of FWA exists. The following list below highlights common industry indicators and red flags that are used to determine whether to investigate an FDR or their claim disposition:

- ► Claims that show any altered information (dates, codes, names).
- ► Photocopies of claim forms and bills, or handwritten claims and bills.
- ► Provider's last name is the same as the member/patient's last name.
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- ► Same provider submits multiple claims for the same treatment for multiple family members or group members of provider's practice.
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Cases identified through these data sources and risk assessments are entered into the FWA case management system and a reports are routinely generated and shared with the Chief Compliance Officer and Compliance Committee. In addition, the Chief Compliance Officer, and/or his/her Designee, shall attend the quarterly DHCS Program Integrity meetings, as scheduled.

V. FWA INVESTIGATIVE PROCESS

Once the SIU receives an allegation of suspected FWA or detects FWA through an evaluation of the data sources identified above, the SIU utilizes the following steps as a guide to investigate and document the case:

- ► The allegation is logged into the case management system;
- ► The allegation is assigned an investigation number (sequentially by year of receipt) and an electronic file is assigned on the internal drive by investigation number and name;
- ► SIU develops an investigative plan;
- ► SIU obtains a legal opinion from legal counsel on specific cases or issues, as necessary;
- ► Quality of care issues are referred to CalOptima Health's Quality Improvement Department;
- ► Where appropriate, SIU will submit a Request for Information (RFI) directly to an FDR to obtain relevant information;
- ► SIU interviews the individual who reported the FWA, affected members and/or FDRs, or any other potential witnesses, as appropriate;
- ► SIU conducts a data analytics review of the allegation for overall patterns, trends, and errors using applicable data sources and reports;
- ► Review of FDR enrollment applications, history, and ownership

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- Review of member enrollment applications and other documents, as necessary;
- Review of applicable contracts and/or All Plan Letters (APLs);
- Discuss allegation and evidence collected with subject matter experts;
- All supporting documentation is scanned and saved in the assigned electronic file. Any pertinent information, gathered during the SIU review/investigation, is placed into the electronic file;
- After an allegation is logged into the case management system, the investigation is tracked to its ultimate conclusion;
- The FWA case report shall reflect all information gathered and documentation received to ensure timely receipt, review, and resolution, and report may be made to applicable state or federal agencies within mandated/required time periods;
- If a referral to another investigative agency is warranted, the information is collected, and a referral is made to the appropriate agency; and/or
- If the investigation results in recommendations for disciplinary or corrective actions, the results of the investigation may be reported to the Chief Compliance Officer, CEO, and Compliance Committee. If a CalOptima Health internal department or FDR has repeat disciplinary or corrective actions, SIU may report the issue(s) to the Compliance Committee for further action.

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- HH.1107: Fraud, Waste, and Abuse Investigation and Reporting
- HH.2002: Sanctions
- HH.2005: Corrective Action Plan
- HH.2007: Compliance Committee
- HH.2014: Compliance Program

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- HH.2018: Compliance and Ethics Hotline
- HH.2019: Reporting Suspected or Actual FWA, Violations of Applicable Laws, and/or CalOptima Health Policies
- HH.2020: Conducting Compliance Investigations
- HH.2023: Compliance and FWA Training Programs
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CalOptima Health

~~2024~~ 2025 HIPAA Privacy and Security Program

Protection of Member Health Information

(Revised September ~~2023~~2024)

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I. OBJECTIVES

This program description is a general introduction for all CalOptima Health employees to the privacy and security regulations dictated by the federal Health Insurance Portability and Accountability Act (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH), other federal and California privacy laws, as well as CalOptima HIPAA security and privacy policies and procedures. This program description will be updated as needed and reviewed on an annual basis.

It is expected that all CalOptima Health employees understand that it is their legal and ethical responsibility to preserve and protect the privacy, confidentiality and security of all confidential information in accordance with these laws, policies, and procedures.

All employees are expected to access, use, and disclose confidential information only in the performance of their duties or when required or permitted by law. Additionally, all employees must disclose information only to persons who have the right to receive that information.

II. HIPAA PRIVACY AND CONFIDENTIALITY OVERVIEW

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law which, in part, protects the privacy of individually identifiable member information, provides for the electronic and physical security of health and member medical information, and simplifies billing and other electronic transactions through the use of standard transactions and code sets (billing codes). HIPAA applies to all "covered entities" such as hospitals, physicians and other providers, health plans, their employees and other members of the covered entities' workforce. HIPAA privacy and security standards were updated in 2009 by the Health Information Technology for Economic and Clinical Health (HITECH) Act and in 2013 by the HIPAA Final Omnibus Rule.

Privacy and security are addressed separately in HIPAA under two distinct rules, the Privacy Rule and the Security Rule. The Privacy Rule sets the standards for how all protected health information (PHI) should be controlled. Privacy standards define what information must be protected, who is authorized to access, use or disclose information, what processes must be in place to control the access, use, and disclosure of information, and member rights.

The Security Rule defines the standards for covered entities' basic security safeguards to protect electronic protected health information (ePHI). Security is the ability to control access to electronic information, and to protect it from accidental or intentional disclosure to unauthorized persons and from alteration, destruction, or loss. The standards include administrative, technical, and physical safeguards designed to protect the confidentiality, integrity, and availability of ePHI.

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III. DEFINITION OF PROTECTED HEALTH INFORMATION (PHI)

The HIPAA privacy regulations apply to "protected health information" (PHI). This term is used throughout this HIPAA Privacy and Security Program as well as in the policies and procedures.

Protected Health Information (PHI) has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media (ePHI), or transmitted or maintained in any other form or medium. This information identifies the individual, or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima Health or its Business Associate(s) and relates to:

1. The past, present, or future physical or mental health or condition of a member;
2. The provision of health care to a member; or
3. Past, present, or future payment for the provision of health care to a member.

PHI excludes:

1. Education records covered by the Family Educational Rights and Privacy Act;
2. Health records held by post-secondary educational institutions; and
3. Employment records held by a covered entity in its role as employer.

Electronic Protected Health Information (EPHI) is individually identifiable health information that is transmitted by electronic media or maintained in electronic media.

What is not considered PHI?

Health information is not PHI if it is de-identified. De-identified information may be used without restriction and without member authorization. The de-identification standard provides a method for which health information can be designated as de-identified. This method requires the removal of all 18 identifying data elements listed in the regulations. To ensure that PHI is de-identified, two methods can be used to satisfy the Privacy Rule's de-identification standard as specific in 45 CFR §164.514(b)(1) Expert Determination, and 45 CFR §164.514(b)(2) Safe Harbor.

The identifiers of an individual or of relatives, employers, or household members of the individual, which must be removed, are:

1. Names;
2. Geographic subdivisions smaller than a State (addresses);
3. Elements of dates (except year) for dates directly related to an individual (birthdates);
4. Telephone numbers;
5. Fax numbers;

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6. Electronic mail addresses;
7. Social security numbers;
8. Medical records numbers;
9. Health plan beneficiary numbers;
10. Account numbers;
11. Certificate or license numbers;
12. Vehicle identifiers and serial numbers (license plate numbers);
13. Device identifiers and serial numbers;
14. Web Universal Resource Locators (URLs);
15. Internet Protocol (IP) address numbers;
16. Biometric identifiers (finger, eye, and voice prints);
17. Full face photographic images and any comparable images; and
18. Any other unique identifying number, characteristic, or code, except as permitted by paragraph c of 45 CFR §164.514(b)(2).

What member information must we protect?

We must protect all PHI including, but not limited to medical/clinical records, prescriptions, billing records, claim data, referral authorizations, member notifications such as explanation of benefits and other member materials including marketing materials that contain PHI.

We have implemented controls, as well as policies and procedures, for protecting member information pertaining to race, ethnicity, language, gender identity[1], and sexual orientation[2].

IV. THE PRIVACY RULE AND THE SECURITY RULE

Purpose of Privacy Rule

The purpose of the Privacy Rule is to protect and enhance the rights of members by providing them access to their health information and controlling the inappropriate use of that information.

Highlights of Privacy Rule

The Privacy Rule requires that access to PHI, including ePHI, by CalOptima Health employees is based on the general principles of "need to know" and "minimum

[1] **Gender identity** is defined as an individual's innermost concept of self and experience of gender (how individuals perceive themselves and what they call themselves). An individual's gender identity may be the same or different from the sex assigned at birth.

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necessary," wherein access is limited only to the member information needed to perform a job function.

The Privacy Rule also affords certain rights to members, such as the right to request copies of their health records in paper or electronic format, or to request an amendment of information in their records.

Potential Consequences of Violating the Privacy Rule

The Privacy Rule imposes penalties for non-compliance and for breaches of privacy. These penalties range from $~~126~~ 137 per violation to $~~1,900,000~~2,067,813 per ~~year~~violation (with an annual penalty limit of $2,067,813), in addition to costs and attorneys' fees and costs, depending on the type of violation. In addition to civil monetary penalties, other consequences may include civil lawsuits, misdemeanor and felony charges, the reporting of individual violators to licensing boards for violations, and imprisonment.

Purpose of Security Rule

The Security Rule encompasses physical, administrative, and technical security, including computer systems and transmissions of ePHI. The rule's purpose is to:

- Ensure the confidentiality, integrity, and availability of all ePHI that is created, received, maintained, or transmitted by the covered entity.
- Protect against any reasonably anticipated threats or hazards to the security or integrity of ePHI.
- Protect against unauthorized uses or disclosures of ePHI.
- Ensure compliance of the covered entity's workforce.

Definition of Security

"**Security**" is defined as having controls, countermeasures, and procedures in place to ensure the appropriate protection of information assets, and to control access to valued resources. The purpose of security is to minimize the vulnerability of assets and resources.

Requirements and Responsibility for Security

CalOptima Health's Information Cybersecurity Department is responsible for maintaining, monitoring, storing and securing transmission of ePHI data along with oversight of all policies and procedures regarding the security of CalOptima Health information assets.

CalOptima Health employees are responsible for protecting all of CalOptima Health's electronic information resources under their control by employing appropriate and applicable security controls.

Protection of CalOptima Health electronic information resources encompasses:

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- Safeguarding ePHI from accidental or intentional disclosure to unauthorized persons.
- Safeguarding ePHI from accidental or intentional alteration, destruction, or loss.
- Safeguarding systems from viruses and malware.
- Taking precautions that will minimize the potential for theft, destruction, or any type of loss.
- Protecting workstations and mobile devices from unauthorized access and theft (e.g., via encryption, password authenticated access and physical lockdown) to ensure that ePHI is accessed, used, and/or disclosed only by authorized persons.
- Protecting other electronic assets and storage media (e.g., USB thumb drives, external hard drives, CD- ROM/DVD disks, floppy disks, magnetic tapes, videotapes, SD memory cards, etc.) from unauthorized access and theft, to ensure that ePHI contained within is accessed, used, and/or disclosed only by authorized persons.

V. WRITTEN POLICIES AND PROCEDURES FOR HIPAA PRIVACY PROGRAM

CalOptima Health's policies and procedures for the HIPAA Privacy and Security Program are located on CalOptima Health's intranet, InfoNet, which is accessible to all employees. Policies and procedures are available to CalOptima providers and health networks on CalOptima Health's website.

CalOptima Health maintains the written policies and procedures and other records related to implementation for ten years from the date created or the date last in effect, whichever is later.

VI. PRIVACY OFFICER, CHIEF INFORMATION SECURITY OFFICER AND COMPLIANCE COMMITTEE

The Privacy Officer and Chief Information Security Officer (CISO) shall work with the Compliance Committee to assist in the implementation of the HIPAA Privacy and Security Program. The Compliance Committee is chaired by the Chief Compliance Officer (CCO), and the members of the Compliance Committee are comprised of key stake holders in the HIPAA Privacy and Security Program, including the Privacy Officer, the CISO, Legal Counsel, Chief Executive Officer (CEO), and Chief Operations Officer (COO). This Committee is responsible for overseeing the following activities:

- Recommending and monitoring, in conjunction with the relevant business units or departments, the development of internal systems to carry out the privacy policies and procedures as part of daily operations;
- Determining the appropriate strategy/approach to promote compliance with the Privacy Program and Security Program and detection of any potential violations, such as through hotlines and other reporting mechanisms;

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- Developing a system to solicit, evaluate and respond to referrals for privacy investigations, security incidents and breaches;
- Monitoring ongoing operations for the purpose of identifying potentially deficient areas and implementing corrective and preventive action;
- Reviewing and tracking of possible confidentiality breaches that may be identified through incident reports, security incident reports, referrals for privacy investigations, etc.;
- Analyzing and data collecting of business processes, systems and relationships to understand the cause of a reportable security incident/HIPAA breach;
- Developing policies to better prevent or address reportable security incidents/HIPAA breaches; and
- Developing resolutions which stem from reportable security incidents/HIPAA breaches.

When a potential problem is identified, the Privacy Officer and the CISO may convene a designated group of individuals to serve on an ad hoc task force to provide assistance in investigating an incident, such as an unauthorized disclosure, implementing mitigation measures and/or designing protocols to prevent a recurrence in the future.

VII. GENERAL PROVISIONS ON SAFEGUARDS AND MITIGATION PROCEDURES

Security Safeguards

CalOptima Health has in place appropriate administrative, technical and physical safeguards to protect the privacy of health information in all forms including electronic and hard copy. CalOptima Health employees are trained and educated on the HIPAA Security regulations to ensure that reasonable measures are taken to safeguard PHI from any use or disclosure that would violate the HIPAA regulations or CalOptima's privacy policies. CalOptima Health employees have limited access to PHI through job-based access and password protection. CalOptima Health also has security tools in place to protect information from those who do not need to access PHI to perform their job functions. CalOptima Health's established physical safeguards include electronic building access, restricted area access, limited access to mailroom processing, clean desk policy and controlled system access to PHI for employees and contracted personnel to perform their job function.

CalOptima Health has processes to limit employee access to member PHI based on the employee's role and job description. Employees have an obligation to limit the use of PHI to the minimum necessary for their business purposes. CalOptima Health prohibits the use of employee-owned equipment within CalOptima Health's network and employees may not transfer PHI to any portable devices for storage or otherwise without the express permission of CalOptima Health's ITS Department, which if granted, will be processed in

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accordance with ITS policies and procedures. CalOptima Health data including member PHI may only be used in connection with business purposes.

E-mail Safeguards

E-mail communications between CalOptima Health and an external entity via the internet shall not contain member identifiable PHI unless the e-mail has been encrypted to safeguard the contents from being read by anyone other than the intended receiver. E-mail that is sent within CalOptima Health may contain member identifiable PHI but must be limited to the minimum necessary data required to complete the message.

Mass Disclosure Safeguards

Any large mailings that include PHI must be carefully reviewed to ensure that PHI is not inadvertently revealed to an unintended recipient. For example, this might include targeted mailings to members with specific health conditions or disease states (e.g., mailings to members with HIV). Electronic and non-electronic data must be appropriately safeguarded to ensure that PHI is protected, pursuant to CalOptima Health policies and procedures.

VIII. EDUCATION AND TRAINING PROGRAMS

CalOptima Health conducts regular training sessions on the HIPAA regulations, the CalOptima Health Privacy Program, the CalOptima Health ITS Cybersecurity awareness program, and the policies and procedures. All new employees are provided with training within a reasonable period at the New Employee Orientation. All CalOptima Health employees are also required to complete an annual mandatory online Compliance training, which includes a module on HIPAA privacy and security compliance. CalOptima Health shall maintain an annual log of training completion dates and assessment scores for all employees. Focused training will be provided as needed. Failure to complete the mandatory training within the specified timeframe may lead to disciplinary action up to and including termination of the employee.

CalOptima Health will periodically update the policies and procedures to reflect changes in operations or changes to applicable statutes and regulations. CalOptima Health will distribute the updates to affected employees and will provide additional training as necessary to ensure that employees and/or contracted personnel understand the revised policies and procedures.

IX. EFFECTIVE LINES OF COMMUNICATION

Member Complaint Procedure

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CalOptima Health has ~~in place~~ procedures in place for handling complaints from its members regarding implementation of and compliance with the HIPAA privacy regulations as well as State and Federal privacy laws. CalOptima Health's Notice of Privacy Practices directs members with complaints to contact CalOptima Health, the DHCS Privacy Officer, the Secretary of the Health and Human Services or the Office for Civil Rights. Upon receipt of a complaint, the Customer Service Department will provide a copy of each complaint to CalOptima Health's Privacy Officer and forward the complaint to the Grievance and Appeals Resolution Services Department (GARS). GARS will follow the same procedure as when handling other complaints submitted by CalOptima Health members. All responses and other documentation relating to a privacy complaint are maintained in the member's file and by the Privacy Officer for ten years from the date of the last communication on the complaint.

Access to Privacy Officer

The Privacy Officer maintains an open door policy for all employees and accepts e-mails, telephone messages or written memoranda regarding any privacy matter. Any individual who has a question or wants to report a potential privacy incident may bring such issues directly to the Privacy Officer, CCO, or CISO. Reports of potential privacy incidents may be made on an anonymous or identifiable basis directly to the Privacy Officer or through the Compliance Hotline at 1-855-507-1805.

Responsibility to Report

CalOptima Health is committed to compliance with the HIPAA and state privacy laws and to correcting violations wherever they may occur in the organization. Every employee is responsible for reporting any activity they suspect violates applicable privacy and security laws, rules, regulations or the HIPAA Privacy and Security Program. CalOptima Health must notify the Department of Health Care Services (DHCS) of any suspected or actual security incident and breaches of unsecure (unencrypted) protected information or other unauthorized use or disclosure of our members' PHI and provide a written report of the investigation. On an as needed basis, CalOptima Health shall notify the Centers for Medicare & Medicaid Services (CMS), and/or the Department of Health and Human Services, Office of Civil Rights (OCR), and/or the California Attorney General of actual privacy and security breaches. The Office of Compliance will maintain documentation of incidents, including the nature of any investigation, mitigation and corrective action. In addition, employees and members have the right to report violations to the California DHCS Privacy Officer or the Secretary of the Department of Health and Human Services (DHHS). Contact information is below:

C/O: Office of HIPAA Compliance
Department of Health Care Services
P.O. Box 997413, MS 4722
Sacramento, CA 95899-7413
Email: privacyofficer@dhcs.ca.gov
Phone: 1-916-445-4646

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Fax: 1-916-440-7680

OR

U.S. Department of Health and Human Services
Office for Civil Rights
Attention: Regional Manager
90 7th Street, Suite 4-100
San Francisco, CA 94103
(800) 368-1019 or FAX (415) 437-8329 or (800) 537-7697 TDD
Email: OCRComplaint@hhs.gov

In addition, employees who have observed a security incident or HIPAA breach (e.g., unsecured transmission of PHI, etc.) may contact the Compliance Hotline anonymously at: 1-855-507-1805, CalOptima Health's Privacy Officer at Privacy@caloptima.org, ~~,~~ or CISO.

Confidentiality and No Retaliation

CalOptima Health will not threaten, intimidate, discriminate, or take other retaliatory action against any individual for filing HIPAA complaints, assisting in HIPAA investigations or compliance reviews, or raising concerns with any act or practice that they suspect is in violation of HIPAA and/or state privacy laws when the individual has a good faith belief that the act may be unlawful.

X. ENFORCING STANDARDS THROUGH DISCIPLINARY GUIDELINES

All violators of the HIPAA Privacy and Security Program or of the policies and procedures will be subject to disciplinary action. The precise discipline will depend on the nature and severity of the violation.

Disciplinary Guidelines

Any employee who fails to comply with CalOptima Health's HIPAA Privacy and Security Program or its policies and procedures is subject to focused and/or additional training or discipline. In coordination with Human Resource policy GA.8022 Progressive Discipline, such discipline may include: 1) a verbal warning; 2) written warning; 3) suspension; or 4) termination. The type of discipline rendered will depend on the degree of wrongdoing, whether there have been past violations and the individual's cooperation in promptly reporting the incident to the appropriate manager or to the Privacy Officer. Intentional or reckless non-compliance will not be tolerated and will subject the employee to discipline up to and including termination of employment.

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CalOptima Health's Office of Compliance may require that an internal department or FDR develop a Corrective Action Plan based on the identified area(s) of non-compliance identified from the HIPAA and/or state privacy laws violation.

Consistent Enforcement of Policies

The range of disciplinary standards for improper conduct will be consistently applied and enforced. All personnel will be treated equally, and disciplinary action will be taken on a fair and equitable basis. CalOptima Health management must comply with and take action to ensure that their direct reports comply with the applicable policies and procedures.

Education on Disciplinary Guidelines

In the training sessions, all employees will be advised of the policy regarding disciplinary actions for non-compliance.

XI. RESPONSE TO DETECTED OFFENSES AND CORRECTIVE ACTION PLANS

Investigation and Corrective Action

If there is a report of non-compliance, or if the Privacy Officer, CISO, a member of the Compliance Committee, or a manager discovers credible evidence of a violation, an investigation will immediately ensue. When CalOptima Health substantiates a reported violation, it is the policy to institute corrective action.

Initiating Systemic Changes to Correct Problems

After a problem has been identified and corrected, the Privacy Officer, CISO, and the Compliance Committee will review the circumstances to determine: 1) whether similar problems have been uncovered elsewhere, and 2) whether modifications of the privacy policies and procedures are necessary to prevent and detect other inappropriate conduct or violations. The Privacy Officer and CISO will work with the Compliance Committee to initiate systemic changes throughout the company to avoid future problems of a similar nature.

Mitigation

If a suspected or actual use or disclosure occurs by CalOptima Health or a business associate that violates the HIPAA regulations and/or state privacy laws, CalOptima Health will take prompt corrective action to mitigate any damaging effects that the potential disclosure could have on the affected members as well as cure any system deficiencies to prevent future unauthorized uses or disclosures. CalOptima Health employees and FDRs are required to report any suspected or actual violation that they observe or learn about to his/her supervisor, or the Privacy Officer, CCO, or CISO immediately so that action to mitigate the damage can commence promptly.

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CalOptima Health

2025 HIPAA Privacy and Security Program

Protection of Member Health Information

(Revised September 2024)

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I. OBJECTIVES

This program description is a general introduction for all CalOptima Health employees to the privacy and security regulations dictated by the federal Health Insurance Portability and Accountability Act (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH), other federal and California privacy laws, as well as CalOptima HIPAA security and privacy policies and procedures. This program description will be updated as needed and reviewed on an annual basis.

It is expected that all CalOptima Health employees understand that it is their legal and ethical responsibility to preserve and protect the privacy, confidentiality and security of all confidential information in accordance with these laws, policies, and procedures.

All employees are expected to access, use, and disclose confidential information only in the performance of their duties or when required or permitted by law. Additionally, all employees must disclose information only to persons who have the right to receive that information.

II. HIPAA PRIVACY AND CONFIDENTIALITY OVERVIEW

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law which, in part, protects the privacy of individually identifiable member information, provides for the electronic and physical security of health and member medical information, and simplifies billing and other electronic transactions through the use of standard transactions and code sets (billing codes). HIPAA applies to all "covered entities" such as hospitals, physicians and other providers, health plans, their employees and other members of the covered entities' workforce. HIPAA privacy and security standards were updated in 2009 by the Health Information Technology for Economic and Clinical Health (HITECH) Act and in 2013 by the HIPAA Final Omnibus Rule.

Privacy and security are addressed separately in HIPAA under two distinct rules, the Privacy Rule and the Security Rule. The Privacy Rule sets the standards for how all protected health information (PHI) should be controlled. Privacy standards define what information must be protected, who is authorized to access, use or disclose information, what processes must be in place to control the access, use, and disclosure of information, and member rights.

The Security Rule defines the standards for covered entities' basic security safeguards to protect electronic protected health information (ePHI). Security is the ability to control access to electronic information, and to protect it from accidental or intentional disclosure to unauthorized persons and from alteration, destruction, or loss. The standards include administrative, technical, and physical safeguards designed to protect the confidentiality, integrity, and availability of ePHI.

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III. DEFINITION OF PROTECTED HEALTH INFORMATION (PHI)

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IX. EFFECTIVE LINES OF COMMUNICATION

Member Complaint Procedure

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CalOptima Health has procedures in place for handling complaints from its members regarding implementation of and compliance with the HIPAA privacy regulations as well as State and Federal privacy laws. CalOptima Health's Notice of Privacy Practices directs members with complaints to contact CalOptima Health, the DHCS Privacy Officer, the Secretary of the Health and Human Services or the Office for Civil Rights. Upon receipt of a complaint, the Customer Service Department will provide a copy of each complaint to CalOptima Health's Privacy Officer and forward the complaint to the Grievance and Appeals Resolution Services Department (GARS). GARS will follow the same procedure as when handling other complaints submitted by CalOptima Health members. All responses and other documentation relating to a privacy complaint are maintained in the member's file and by the Privacy Officer for ten years from the date of the last communication on the complaint.

Access to Privacy Officer

The Privacy Officer maintains an open door policy for all employees and accepts e-mails, telephone messages or written memoranda regarding any privacy matter. Any individual who has a question or wants to report a potential privacy incident may bring such issues directly to the Privacy Officer, CCO, or CISO. Reports of potential privacy incidents may be made on an anonymous or identifiable basis directly to the Privacy Officer or through the Compliance Hotline at 1-855-507-1805.

Responsibility to Report

CalOptima Health is committed to compliance with the HIPAA and state privacy laws and to correcting violations wherever they may occur in the organization. Every employee is responsible for reporting any activity they suspect violates applicable privacy and security laws, rules, regulations or the HIPAA Privacy and Security Program. CalOptima Health must notify the Department of Health Care Services (DHCS) of any suspected or actual security incident and breaches of unsecure (unencrypted) protected information or other unauthorized use or disclosure of our members' PHI and provide a written report of the investigation. On an as needed basis, CalOptima Health shall notify the Centers for Medicare & Medicaid Services (CMS), and/or the Department of Health and Human Services, Office of Civil Rights (OCR), and/or the California Attorney General of actual privacy and security breaches. The Office of Compliance will maintain documentation of incidents, including the nature of any investigation, mitigation and corrective action. In addition, employees and members have the right to report violations to the California DHCS Privacy Officer or the Secretary of the Department of Health and Human Services (DHHS). Contact information is below:

C/O: Office of HIPAA Compliance
Department of Health Care Services
P.O. Box 997413, MS 4722
Sacramento, CA 95899-7413
Email: privacyofficer@dhcs.ca.gov
Phone: 1-916-445-4646

Fax: 1-916-440-7680

OR

U.S. Department of Health and Human Services
Office for Civil Rights
Attention: Regional Manager
90 7th Street, Suite 4-100
San Francisco, CA 94103
(800) 368-1019 or FAX (415) 437-8329 or (800) 537-7697 TDD
Email: OCRComplaint@hhs.gov

In addition, employees who have observed a security incident or HIPAA breach (e.g., unsecured transmission of PHI, etc.) may contact the Compliance Hotline anonymously at: 1-855-507-1805, CalOptima Health's Privacy Officer at Privacy@caloptima.org, or CISO.

Confidentiality and No Retaliation

CalOptima Health will not threaten, intimidate, discriminate, or take other retaliatory action against any individual for filing HIPAA complaints, assisting in HIPAA investigations or compliance reviews, or raising concerns with any act or practice that they suspect is in violation of HIPAA and/or state privacy laws when the individual has a good faith belief that the act may be unlawful.

X. ENFORCING STANDARDS THROUGH DISCIPLINARY GUIDELINES

All violators of the HIPAA Privacy and Security Program or of the policies and procedures will be subject to disciplinary action. The precise discipline will depend on the nature and severity of the violation.

Disciplinary Guidelines

Any employee who fails to comply with CalOptima Health's HIPAA Privacy and Security Program or its policies and procedures is subject to focused and/or additional training or discipline. In coordination with Human Resource policy GA.8022 Progressive Discipline, such discipline may include: 1) a verbal warning; 2) written warning; 3) suspension; or 4) termination. The type of discipline rendered will depend on the degree of wrongdoing, whether there have been past violations and the individual's cooperation in promptly reporting the incident to the appropriate manager or to the Privacy Officer. Intentional or reckless non-compliance will not be tolerated and will subject the employee to discipline up to and including termination of employment.

CalOptima Health's Office of Compliance may require that an internal department or FDR develop a Corrective Action Plan based on the identified area(s) of non-compliance identified from the HIPAA and/or state privacy laws violation.

Consistent Enforcement of Policies

The range of disciplinary standards for improper conduct will be consistently applied and enforced. All personnel will be treated equally, and disciplinary action will be taken on a fair and equitable basis. CalOptima Health management must comply with and take action to ensure that their direct reports comply with the applicable policies and procedures.

Education on Disciplinary Guidelines

In the training sessions, all employees will be advised of the policy regarding disciplinary actions for non-compliance.

XI. RESPONSE TO DETECTED OFFENSES AND CORRECTIVE ACTION PLANS

Investigation and Corrective Action

If there is a report of non-compliance, or if the Privacy Officer, CISO, a member of the Compliance Committee, or a manager discovers credible evidence of a violation, an investigation will immediately ensue. When CalOptima Health substantiates a reported violation, it is the policy to institute corrective action.

Initiating Systemic Changes to Correct Problems

After a problem has been identified and corrected, the Privacy Officer, CISO, and the Compliance Committee will review the circumstances to determine: 1) whether similar problems have been uncovered elsewhere, and 2) whether modifications of the privacy policies and procedures are necessary to prevent and detect other inappropriate conduct or violations. The Privacy Officer and CISO will work with the Compliance Committee to initiate systemic changes throughout the company to avoid future problems of a similar nature.

Mitigation

If a suspected or actual use or disclosure occurs by CalOptima Health or a business associate that violates the HIPAA regulations and/or state privacy laws, CalOptima Health will take prompt corrective action to mitigate any damaging effects that the potential disclosure could have on the affected members as well as cure any system deficiencies to prevent future unauthorized uses or disclosures. CalOptima Health employees and FDRs are required to report any suspected or actual violation that they observe or learn about to his/her supervisor, or the Privacy Officer, CCO, or CISO immediately so that action to mitigate the damage can commence promptly.

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Attachment 6: Summary of Proposed Actions for Office of Compliance Policies and Procedures

Table 1: Revisions to the Office of Compliance Policies and Procedures

The following table lists the proposed revisions to the CalOptima Office of Compliance policies and procedures, by department.

POLICY & DEPARTMENT	REVISION & PROGRAM	A – NEW B – REVISED C – RETIREMENT D – REVISED [MINOR EDITS]: E – ANNUAL REVIEW [NO EDITS]:
HH.3024: Confidentiality of Medical Information Act Compliance *Privacy*	**A – NEW:** This new policy was developed to support requirements of the Confidentiality of Medical Information Act (CMIA). **Program(s):** Medi-Cal; OneCare; PACE Department Point(s) of Contact: Tamekia Mosley; Eric Royal; John Tanner	
AA.1270: Certification of Document and Data Submissions *Regulatory Affairs & Compliance*	**B – REVISED:** This policy was revised to add terms and references to appropriate regulations to ensure compliance with regulatory and interoperability requirements related to data, information, and documentation submitted to DHCS, to which a DHCS-approved certification statement applies. Additional updates involve the inclusion of language to clarify the responsibility of CalOptima Health's Provider Relations department to collect monthly data attestations from each delegated Health Network for data, information, and documentation submitted to CalOptima Health. Reference and glossary updates were also made to align with current contractual and regulatory guidelines. **Program(s):** Medi-Cal; OneCare Department Point(s) of Contact: Annabel Vaughn; John Tanner	

POLICY & DEPARTMENT	REVISION & PROGRAM	A – NEW B – REVISED C – RETIREMENT D – REVISED [MINOR EDITS]: E – ANNUAL REVIEW [NO EDITS]:
AA.1275: Department of Health Care Services (DHCS) File and Use Submission Process *Regulatory Affairs & Compliance*	**B – REVISED:** This policy was updated to clarify procedures performed by CalOptima Health's Regulatory Affairs & Compliance Medi-Cal (RAC Medi-Cal) department to verify readiness of and submit revised deliverables/submissions and policies, including the signed DHCS Medi-Cal Managed Care Plan File and Use Attestation Form to DHCS as File and Use. Glossary updates were also made to align with current contractual and regulatory guidelines. **Program(s):** Medi-Cal Department Point(s) of Contact: Annabel Vaughn; John Tanner	
GA.7505: Regulatory Liaison Responsibilities *Regulatory Affairs & Compliance*	**B – REVISED:** This policy was updated to clarify CalOptima Health's submission timeframe for revised Corrective Action Plans (CAPs) to DHCS for DHCS approval as being within 15 calendar days after receipt of DHCS's request for CAP revisions. Glossary updates were also made to align with current contractual and regulatory guidelines. **Program(s):** Administrative Department Point(s) of Contact: Annabel Vaughn; John Tanner	
HH.1105: Fraud, Waste, and Abuse Detection *Fraud, Waste & Abuse*	**B – REVISED:** This policy was updated to add additional sources in which CalOptima Health may receive complaints of suspected fraud, waste, and abuse (FWA), which include memorandums and resources from the Centers for Medicare and Medicaid Services (CMS) and referrals from the Department of Health Care Services (DHCS). Reference and glossary updates were also made to align with current contractual and regulatory guidelines. **Program(s):** Medi-Cal; OneCare; PACE Department Point(s) of Contact: Cynthia Valencia; Fay Ho; John Tanner	

POLICY & DEPARTMENT	REVISION & PROGRAM	A – NEW B – REVISED C – RETIREMENT D – REVISED [MINOR EDITS]: E – ANNUAL REVIEW [NO EDITS]:
HH.2005: Corrective Action Plan *Regulatory Affairs & Compliance*	**B – REVISED:** This policy was revised to provide additional elements to be included in an Immediate Corrective Action Plan (ICAP) and Corrective Action Plan (CAP) response, and the provision to make a publicly available report containing CAP status and action taken to close out findings by CalOptima Health's Office of Compliance on a quarterly basis to align with the 2024 DHCS MCP Contract. Attachment A, ICAP/CAP Request Template was also updated for formatting and language changes to align with the 2024 DHCS MCP Contract. Glossary updates were also made to align with current contractual and regulatory guidelines. **Program(s):** Medi-Cal; OneCare; PACE Department Point(s) of Contact: Annabel Vaughn; John Tanner	
HH.2007: Compliance Committee *Office of Compliance*	**B – REVISED:** This policy was updated to clarify the role of CalOptima Health's Compliance Committee, including procedures regarding designation and/or selection of its members, review of the Compliance Plan and responsibilities within CalOptima Health to align with the 2024 Department of Health Care Services (DHCS) Contract. Glossary updates were also made to align with current contractual and regulatory guidelines. **Program(s):** Medi-Cal; OneCare; PACE Department Point(s) of Contact: Annie Phillips; Annabel Vaughn; John Tanner	
HH.2014: Compliance Program *Office of Compliance*	**B – REVISED:** This policy was updated to clarify the review of CalOptima Health's Compliance Program will occur no less than annually, the roles of CalOptima Health's Board of Directors and Compliance Officer regarding the review, approval, and development of the Compliance Program, and requirements to publicly post the Compliance Plan on CalOptima Health's website. Glossary updates were also made to align with current contractual and regulatory guidelines. **Program(s):** Medi-Cal; OneCare; PACE; Administrative Department Point(s) of Contact: Annie Phillips; Annabel Vaughn; John Tanner	

POLICY & DEPARTMENT	REVISION & PROGRAM	A – NEW B – REVISED C – RETIREMENT D – REVISED [MINOR EDITS]: E – ANNUAL REVIEW [NO EDITS]:
HH.2022: Record Retention and Access *Regulatory Affairs & Compliance*	**B – REVISED:** This policy was updated for the addition of documentation of disciplinary actions for a period of at least ten (10) years to be included in CalOptima Health's and its First Tier, Downstream, and Related Entities (FDR's) requirements to retain and make available contracts, books, documents, records, and financial statements and reference CalOptima Health's Document Retention Schedule. Reference and glossary updates were also made to align with current contractual and regulatory guidelines. **Program(s):** Medi-Cal; OneCare; PACE Department Point(s) of Contact: Annie Phillips; Annabel Vaughn; John Tanner	
HH.2023: Compliance Training *Regulatory Affairs & Compliance*	**B – REVISED:** Language and grammatical revisions were made throughout this policy to provide clarity and improve readability. Attachment A, First Tier, Downstream, and Related Entities (FDR) Compliance Attestation was also updated to remove language regarding mail-in options. Glossary updates were also made to align with current contractual and regulatory guidelines. **Program(s):** Medi-Cal; OneCare; PACE Department Point(s) of Contact: Annie Phillips; Annabel Vaughn; John Tanner	
HH.2028: Code of Conduct *Regulatory Affairs & Compliance*	**B – REVISED:** This policy was updated to include language to ensure approval of the Code of Conduct by CalOptima Health's Board of Directors and clarify availability of the Code of Conduct on CalOptima Health's public website to align with the 2024 Department of Health Care Services (DHCS) Contract. Attachment A, CalOptima Health Code of Conduct was also added to this policy. Glossary updates were also made to align with current contractual and regulatory guidelines. **Program(s):** Medi-Cal; OneCare; PACE Department Point(s) of Contact: Annie Phillips; Annabel Vaughn; John Tanner	

POLICY & DEPARTMENT	REVISION & PROGRAM	A – NEW B – REVISED C – RETIREMENT D – REVISED [MINOR EDITS]: E – ANNUAL REVIEW [NO EDITS]:
HH.3000: Notice of Privacy Practices *Privacy*	**B – REVISED:** This policy was updated to clarify controls for physical/electronic access and impermissible/permissible uses of member data including Protected Health Information (PHI) and Personally Identifiable Information (PII). Language revisions were also applied for clarity in directives and procedural clarifications were made to outline elements that must be included in the content of the Notice of Privacy Practice (NPP) to align with the Health Insurance Portability and Accountability Act (HIPAA) Final Privacy Rule and Title 42 Code of Federal Regulations (C.F.R.) Part 2. The content throughout Attachment A, NPP was also updated to align with Title 42 C.F.R. Part 2, Health Equity (HE) Accreditation Standards, and Section 1157 Final Rule. Reference and glossary updates were also made to align with current contractual and regulatory guidelines. **Program(s):** Medi-Cal; OneCare; PACE Department Point(s) of Contact: Tamekia Mosley; Eric Royal; John Tanner	
HH.3002: Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls *Privacy*	**B – REVISED:** This policy was revised to add language referencing Personally Identifiable Information (PII) and to add reproductive health care as minimum necessary data. Procedures were also updated regarding the minimum disclosure of Protected Health Information (PHI), requests for PHI/PII and federal and state law criteria for determinations of requests for the release of PHI/PII by CalOptima Health's Privacy Officer or designee. Reference and glossary updates were also made to align with current contractual and regulatory guidelines and CalOptima Health policies. **Program(s):** Medi-Cal; OneCare; PACE Department Point(s) of Contact: Tamekia Mosley; Eric Royal; John Tanner	
HH.3008: Member Right to Request Confidential Communications *Privacy*	**B – REVISED:** This policy was revised to clarify processes for CalOptima Health's Customer Service department to route Request for Restriction on Manner/Method of Confidential Communications Forms to the Privacy department when completed and submitted by a member. Glossary updates were also made to align with current contractual and regulatory guidelines. **Program(s):** Medi-Cal; OneCare; PACE Department Point(s) of Contact: Tamekia Mosley; Eric Royal; John Tanner	

POLICY & DEPARTMENT	REVISION & PROGRAM	A – NEW B – REVISED C – RETIREMENT D – REVISED [MINOR EDITS]: E – ANNUAL REVIEW [NO EDITS]:
New Title **HH.3010:** Protected Health Information Disclosures Permitted and Required by Law *Privacy*	**B – REVISED:** This policy was updated to include language clarifying CalOptima Health's responsibility not to use or disclose PHI related to lawful Reproductive Health Care and procedures for attestation requirements for a use or disclosure of Reproductive Health Care related PHI for non-prohibited purposes to align with requirements of the HIPAA Privacy Final Rule and advisory by Legal. Attachment A, Attestation Regarding Requested Use or Disclosure of Protected Health Information Potentially Related to Reproductive Health Care was also added to this policy. Reference and glossary updates were also made to align with current contractual and regulatory guidelines. **Program(s):** Medi-Cal; OneCare; PACE Department Point(s) of Contact: Tamekia Mosley; Eric Royal; John Tanner	
Title Revision **HH.3014:** Use of Electronic Mail with Protected Health Information (PHI) and Personally Identifiable Information (PII) *Privacy*	**B – REVISED:** This policy was updated to include language referencing PHI/PII to align with the National Committee of Quality Assurance (NCQA) requirements and clarify references to CalOptima Health policies. Reference and glossary updates were also made to align with current contractual and regulatory guidelines and CalOptima Health policies. **Program(s):** Medi-Cal; OneCare; PACE Department Point(s) of Contact: Tamekia Mosley; Eric Royal; John Tanner	
HH.3016: Guidelines for Handling Protected Health Information (PHI) Offsite *Privacy*	**B – REVISED:** General guidelines within this policy were updated to clarify that CalOptima Health staff shall not access, use, or disclose any member Protected Health Information (PHI) via CalOptima Health's system without a business need. **Program(s):** Medi-Cal; OneCare; PACE Department Point(s) of Contact: Tamekia Mosley; Eric Royal; John Tanner	

POLICY & DEPARTMENT	REVISION & PROGRAM	A – NEW B – REVISED C – RETIREMENT D – REVISED [MINOR EDITS]: E – ANNUAL REVIEW [NO EDITS]:
Title Revision **HH.3020:** Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PII or other Unauthorized Use or Disclosure of PHI/PII *Privacy*	**B – REVISED:** This policy was updated to include language referencing PII throughout to align with the Health Plan Management System (HPMS) Memorandum: Update on Security and Privacy Breach Reporting Procedures. Updates were also made to include procedures regarding Centers for Medicare and Medicaid (CMS) reporting related to Health Information and Technology for Economic and Clinical Health (HITECH) breach notification regulations, notifications to the CMS Account Manager if there is potential for significant member harm, monthly breach reports by CalOptima Health's Privacy department, and notifications to PACE Account Managers regarding security and privacy breaches involving PACE participants. Attachment C, PACE Privacy Breach Notification Timeline and Summary Form was added to this policy. Reference and glossary updates were also made to align with current contractual and regulatory guidelines. **Program(s):** Medi-Cal; OneCare; PACE Department Point(s) of Contact: Tamekia Mosley; Eric Royal; John Tanner	
HH.3022: Business Associate Agreements *Privacy*	**B – REVISED:** This policy was revised to include language and directives regarding CalOptima Health's monitoring of its business associates. Procedural updates were also made to include regulatory amendments to Business Associate Agreements (BAAs) and compliance requirements for business associates via BAAs to provide more protections to member medical information. Provisional updates were made to Attachment C, CalOptima Health Business Associate Agreement Template, to ensure member medical information protection. Glossary updates were also made to align with current contractual and regulatory guidelines. **Program(s):** Medi-Cal; OneCare; PACE; Administrative Department Point(s) of Contact: Tamekia Mosley; Eric Royal; John Tanner	

POLICY & DEPARTMENT	REVISION & PROGRAM	A – NEW B – REVISED C – RETIREMENT D – REVISED [MINOR EDITS]: E – ANNUAL REVIEW [NO EDITS]:
HH.5000: Provider Overpayment Investigation and Determination *Fraud, Waste & Abuse*	**B – REVISED:** This policy was revised to include appropriate cross-reference to CalOptima Health policy(s) for maintaining medical records, update reference to former title 'Audit & Oversight Committee' to current title 'Delegation Oversight Committee (DOC),' add rendering provider NPI as an additional required detail to include in the "Overpayment Spreadsheet" to adequately review, investigate, and determine if claims were overpaid, and clarify timelines and procedures for notifying DHCS and/or CMS of overpayment determinations after the date CalOptima Health identified the overpayment. Reference and glossary updates were also made to align with current contractual and regulatory guidelines. **Program(s):** Medi-Cal; OneCare; PACE Department Point(s) of Contact: Cynthia Valencia; Fay Ho; John Tanner	

Table 2: Office of Compliance Policies and Procedures: Non-substantive Revisions

The following table contains the proposed list of policies without substantive revisions for the CalOptima Office of Compliance, by department.

POLICY	DEPARTMENT
HH.1107: Fraud, Waste, and Abuse Investigation and Reporting	*Fraud, Waste, and Abuse*
HH.5004: False Claims Act Education	*Fraud, Waste, and Abuse*
HH.4003: Annual Risk Assessment	*Internal Audit*
HH.3004: Member Request to Amend Records	*Privacy*
HH.3005: Member Request for Accounting of Disclosures	*Privacy*
HH.3006: Tracking and Reporting Disclosures of Protected Health Information (PHI)	*Privacy*
HH.3007: Member Rights to Request Restrictions on Use and Disclosure of Protected Health Information (PHI)	*Privacy*
HH.3009: Access by Member's Personal Representative	*Privacy*
HH.3011: Use and Disclosure of PHI for Treatment, Payment, and Health Care Operations	*Privacy*
HH.3019: De-identification of Protected Health Information (PHI)	*Privacy*
HH.3023: Information Sharing	*Privacy*
GA.7501: Regulatory Communications	*Regulatory Affairs & Compliance*
GA.7508: CalOptima Health Policy and Procedure Review Process	*Regulatory Affairs & Compliance*
HH.2002: Sanctions	*Regulatory Affairs & Compliance*
HH.2018: Compliance and Ethics Hotline	*Regulatory Affairs & Compliance*
HH.2019: Reporting Suspected or Actual Fraud, Waste, or Abuse (FWA) and Violations of Applicable Laws and Regulations and/or CalOptima Health Policies	*Regulatory Affairs & Compliance*
HH.2020: Conducting Compliance Investigations	*Regulatory Affairs & Compliance*
HH.2021: Exclusion and Preclusion Monitoring	*Regulatory Affairs & Compliance*

POLICY	DEPARTMENT
MA.9124: CMS Self-Disclosure	*Regulatory Affairs & Compliance*

Policy:	AA.1270
Title:	**Certification of Document and Data Submissions**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	*/s/*
Effective Date:	07/01/2017
Revised Date:	11/07/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy describes the process for certification of data, information, and documentation submitted to the Department of Health Care Services (DHCS) by CalOptima Health.

II. POLICY

A. In accordance with Title 42, Code of Federal Regulations (CFR), Sections 438.604 and 438.606 and contractual requirements, CalOptima Health shall certify data, information, and documentation submitted to DHCS.

B. CalOptima Health shall submit a completed and signed DHCS-approved certification statement on CalOptima Health letterhead by the final business day of each month to DHCS.

1. The signatory to the signed certification statement shall be the Chief Executive Officer (CEO), Chief Financial Officer (CFO), or an individual who reports directly to the CEO, or CFO, and has delegated authority to sign on his or her behalf. The CEO or CFO shall remain ultimately responsible for the certification and the data, information, and documentation submitted by CalOptima Health to DHCS.

2. The certification statement shall apply to all data, information, and documentation submitted to DHCS, as follows:

   a. Encounter data; as set forth in Title 42 CFR Section 438.604(a)(1);

   b. Provider network 274 data;

   c. Other documentation and data submitted to DHCS describing CalOptima Health's accessibility and availability of services, including network adequacy;

   d. Data submitted for the purpose of determining CalOptima Health's capitation rates, such as the rate development templates (RDT) and supplemental requests to support the rate setting process;

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e. Data submitted for the purpose of determining CalOptima Health's Medical Loss Ratio (MLR);

f. Documentation submitted to DHCS on a monthly, quarterly, or annual basis related to CalOptima Health's financial status;

g. Ownership and control information, including ownership and control information for ~~subcontractors~~Subcontractors, Downstream Subcontractors, and Network Providers as required under Title 42, ~~Code of Federal Regulations (~~CFR~~) section~~ Sections 438.602(c), 438.608(c)(2), and 455.104.

h. Annual report of overpayment recoveries~~;~~ as required in 42 CFR, section 438.608(d)(3);

i. Documentation confirming compliance with CalOptima Health's interoperability requirements and DHCS All Plan Letter (APL) 22-026: Interoperability and Patient Access Final Rule;

~~i.~~j. Monthly and quarterly template data;

~~j.~~k. Monthly number of members enrolled in Dual Eligible Special Needs Plans (D-SNP); and

~~k.~~l. Any other data, information or documentation related to the performance of CalOptima Health's obligations under its contract with DHCS upon notification from DHCS that such data, information, or documentation, must be certified.

3. The certification statement shall include the following:

a. The current month during which all data, information, and documentation submitted to DHCS is certified;

b. Reference all types of data, information, and documentation as described in Section II.B.2 of this Policy;

c. A statement that the data, information, and documentation to which the certification applies is accurate, complete, and truthful to CalOptima Health's best information, knowledge, and belief; and

d. Signature of the CEO, CFO, or an individual who reports directly to the CEO, or CFO, and has delegated authority to sign on their behalf.

III. PROCEDURE

A. Submissions to DHCS not via RAC

1. In limited instances, certain CalOptima Health departments submit data, information, and documentation to DHCS not via the Regulatory Affairs & Compliance (RAC) Department, but instead either directly or via another CalOptima Health Department (e.g., Information Technology Services). Additionally, in limited instances, certain CalOptima Health departments oversee automated processes that result in the submission of data, information, and documentation directly to DHCS. In either of these scenarios, the following shall occur:

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a. A Designee from each CalOptima Health department responsible for data, information, and documentation submitted to DHCS, not via the RAC Department, shall submit an attestation to the RAC Department no later than three (3) business days prior to the end of the month, in any month(s) during which such information is submitted to DHCS.

i. The attestation shall be completed on RAC's attestation form template ("[DEPT NAME][MONTH YEAR] Attestation (Submissions not via RAC)") and state that such data, information, and documentation is accurate, complete, and truthful to the submitting individual's best information, knowledge, and belief.

ii. RAC shall track the timely submission of the attestation and report. Repeated failure to submit the attestation by the due date indicated may result in a request for corrective action, in accordance with CalOptima Health policy HH.2005: Corrective Action Plan.

B. Submissions to DHCS via RAC

1. In most instances, CalOptima Health departments submit data, information, and documentation to the RAC Department that in turn completes the submission(s) to DHCS.

a. In these instances, a Designee from each CalOptima Health department responsible for data, information, and documentation shall include an attestation to accompany each submission of required data, information, or documentation to the RAC Department.

i. The attestation shall be completed on RAC's attestation form template ("[DEPT NAME]_[REPORT NAME(S)]_ Attestation (Submissions via RAC)") and state that such data, information, and documentation is accurate, complete, and truthful to the submitting individual's best information, knowledge, and belief.

ii. RAC shall track the timely submission of the attestation and report. Repeated failure to submit the attestation by the due date indicated may result in a request for corrective action, in accordance with CalOptima Health policy HH.2005: Corrective Action Plan.

iii. RAC shall conduct a cursory review of the submitted reports, prior to submission to DHCS, to verify that applicable instructions and/or technical specifications have been followed. On a quarterly basis, each business area responsible for reporting will receive feedback on data quality and timeliness via a report card. Repeated quality and timeliness issues may result in a request for corrective action, in accordance with CalOptima Health Policy HH.2005: Corrective Action Plan.

C. CalOptima Health's Provider Relations Department shall collect monthly data attestations from each delegated Health Network for data, information, and documentation submitted to CalOptima Health.

~~C.~~D. Based on these internal and Health Network attestations, the RAC Department shall submit the signed certification statement as required by DHCS and pursuant to Section II.B. of this Policy.

IV. ATTACHMENT(S)

A. Document and Data Attestation - Attestation (Submissions via RAC)
B. Document and Data Attestation - Attestation (Submissions not via RAC)
C. Document and Data Attestation - FAQs

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Policy HH.2005: Corrective Action Plan
~~C. Department of Health Care Services All Plan Letter (APL) 17-005: Certification of Document and Data Submissions~~
~~D. Title 42, Code of Federal Regulations (C.F.R), §§438.604, 438.606 and 455.104.~~
~~E.~~C. CalOptima Health State Medicaid Agency Contract (SMAC) with DHCS for Dual Eligible Special Needs Plan (D-SNP)
D. Department of Health Care Services (DHCS) All Plan Letter (APL) 17-005: Certification of Document and Data Submissions
E. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-026: Interoperability and Patient Access Final Rule
F. Title 42, Code of Federal Regulations (C.F.R), §§438.602, 438.604, 438.606, 438.608, and 455.104.

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
05/31/2017	Department of Health Care Services (DHCS)	Approved as Submitted
09/23/2019	Department of Health Care Services (DHCS)	Approved as Submitted
09/27/2021	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
12/01/2022	Regular Meeting of the CalOptima Health Board of Directors
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	07/01/2017	AA.1270	Certification of Document and Data Submissions	Medi-Cal
Revised	11/01/2018	AA.1270	Certification of Document and Data Submissions	Medi-Cal
Revised	07/01/2019	AA.1270	Certification of Document and Data Submissions	Medi-Cal
Revised	11/01/2020	AA.1270	Certification of Document and Data Submissions	Medi-Cal
Revised	08/01/2021	AA.1270	Certification of Document and Data Submissions	Medi-Cal
Revised	12/31/2022	AA.1270	Certification of Document and Data Submissions	Medi-Cal OneCare
Revised	09/01/2023	AA.1270	Certification of Document and Data Submissions	Medi-Cal OneCare
Revised	11/07/2024	AA.1270	Certification of Document and Data Submissions	Medi-Cal OneCare

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IX. GLOSSARY

Term	Definition
Appeal	Medi-Cal: A review by CalOptima Health of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the timeframes provided in 42 CFR 438.408(b). OneCare: ~~Any of~~As defined at 42 CFR §~~4~~22.561 and §423.560, the procedures that deal with the review of ~~an~~ adverse initial ~~determination~~determinations made by ~~CalOptima Health~~ the plan on health care services or benefits under Part C or D the ~~Member~~enrollee believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the ~~Member),~~enrollee) or on any amounts the ~~Member~~enrollee must pay for a service or drug as defined in 42 CFR §422.566(b) and §423.566(b). These appeal procedures include a plan reconsideration or redetermination ~~,~~(also referred to as a level 1 appeal), a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (~~MAC), and judicial review.~~Council), and judicial review. Appeal also includes the review of at-risk determinations made under a drug management program in accordance with § 423.153(f).
Department of Health Care Services (DHCS)	~~The California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as~~ Medi-Cal: The single State department responsible for the administration of the Medi-Cal Program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health related programs as provided by statute and/or regulation. OneCare: The single State Department responsible for administration of the Medi-Cal program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.~~Medi-Cal.~~
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Downstream Subcontractor	An individual or an entity that has a Downstream Subcontractor Agreement with a Subcontractor or a Downstream Subcontractor. A Network Provider is not a Downstream Subcontractor solely because it enters into a Network Provider Agreement.

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Term	Definition
Grievance	Medi-Cal: ~~An oral or written~~Any expression of dissatisfaction about any matter other than an ~~action that is an adverse benefit determination, as identified within the definition of an Appeal,~~Adverse Benefit Determination (ABD), and may include, but is not limited to~~:~~ the ~~quality~~Quality of ~~care~~Care or services provided, aspects of interpersonal relationships with a Provider or CalOptima Health's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima Health to make an authorization decision. A complaint is the same as Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other CalOptima Health processes. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, it must be considered a Grievance. OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Medical Loss Ratio (MLR)	The percentage calculated by dividing the Health Network's total medical costs paid on behalf of CalOptima Health Members by the total revenue received from CalOptima Health. Health Network medical costs would include payments to physicians (i.e. capitation, fee-for-service, or salary), medical groups/Independent Practice Associations (IPAs), hospitals, labs, ambulance companies, and other providers of service.
Network Provider	Any Provider or entity that has a Network Provider Agreement with CalOptima Health or CalOptima Health's Subcontractor(s) and receives Medi-Cal funding directly or indirectly to order refer or render Covered Services under the contract between said parties. A Network Provider is not a Subcontractor by virtue of the Network Provider Agreement.
Subcontractor	An individual or entity that has a Subcontractor Agreement with CalOptima Health or CalOptima Health's Subcontractor that relates directly or indirectly to the performance of CalOptima Health's obligations under its contract with DHCS. A Network Provider is not a Subcontractor solely because it enters into a Network Provider Agreement.

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Policy:	AA.1270
Title:	**Certification of Document and Data Submissions**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	*/s/*
Effective Date:	07/01/2017
Revised Date:	11/07/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy describes the process for certification of data, information, and documentation submitted to the Department of Health Care Services (DHCS) by CalOptima Health.

II. POLICY

A. In accordance with Title 42, Code of Federal Regulations (CFR), Sections 438.604 and 438.606 and contractual requirements, CalOptima Health shall certify data, information, and documentation submitted to DHCS.

B. CalOptima Health shall submit a completed and signed DHCS-approved certification statement on CalOptima Health letterhead by the final business day of each month to DHCS.

1. The signatory to the signed certification statement shall be the Chief Executive Officer (CEO), Chief Financial Officer (CFO), or an individual who reports directly to the CEO, or CFO, and has delegated authority to sign on his or her behalf. The CEO or CFO shall remain ultimately responsible for the certification and the data, information, and documentation submitted by CalOptima Health to DHCS.

2. The certification statement shall apply to all data, information, and documentation submitted to DHCS, as follows:

   a. Encounter data as set forth in Title 42 CFR Section 438.604(a)(1);

   b. Provider network 274 data;

   c. Other documentation and data submitted to DHCS describing CalOptima Health's accessibility and availability of services, including network adequacy;

   d. Data submitted for the purpose of determining CalOptima Health's capitation rates, such as the rate development templates (RDT) and supplemental requests to support the rate setting process;

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e. Data submitted for the purpose of determining CalOptima Health's Medical Loss Ratio (MLR);

f. Documentation submitted to DHCS on a monthly, quarterly, or annual basis related to CalOptima Health's financial status;

g. Ownership and control information, including ownership and control information for Subcontractors, Downstream Subcontractors, and Network Providers as required under Title 42, CFR Sections 438.602(c), 438.608(c)(2), and 455.104.

h. Annual report of overpayment recoveries as required in 42 CFR, section 438.608(d)(3);

i. Documentation confirming compliance with CalOptima Health's interoperability requirements and DHCS All Plan Letter (APL) 22-026: Interoperability and Patient Access Final Rule;

j. Monthly and quarterly template data;

k. Monthly number of members enrolled in Dual Eligible Special Needs Plans (D-SNP); and

l. Any other data, information or documentation related to the performance of CalOptima Health's obligations under its contract with DHCS upon notification from DHCS that such data, information, or documentation, must be certified.

3. The certification statement shall include the following:

a. The current month during which all data, information, and documentation submitted to DHCS is certified;

b. Reference all types of data, information, and documentation as described in Section II.B.2 of this Policy;

c. A statement that the data, information, and documentation to which the certification applies is accurate, complete, and truthful to CalOptima Health's best information, knowledge, and belief; and

d. Signature of the CEO, CFO, or an individual who reports directly to the CEO, or CFO, and has delegated authority to sign on their behalf.

III. PROCEDURE

A. Submissions to DHCS not via RAC

1. In limited instances, certain CalOptima Health departments submit data, information, and documentation to DHCS not via the Regulatory Affairs & Compliance (RAC) Department, but instead either directly or via another CalOptima Health Department (e.g., Information Technology Services). Additionally, in limited instances, certain CalOptima Health departments oversee automated processes that result in the submission of data, information, and documentation directly to DHCS. In either of these scenarios, the following shall occur:

a. A Designee from each CalOptima Health department responsible for data, information, and documentation submitted to DHCS, not via the RAC Department, shall submit an

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attestation to the RAC Department no later than three (3) business days prior to the end of the month, in any month(s) during which such information is submitted to DHCS.

i. The attestation shall be completed on RAC's attestation form template ("[DEPT NAME][MONTH YEAR] Attestation (Submissions not via RAC)") and state that such data, information, and documentation is accurate, complete, and truthful to the submitting individual's best information, knowledge, and belief.

ii. RAC shall track the timely submission of the attestation and report. Repeated failure to submit the attestation by the due date indicated may result in a request for corrective action, in accordance with CalOptima Health policy HH.2005: Corrective Action Plan.

B. Submissions to DHCS via RAC

1. In most instances, CalOptima Health departments submit data, information, and documentation to the RAC Department that in turn completes the submission(s) to DHCS.

a. In these instances, a Designee from each CalOptima Health department responsible for data, information, and documentation shall include an attestation to accompany each submission of required data, information, or documentation to the RAC Department.

i. The attestation shall be completed on RAC's attestation form template ("[DEPT NAME]_[REPORT NAME(S)]_ Attestation (Submissions via RAC)") and state that such data, information, and documentation is accurate, complete, and truthful to the submitting individual's best information, knowledge, and belief.

ii. RAC shall track the timely submission of the attestation and report. Repeated failure to submit the attestation by the due date indicated may result in a request for corrective action, in accordance with CalOptima Health policy HH.2005: Corrective Action Plan.

iii. RAC shall conduct a cursory review of the submitted reports, prior to submission to DHCS, to verify that applicable instructions and/or technical specifications have been followed. On a quarterly basis, each business area responsible for reporting will receive feedback on data quality and timeliness via a report card. Repeated quality and timeliness issues may result in a request for corrective action, in accordance with CalOptima Health Policy HH.2005: Corrective Action Plan.

C. CalOptima Health's Provider Relations Department shall collect monthly data attestations from each delegated Health Network for data, information, and documentation submitted to CalOptima Health.

D. Based on these internal and Health Network attestations, the RAC Department shall submit the signed certification statement as required by DHCS and pursuant to Section II.B. of this Policy.

IV. ATTACHMENT(S)

A. Document and Data Attestation - Attestation (Submissions via RAC)
B. Document and Data Attestation - Attestation (Submissions not via RAC)
C. Document and Data Attestation - FAQs

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal

B. CalOptima Health Policy HH.2005: Corrective Action Plan
C. CalOptima Health State Medicaid Agency Contract (SMAC) with DHCS for Dual Eligible Special Needs Plan (D-SNP)
D. Department of Health Care Services (DHCS) All Plan Letter (APL) 17-005: Certification of Document and Data Submissions
E. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-026: Interoperability and Patient Access Final Rule
F. Title 42, Code of Federal Regulations (C.F.R), §§438.602, 438.604, 438.606, 438.608, and 455.104.

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
05/31/2017	Department of Health Care Services (DHCS)	Approved as Submitted
09/23/2019	Department of Health Care Services (DHCS)	Approved as Submitted
09/27/2021	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
12/01/2022	Regular Meeting of the CalOptima Health Board of Directors
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	07/01/2017	AA.1270	Certification of Document and Data Submissions	Medi-Cal
Revised	11/01/2018	AA.1270	Certification of Document and Data Submissions	Medi-Cal
Revised	07/01/2019	AA.1270	Certification of Document and Data Submissions	Medi-Cal
Revised	11/01/2020	AA.1270	Certification of Document and Data Submissions	Medi-Cal
Revised	08/01/2021	AA.1270	Certification of Document and Data Submissions	Medi-Cal
Revised	12/31/2022	AA.1270	Certification of Document and Data Submissions	Medi-Cal OneCare
Revised	09/01/2023	AA.1270	Certification of Document and Data Submissions	Medi-Cal OneCare
Revised	11/07/2024	AA.1270	Certification of Document and Data Submissions	Medi-Cal OneCare

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IX. GLOSSARY

Term	Definition
Appeal	Medi-Cal: A review by CalOptima Health of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the timeframes provided in 42 CFR 438.408(b). OneCare: As defined at 42 CFR §422.561 and §423.560, the procedures that deal with the review of adverse initial determinations made by the plan on health care services or benefits under Part C or D the enrollee believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the enrollee) or on any amounts the enrollee must pay for a service or drug as defined in 42 CFR §422.566(b) and §423.566(b). These appeal procedures include a plan reconsideration or redetermination (also referred to as a level 1 appeal), a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (Council), and judicial review. Appeal also includes the review of at-risk determinations made under a drug management program in accordance with § 423.153(f).
Department of Health Care Services (DHCS)	Medi-Cal: The single State department responsible for the administration of the Medi-Cal Program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health related programs as provided by statute and/or regulation. OneCare: The single State Department responsible for administration of the Medi-Cal program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Downstream Subcontractor	An individual or an entity that has a Downstream Subcontractor Agreement with a Subcontractor or a Downstream Subcontractor. A Network Provider is not a Downstream Subcontractor solely because it enters into a Network Provider Agreement.

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Term	Definition
Grievance	Medi-Cal: Any expression of dissatisfaction about any matter other than an Adverse Benefit Determination (ABD), and may include, but is not limited to the Quality of Care or services provided, aspects of interpersonal relationships with a Provider or CalOptima Health's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima Health to make an authorization decision. A complaint is the same as Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other CalOptima Health processes. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, it must be considered a Grievance. OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Medical Loss Ratio (MLR)	The percentage calculated by dividing the Health Network's total medical costs paid on behalf of CalOptima Health Members by the total revenue received from CalOptima Health. Health Network medical costs would include payments to physicians (i.e. capitation, fee-for-service, or salary), medical groups/Independent Practice Associations (IPAs), hospitals, labs, ambulance companies, and other providers of service.
Network Provider	Any Provider or entity that has a Network Provider Agreement with CalOptima Health or CalOptima Health's Subcontractor(s) and receives Medi-Cal funding directly or indirectly to order refer or render Covered Services under the contract between said parties. A Network Provider is not a Subcontractor by virtue of the Network Provider Agreement.
Subcontractor	An individual or entity that has a Subcontractor Agreement with CalOptima Health or CalOptima Health's Subcontractor that relates directly or indirectly to the performance of CalOptima Health's obligations under its contract with DHCS. A Network Provider is not a Subcontractor solely because it enters into a Network Provider Agreement.

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Document and Data Attestation

Submissions via RAC

Background:

Title 42, Code of Federal Regulations (42 CFR), Sections (§§) 438.604 and 438.606 (revised in May 2016), require certification of data, information, and documentation that are submitted to the Department of Health Care Services (DHCS). Accordingly, DHCS released APL 17-005: Certification of Document and Data Submissions which requires MCPs (the MCP's CEO, CFO, or designee) to submit a monthly certification statement to DHCS attesting that all data, information, and documentation submitted to DHCS for that month are accurate, complete, and truthful to the MCP's best information, knowledge, and belief. CalOptima Health has mirrored this process to require each department that submits data to DHCS (via or not via the Medi-Cal Regulatory Affairs & Compliance (RAC)) to submit an attestation to Medi-Cal RAC Department. Based on these internal attestations, the CEO signs CalOptima Health's monthly certification statement.

Instructions:

Please complete the below information and submit this attestation concurrently with the submission of the data, documentation or information mentioned below. If a section in the table does not apply, please note this. Do not leave any blank fields. A submission will be rejected if the attestation is not provided or is incomplete. Additional information regarding the attestation process is available here in an FAQ document. If you have any questions with regards to this submission or attestation, please contact Mike Wood at mwood@caloptima.org or Monica Domicolo at mdomicolo@caloptima.org.

Data, information, and documentation being attested to:

Report Name *[Title of report, document, or submission]*	**Tab Name (if applicable)** *[Title of tab within the report. If this is not applicable, please note]*	**Reporting Period** *[Data reflected within the submission to DHCS (e.g., Month Year, Quarter Year, Date range]*

By completing and signing the section below, I am attesting that this submission is based on best information, knowledge, and belief, that the data, documentation, and information specified in the table above is accurate, complete, and truthful. I furthermore attest that I have the authority to make such attestation. *(Please refer to the FAQ document linked above for info on who can attest.)*

Additionally, I attest that I have completed the following as appropriate (please check boxes below):

Determined if health network (HN) data, or other subcontractor data, is necessary for a complete submission. Unless specified otherwise, I have consolidated data into Plan-level data. I will maintain a record of internal versus HN data should DHCS have any follow up questions.

Quality checked data (including HN data) in my submission, which at a minimum may include the data checks below. Data errors have been resolved in the submission and the source data. Note that Health Network

Relations requires the reporting department to make initial outreach attempts to the health networks to correct any data issues before escalating to them for assistance.

- ✓ Confirmed data is consistent with DHCS' reporting instructions and guidance.
- ✓ Data is complete, accurate, and reasonable (i.e. makes sense).
- ✓ Confirmed use of DHCS' drop-down lists where applicable. DHCS does not allow any changes to drop-down selections as it interferes with their data analysis.
- ✓ No blanks/missing/incomplete data as appropriate.
- ✓ Compared data to prior submission for outliers or significant changes that may require explanation.
- ✓ Provided comments and explained "Other" responses as required in reporting instructions.
- ✓ Incorporated any DHCS' Quality Data for Program Integrity (QDPI) data checks and any prior feedback from DHCS or RAC into the review process.

Name: _____

Title: _____

Department: _____

Signature: _____

NOTE: *If you are using an electronic signature, please be sure the time stamp reflects the current date. If you are using a wet signature, you will need to complete the date below and scan a copy of the attestation.*

Date: _____

Document and Data Attestation

Submissions not via RAC

Background:
Title 42, Code of Federal Regulations (42 CFR), Sections (§§) 438.604 and 438.606 (revised in May 2016), require certification of data, information, and documentation that are submitted to the Department of Health Care Services (DHCS). Accordingly, DHCS released APL 17-005: Certification of Document and Data Submissions which requires managed care plans (MCPs) (the MCP's CEO, CFO, or designee) to submit a monthly certification statement to DHCS attesting that all data, information, and documentation submitted to DHCS for that month are accurate, complete, and truthful to the MCP's best information, knowledge, and belief. CalOptima Health has mirrored this process to require each department that submits data to DHCS (via or not via Regulatory Affairs & Compliance (RAC) Medi-Cal) to submit an attestation to RAC (Medi-Cal). Based on these internal attestations, the CEO signs CalOptima Health's monthly certification statement.

Instructions: Please complete the below information and submit this attestation to RAC no later than three (3) business days prior to the end of the month, in any month(s) during which such information is submitted to DHCS not via RAC. If a section in the table does not apply, please note this. Do not leave any blank fields. Additional information regarding the attestation process is available here in an FAQ document. If you have any questions with regards to this submission or attestation, please contact Mike Wood or Monica Domicolo.

Data, information, and documentation being attested to:

Report Name *[Title of report, document, or submission]*	**Tab Name (if applicable)** *[Title of tab within the report. If this is not applicable, please note]*	**Reporting Period** *[Data reflected within the submission to DHCS (e.g., Month Year, Quarter Year, Date range]*

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Report Name *[Title of report, document, or submission]*	**Tab Name (if applicable)** *[Title of tab within the report. If this is not applicable, please note]*	**Reporting Period** *[Data reflected within the submission to DHCS (e.g., Month Year, Quarter Year, Date range]*

By completing and signing the section below, I am attesting that this submission is based on best information, knowledge, and belief, that the data, documentation, and information specified in the table above is accurate, complete, and truthful. I furthermore attest that I have the authority to make such attestation *(refer to the FAQ document linked above for info on who can attest)* **and that the submission was timely to DHCS. Please be sure to notify RAC of any issues of non-compliance (e.g., inaccurate, late, incomplete, etc.) to determine appropriate next steps.**

Name: _____

Title: _____

Department: _____

Signature: _____

NOTE: If you are using an electronic signature, please be sure the time stamp reflects the current date. If you are using a wet signature, you will need to complete the date below and scan a copy of the attestation.

Date: _____

Document and Data Attestation – Frequently Asked Questions (FAQ):

1. **Question:** Who may attest to the data being provided?
   Answer: RAC recommends that the attestation be completed by a person who has the *authority* and/or *knowledge* to make such an attestation. By way of reference, similar attestations are completed by a supervisor or higher.

2. **Question:** Can the attestation include an electronic signature?
   Answer: Yes, as long as the signatory has sole control of the electronic signature. For example, a name typed in cursive font alone is not considered an electronic signature. Please contact IS for technical support if you need assistance to activate the electronic signature function in the form.

   Note: If you choose to use an electronic signature, please be sure the time stamp within the signature reflects the current date.

3. **Question:** My report includes data from CalOptima Health delegates that I do not feel comfortable attesting to. Do I still need to attest to the information?
   Answer: You must attest to the information *your business area* is providing to RAC. If the report submission requires that you consolidate data/information on behalf of the delegates, for the purpose of submission, a separate attestation will be required by the delegate. Health Network Relations is responsible for collecting these on a monthly basis.

4. **Question:** Where can I find a copy of the attestation templates?
   Answer: A copy of the most recent attestation templates can be found on SharePoint for Office of Compliance under "Data Attestations".

   The "Attestation (Submissions via RAC)" template is to be used for submissions to DHCS via RAC. Whereas, the "Attestation (Submissions not via RAC)" template is to be used for any data that you submit to DHCS not via RAC, but rather directly or via another CalOptima Health department (such as ITS).

5. **Question:** If I submit multiple reports to RAC, can I submit one attestation for all of the data?
   Answer: It depends on whether you are submitting data via or not via RAC to DHCS, as outlined below.

   Submissions via RAC: Generally, each report will have its own attestation since you will be submitting the attestation concurrently with the data submission. However, if you contribute data to multiple tabs within a report, you only need to submit a single attestation and note the multiple tabs within that report.

   Submissions not via RAC: Yes, you may list all the data submissions for that month in the table within the attestation form. If you need additional space to list submissions, please use multiple forms.

6. **Question:** If an error is identified in my report, post submission to RAC, will I be required to resubmit my attestation?
   Answer: RAC will not require a resubmission, however, continued issues with the quality of the data may result in an investigation to determine the root cause and a corrective action plan may result.

7. **Question:** What happens if I do not submit attestations in a timely manner?
   Answer: Medi-Cal RAC is monitoring attestation submissions and tracking timeliness of these submissions. Continued non-compliance for any requirement may result in a notice of non-compliance and a request for corrective action in accordance with CalOptima Health policy HH.2005: Corrective Action Plan.

Policy:	AA.1275
Title:	**Department of Health Care Services (DHCS) File and Use Submission Process**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	*/s/*
Effective Date:	05/05/2022
Revised Date:	11/07/2024
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This Policy outlines CalOptima Health's process for Department of Health Care Services (DHCS) File and Use materials submissions.

II. POLICY

A. CalOptima Health may submit the following applicable Medi-Cal materials to DHCS through the File and Use submission process:

1. Policies not required by DHCS, by contract or an All Plan Letter (APL) requirement.

2. Policies (including policy attachments), with minor revisions required by DHCS that do not impact CalOptima Health's compliance with all legal and contractual requirements, DHCS policy, and DHCS guidance. Examples of these minor revisions include but may not be limited to:

   a. An adjustment of internal timelines or functions between CalOptima Health departments that do not impact DHCS contractual requirements;

   b. Rearrangement of policy and procedure language that does not alter policy intent, or impact DHCS contractual requirements;

   c. Revisions to grammar or punctuation, or updates to glossary terms, or references;

   d. Updates to phone numbers or addresses; and

   e. Language clarifications that do not substantively change the Policy, such as revising 'working' to 'business' days.

3. Redline versions of minor changes to deliverables/submissions that were already reviewed and approved by the DHCS within the last six (6) months and do not impact CalOptima Health's compliance with all legal and contractual requirements, DHCS policy, and DHCS guidance. Examples of these minor revisions may include but are not limited to:

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a. An adjustment of internal timelines or functions between CalOptima Health departments that do not impact DHCS contractual requirements;

b. Updates to phone numbers or addresses; ~~and~~

c. Grammatical or punctuation updates~~.~~; and

d. Page reference updates to previously approved Member Material Approval (MMA) documents.

4. Consent forms (i.e., authorized representative forms, minor consent forms)

B. By contract, DHCS reserves the right to review, modify, stop, approve, deny CalOptima Health's right to use, or require CalOptima Health to edit, submitted materials at any time.

III. PROCEDURE

A. If materials have met the requirements for DHCS' File and Use flexibilities in accordance with Section II.A. of this Policy, Departments shall submit File and Use materials as follows:

1. Policies

a. Policy Owners shall submit the following to the Regulatory Affairs & Compliance Policies and Procedures (RAC P&P) team:

~~i. The DHCS Medi-Cal Managed Care Plan File and Use Attestation Form completed in accordance with Section III.B.;~~

~~ii.~~i. Revised policy, attachment(s) if applicable, and the Policy Intake Form [PIF]; and

~~iii.~~ii. Any ~~additionally~~additional required documents in accordance with the CalOptima Health Policy Owner Manual.

b. Upon receipt of the completed submission, the RAC P&P team will verify readiness, and coordinate with the Regulatory Affairs & Compliance Medi-Cal (RAC Medi-Cal) team for File and Use submission to DHCS.

c. The RAC Medi-Cal team will submit the signed DHCS Medi-Cal Managed Care Plan File and Use Attestation Form and the revised policies to DHCS as File and Use.

2. Deliverables/Submissions

a. The department responsible for the specific deliverables/submissions shall submit the following to the RAC Medi-Cal team:

~~i. The DHCS Medi-Cal Managed Care Plan File and Use Attestation Form completed in accordance with Section III.B;~~

~~ii.~~i. Redline versions of all minor changes to deliverables/submissions from the responsible department.

ii. Upon receipt of the completed submission, the RAC Medi-Cal team will verify readiness and submit the signed DHCS Medi-Cal Managed Care Plan File and Use Attestation Form and revised deliverables/submissions to DHCS as File and Use.

3. Upon review of materials listed in Sections III.A.1 and III.A.2, the RAC Medi-Cal and RAC P&P teams reserve the right to reclassify materials if deemed inappropriate for submission as a File and Use material.

B. Attestation Form

1. The completed Medi-Cal Managed Care Plan File and Use Attestation Form is required to accompany each submission and must be completed when CalOptima Health intends to use or implement any CalOptima Health materials prior to DHCS review and approval (File and Use).

2. The Attestation Form must be signed by CalOptima Health's Chief Executive Officer (CEO), Chief Operating Officer (COO), or Chief Compliance Officer (CCO), or an individual who reports directly to the CEO, COO, or CCO with delegated authority to sign for the CEO, COO, or CCO, so that the CEO, COO, or CCO is ultimately responsible for the Attestation Form.

~~3. The Policy Owner or department responsible for the specific deliverables/submissions is responsible for obtaining the appropriate signature according to department hierarchy and as listed in Section III.B.2.~~

IV. ATTACHMENT(S)

A. DHCS File and Use Attestation Form
B. ~~2023~~ Policy Intake Form [PIF]

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Policy Owner Manual
C. Department of Health Care Services (DHCS), [Medi-Cal]: File and Use Flexibilities Memo

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
06/08/2022	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
05/05/2022	Regular Meeting of the CalOptima Board of Directors
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/05/2022	AA.1275	Department of Health Care Services (DHCS) File and Use Submission Process	Medi-Cal

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Action	Date	Policy	Policy Title	Program(s)
Revised	09/01/2023	AA.1275	Department of Health Care Services (DHCS) File and Use Submission Process	Medi-Cal
Revised	11/07/2024	AA.1275	Department of Health Care Services (DHCS) File and Use Submission Process	Medi-Cal

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IX. GLOSSARY

Term	Definition
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi-Cal program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), ~~Child Health and Disabilities Prevention (CHDP), and~~and other health related programs as provided by statute and/or regulation.
File and Use	A submission to DHCS that does not need review and approval prior to use or implementation, but which DHCS can require edits as determined.
Policy	~~A~~ For purposes of this policy, a formal document that communicates broad principles of operation and standards on a particular subject to guide the actions and decision-making of individuals. Desktop policies and procedures are not included.
Policy Owner	~~The~~For purposes of this policy, the Director-level staff member who has lead responsibility for the policy and procedure, as part of his/her job duties.

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Policy:	AA.1275
Title:	**Department of Health Care Services (DHCS) File and Use Submission Process**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	*/s/*
Effective Date:	05/05/2022
Revised Date:	11/07/2024
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This Policy outlines CalOptima Health's process for Department of Health Care Services (DHCS) File and Use materials submissions.

II. POLICY

A. CalOptima Health may submit the following applicable Medi-Cal materials to DHCS through the File and Use submission process:

1. Policies not required by DHCS, by contract or an All Plan Letter (APL) requirement.

2. Policies (including policy attachments), with minor revisions required by DHCS that do not impact CalOptima Health's compliance with all legal and contractual requirements, DHCS policy, and DHCS guidance. Examples of these minor revisions include but may not be limited to:

   a. An adjustment of internal timelines or functions between CalOptima Health departments that do not impact DHCS contractual requirements;

   b. Rearrangement of policy and procedure language that does not alter policy intent, or impact DHCS contractual requirements;

   c. Revisions to grammar or punctuation, or updates to glossary terms, or references;

   d. Updates to phone numbers or addresses; and

   e. Language clarifications that do not substantively change the Policy, such as revising 'working' to 'business' days.

3. Redline versions of minor changes to deliverables/submissions that were already reviewed and approved by the DHCS within the last six (6) months and do not impact CalOptima Health's compliance with all legal and contractual requirements, DHCS policy, and DHCS guidance. Examples of these minor revisions may include but are not limited to:

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a. An adjustment of internal timelines or functions between CalOptima Health departments that do not impact DHCS contractual requirements;

b. Updates to phone numbers or addresses;

c. Grammatical or punctuation updates; and

d. Page reference updates to previously approved Member Material Approval (MMA) documents.

4. Consent forms (i.e., authorized representative forms, minor consent forms)

B. By contract, DHCS reserves the right to review, modify, stop, approve, deny CalOptima Health's right to use, or require CalOptima Health to edit, submitted materials at any time.

III. PROCEDURE

A. If materials have met the requirements for DHCS' File and Use flexibilities in accordance with Section II.A. of this Policy, Departments shall submit File and Use materials as follows:

1. Policies

a. Policy Owners shall submit the following to the Regulatory Affairs & Compliance Policies and Procedures (RAC P&P) team:

i. Revised policy, attachment(s) if applicable, and the Policy Intake Form [PIF]; and

ii. Any additional required documents in accordance with the CalOptima Health Policy Owner Manual.

b. Upon receipt of the completed submission, the RAC P&P team will verify readiness, and coordinate with the Regulatory Affairs & Compliance Medi-Cal (RAC Medi-Cal) team for File and Use submission to DHCS.

c. The RAC Medi-Cal team will submit the signed DHCS Medi-Cal Managed Care Plan File and Use Attestation Form and the revised policies to DHCS as File and Use.

2. Deliverables/Submissions

a. The department responsible for the specific deliverables/submissions shall submit the following to the RAC Medi-Cal team:

i. Redline versions of all minor changes to deliverables/submissions from the responsible department.

ii. Upon receipt of the completed submission, the RAC Medi-Cal team will verify readiness and submit the signed DHCS Medi-Cal Managed Care Plan File and Use Attestation Form and revised deliverables/submissions to DHCS as File and Use.

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3. Upon review of materials listed in Sections III.A.1 and III.A.2, the RAC Medi-Cal and RAC P&P teams reserve the right to reclassify materials if deemed inappropriate for submission as a File and Use material.

B. Attestation Form

1. The completed Medi-Cal Managed Care Plan File and Use Attestation Form is required to accompany each submission and must be completed when CalOptima Health intends to use or implement any CalOptima Health materials prior to DHCS review and approval (File and Use).

2. The Attestation Form must be signed by CalOptima Health's Chief Executive Officer (CEO), Chief Operating Officer (COO), or Chief Compliance Officer (CCO), or an individual who reports directly to the CEO, COO, or CCO with delegated authority to sign for the CEO, COO, or CCO, so that the CEO, COO, or CCO is ultimately responsible for the Attestation Form.

IV. ATTACHMENT(S)

A. DHCS File and Use Attestation Form
B. Policy Intake Form [PIF]

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Policy Owner Manual
C. Department of Health Care Services (DHCS), [Medi-Cal]: File and Use Flexibilities Memo

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
06/08/2022	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
05/05/2022	Regular Meeting of the CalOptima Board of Directors
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/05/2022	AA.1275	Department of Health Care Services (DHCS) File and Use Submission Process	Medi-Cal
Revised	09/01/2023	AA.1275	Department of Health Care Services (DHCS) File and Use Submission Process	Medi-Cal
Revised	11/07/2024	AA.1275	Department of Health Care Services (DHCS) File and Use Submission Process	Medi-Cal

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IX. GLOSSARY

Term	Definition
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi-Cal program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health related programs as provided by statute and/or regulation.
File and Use	A submission to DHCS that does not need review and approval prior to use or implementation, but which DHCS can require edits as determined.
Policy	For purposes of this policy, a formal document that communicates broad principles of operation and standards on a particular subject to guide the actions and decision-making of individuals. Desktop policies and procedures are not included.
Policy Owner	For purposes of this policy, the Director-level staff member who has lead responsibility for the policy and procedure, as part of his/her job duties.

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Medi-Cal Managed Care Plan
File and Use Attestation Form

This File and Use Attestation Form (Attestation Form) is required to be completed when CalOptima Health (Contractor) intends to use or implement any Contractor materials prior to DHCS review and approval (File and Use).

This Attestation Form must be completed by the Chief Executive officer (CEO), Chief Operating Officer (COO), or Compliance Officer (CO), or or an individual who reports directly to the CEO, COO, or CO with delegated authority to sign for the CEO, COO, or CO, so that the CEO, COO, or CO is ultimately responsible for the Attestation Form.Contractor must submit this Attestation Form whenever Contractor submits a Contractor material for File and Use, and Contractor must attach the Contractor material to this Attestation Form.

The following types of Contractor materials may be submitted for File and Use:

- P&Ps not required by DHCS (i.e., P&Ps that are not a contract or an APL requirement)
- Minor updates to P&Ps required by DHCS (i.e. minor updates to P&Ps that do not impact Contractor's compliance with all legal and contractual requirements, DHCS policy, and DHCS guidance)
- Minor changes to deliverables/submissions that were already reviewed and approved by DHCS within the last six months. Contractor must submit a redline version of all changes. In addition, the changes must not impact Contractor's compliance with all legal and contractual requirements, DHCS policy, and DHCS guidance.
- Consent forms (i.e. authorized representative forms, minor consent forms, etc.)
- In-person marketing events, not including Annual Marketing Plans. All Annual Marketing Plans must be submitted to DHCS for review and approval prior to use.

By signing this Attestation Form, Contractor represents, warrants, and attests that the attached Contractor materials comply with all federal and state laws, regulations, and guidance, and contractual requirements as set forth in the Medi-Cal managed care contract (Contract) between the Department of Health Care Services (DHCS) and Contractor. Contractor also certifies that the attached Contractor materials are

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complete,accurate, and truthful based upon Contractor's best information, knowledge and belief after making a diligent and thorough search and review of all records and information within Contractor's control.

Contractor retains full legal responsibility for the use of the attached Contractor materials and agrees to indemnify and hold harmless the State of California, DHCS, and its officers, agents, employees, control agencies, and other state agencies for any and all claims, losses, injuries, damages, attorneys' fees and costs, and judgments resulting from the use of the attached Contractor materials. Contractor also agrees and acknowledges to abide by all other indemnification provisions contained in its Contract with DHCS.

Contractor acknowledges DHCS retains all of its rights under the Contract, including but not limited to, its right to review, modify, stop, approve, or deny the Contractor's right to use the attached Contractor materials. Alternatively, Contractor acknowledges DHCS' right to require Contractor to edit the Contractor materials at any time.

Attestation

I hereby attest on behalf of CalOptima Health (Contractor) that it has complied with and will continue to comply with all requirements set forth above.

Signature _____ Date _____

_____
(Name of CEO, COO, or Compliance Officer)

CalOptima Health
(Printed Name of Contractor)

Orange, California
(City, State)

The following shall have the same legal force and effect as an original of the signed Attestation Form: a facsimile, photocopy, imaged or other electronic version.

When completed, please send the signed Attestation Form to your assigned DHCS Contract Manager.

POLICY INTAKE FORM (PIF)

Please complete **ALL FIELDS** below and submit form to ***RACPolicies@caloptima.org***
along with the draft policy, supporting documentation for change (listed in "Source" column in Section 7), and any attachments.
If submitting for retirement, a retirement crosswalk with all impacted policies must be included.

1. SUBMISSION DATE:	Click or tap here to enter text.	
2. POLICY NUMBER:	If this is a new policy, the number will be assigned by RAC P&P.	
3. POLICY TITLE:	Click or tap here to enter text.	If **REVISING** the title, please provide the new title: Click or tap here to enter text.
4. RESPONSIBLE DEPARTMENT:	Click or tap here to enter text.	If **TRANSFERRING** the policy, list the department confirming acceptance of transfer and confirmation of review: Click or tap here to enter text.
5. PROGRAM(S):	☐ MEDI-CAL ☐ ONECARE ☐ PACE ☐ ADMINISTRATIVE	
6. REASON FOR POLICY SUBMISSION:	☐ ANNUAL REVIEW	[If no revisions, please confirm policy Section V. Reference(s) have been reviewed]
	☐ AUDIT REMEDIATION	[Please include evidence/sourced documentation]
	☐ BOARD/COMMITTEE REQUEST	[Please include evidence/sourced documentation]
	☐ NEW POLICY	[Please include evidence/sourced documentation]
	☐ OPERATIONAL CHANGE(S)	[Please include evidence/sourced documentation]
	☐ REGULATORY GUIDANCE AND/OR CONTRACT UPDATE(S)	[Please include evidence/sourced documentation]
	☐ RETIREMENT	[Requires Crosswalk Document if content is transferring to another policy]
	☐ OTHER	[Please include evidence/sourced documentation]

7. SUMMARY OF MAIN EDITS:

- All columns **must be completed** ("n/a" is not a valid response).
- **All** documents referred to in the 'Source' column **must** be submitted with the policy as supporting documentation.

Any edits involving other departments must be coordinated between the Policy Owner and impacted department prior to submission and documented below.

POLICY OR ATTACHMENT SECTION	SPECIFIC TEXT REVISION	REASON FOR REVISION	SOURCE (REQUIRED) (e.g., regulatory guidance, contract, legal recommendation, or COBAR) *Include Page and Section*

Please add rows above as needed.

8. ATTACHMENTS	☐ **No Attachments**
	☐ **Attachments** *Note: The Policy Owner is responsible for ensuring attachments posted elsewhere (or associated with another policy) are updated or retired upon policy completion. If the document is managed by another department, please ensure the current attachment is in use.*

Attachment:	**Title:**	**Update [Choose #1, 2, 3, or 4 for each attachment]:** 1. Reviewed / No Revisions 2. Revisions [*List in #7. Summary of Main Edits, above*] 3. New Attachment [*or updated Template Form*] 4. Retiring Attachment
Attachment A:		
Attachment B:		
Attachment C:		
Attachment D:		
Attachment E:		
Attachment F:		
Attachment G:		
Attachment H:		
Attachment I:		
Attachment J:		
Attachment K:		
Attachment L:		
Attachment M:		
Attachment N:		
Attachment O:		

9. LEGAL COUNSEL REVIEW:	Legal review will automatically be requested by RAC P&P for all new policies, policies with substantive edits not driven by regulatory requirements and Human Resources policies. Policy Owners may also initiate a request for guidance. If you would like to request guidance for this review cycle, please provide your specific question here: Click or tap here to enter text.

10. BOARD OR COMMITTEE MEETING DATES (*if required*)**:**	☐ **Board of Directors Date** [*Required for New Policies*]: Click or tap to enter a date. ☐ **Meeting(s) or Committee(s)**: Enter Name & Date	
11. POINT(S) OF CONTACT:	**Primary:**	Click or tap here to enter text.
	Secondary:	Click or tap here to enter text.
12. ATTESTATION:	[***Note:*** Only Manager or Director-level staff can Attest] *I attest that the information contained in this document is true and accurate to the best of my knowledge and that department management (**including Executive Director/Chief**) has been informed of the operational changes and revisions made to this policy. I further understand that any misrepresentation of information on this document may cause a delay in processing or rejection of the policy for processing.* ☐ I agree Name: Click or tap here to enter text.	
13. NOTES/COMMENTS:	Click or tap here to enter text.	

Policy:	GA.7505
Title:	**Regulatory Liaison Responsibilities**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	*/s/*
Effective Date:	05/01/2007
Revised Date:	11/07/2024
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ PACE ☒ Administrative

I. PURPOSE

This policy defines CalOptima Health's regulatory liaison responsibilities.

II. POLICY

A. CalOptima Health's Regulatory Affairs & Compliance (RAC) Department shall be responsible for the regulatory liaison functions defined in this Policy.

B. RAC shall serve as CalOptima Health's liaison with the following regulatory agencies:

1. Centers for Medicare & Medicaid Services (CMS);

2. California Department of Health Care Services (DHCS); and

3. California Department of Managed Health Care (DMHC).

C. RAC shall serve as CalOptima Health's liaison with authorized contractors operating on behalf of the regulatory agencies identified in Section II.B. of this Policy.

D. As the regulatory liaison, RAC shall:

1. Ensure timely reports and submissions to regulatory agencies in accordance with appropriate rules, requirements, and regulations;

2. Disseminate regulatory communications to CalOptima Health's internal departments; and

3. Serve as a central point of contact between CalOptima Health and regulatory agencies.

III. PROCEDURE

A. Required reports and submissions to CMS:

1. RAC shall submit required reports and filings to CMS pursuant to CalOptima Health's Contract with CMS.

2. RAC shall coordinate such reports and filings with the CalOptima Health Medicare Programs (OneCare, and PACE) business owners.

3. RAC shall provide ad-hoc reports to CMS, as requested. Such ad-hoc reports include, but are not limited to, reports related to:

   a. Specific Member issues;

   b. CalOptima Health staffing changes;

   c. Health Network changes; and

   d. Self-Disclosure of Non-Compliance.

B. Required reports and submissions to DHCS:

1. RAC shall submit required reports and filings to DHCS pursuant to CalOptima Health's Contract(s) with DHCS. DHCS reporting includes, but is not limited to, reporting related to the Medi-Cal program, and the Program of All-Inclusive Care for the Elderly (PACE).

2. If DHCS provides CalOptima Health with written notice of any problems or deficiencies related to the submittal of data to DHCS, or of any changes or clarifications related to CalOptima Health's Management Information System (MIS) system, RAC shall coordinate with impacted business areas to submit a Corrective Action Plan (CAP) response, with measurable benchmarks, within fifteen (15) calendar days from the date of DHCS' written notice to CalOptima Health. If DHCS requests revisions, CalOptima Health shall submit a revised CAP for DHCS' approval ~~with DHCS required timeframes~~within fifteen (15) calendar days after receipt of the request.

3. RAC shall coordinate DHCS-required reports and filings with CalOptima Health business owners, as necessary.

4. RAC shall provide ad-hoc reports to DHCS, as requested. Such ad-hoc reports may include, but are not limited to, reports related to:

   a. Specific Member issues;

   b. New CalOptima Health programs or initiatives;

   c. New DHCS programs or initiatives;

   d. CalOptima Health issued CAP requests related to Medi-Cal, in accordance with CalOptima Health Policy HH.2005: Corrective Action Plan and DHCS All Plan Letter (APL) 23-006: Delegation and Subcontractor Network Certification; and

   e. Health Network issues.

C. Required reports and submissions to DMHC:

1. As applicable, RAC shall submit required reports and filings to DMHC, required by the Knox Keene Act and codified in Title 28, California Code of Regulations.

2. As applicable and requested, RAC shall provide ad-hoc reports to DMHC.

D. RAC shall provide a regulatory update to interested CalOptima Health parties at least once a month, as outlined in CalOptima Health Policy GA.7501: Regulatory Communications.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Compliance Plan
B. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Health PACE Program Agreement
E. CalOptima Health Policy GA.7501: Regulatory Communications
F. CalOptima Health Policy HH.2005: Corrective Action Plan
G. Department of Health Care Services (DHCS) All Plan Letter 23-006: Delegation and Subcontractor Network Certification (Supersedes APL 17-004)
H. Knox Keene Act of 1975
I. Title 28, California Code of Regulations (C.C.R)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
02/21/2024	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/2007	GA.7505	Regulatory Liaison Responsibilities	Administrative
Revised	04/01/2016	GA.7505	Regulatory Liaison Responsibilities	Administrative
Revised	04/01/2017	GA.7505	Regulatory Liaison Responsibilities	Administrative
Revised	09/01/2018	GA.7505	Regulatory Liaison Responsibilities	Administrative
Revised	07/01/2019	GA.7505	Regulatory Liaison Responsibilities	Administrative
Revised	11/01/2020	GA.7505	Regulatory Liaison Responsibilities	Administrative
Revised	10/01/2021	GA.7505	Regulatory Liaison Responsibilities	Administrative
Revised	12/31/2022	GA.7505	Regulatory Liaison Responsibilities	Administrative
Revised	09/01/2023	GA.7505	Regulatory Liaison Responsibilities	Administrative
Revised	02/01/2024	GA.7505	Regulatory Liaison Responsibilities	Administrative
Revised	11/07/2024	GA.7505	Regulatory Liaison Responsibilities	Administrative

IX. GLOSSARY

Term	Definition
Centers for Medicare & Medicaid Services (CMS)	The federal agency within the United States Department of Health and Human Services (DHHS) that administers the Federal Medicare program and works in partnership with state governments to administer Medicaid programs.
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi-Cal Program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), ~~Child Health and Disabilities Prevention (CHDP), and~~and other health related programs as provided by statute and/or regulation.
Department of Managed Health Care (DMHC)	The state Agency that is responsible for licensing and regulating health care services plans/health maintenance organizations in accordance with the Knox Keene Health Care Service Plan Act of 1975 and as subsequently amended.
Knox-Keene Health Care Services Plan Act of 1975 (Knox-Keene)	The law that regulates HMOs and is administrated by the Department of Managed Health Care (DMHC), commencing with Section 1340 of the California Health and Safety Code.

Policy:	GA.7505
Title:	**Regulatory Liaison Responsibilities**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	*/s/*
Effective Date:	05/01/2007
Revised Date:	11/07/2024
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ PACE ☒ Administrative

I. PURPOSE

This policy defines CalOptima Health's regulatory liaison responsibilities.

II. POLICY

A. CalOptima Health's Regulatory Affairs & Compliance (RAC) Department shall be responsible for the regulatory liaison functions defined in this Policy.

B. RAC shall serve as CalOptima Health's liaison with the following regulatory agencies:

1. Centers for Medicare & Medicaid Services (CMS);
2. California Department of Health Care Services (DHCS); and
3. California Department of Managed Health Care (DMHC).

C. RAC shall serve as CalOptima Health's liaison with authorized contractors operating on behalf of the regulatory agencies identified in Section II.B. of this Policy.

D. As the regulatory liaison, RAC shall:

1. Ensure timely reports and submissions to regulatory agencies in accordance with appropriate rules, requirements, and regulations;
2. Disseminate regulatory communications to CalOptima Health's internal departments; and
3. Serve as a central point of contact between CalOptima Health and regulatory agencies.

III. PROCEDURE

A. Required reports and submissions to CMS:

1. RAC shall submit required reports and filings to CMS pursuant to CalOptima Health's Contract with CMS.

2. RAC shall coordinate such reports and filings with the CalOptima Health Medicare Programs (OneCare, and PACE) business owners.

3. RAC shall provide ad-hoc reports to CMS, as requested. Such ad-hoc reports include, but are not limited to, reports related to:

   a. Specific Member issues;

   b. CalOptima Health staffing changes;

   c. Health Network changes; and

   d. Self-Disclosure of Non-Compliance.

B. Required reports and submissions to DHCS:

1. RAC shall submit required reports and filings to DHCS pursuant to CalOptima Health's Contract(s) with DHCS. DHCS reporting includes, but is not limited to, reporting related to the Medi-Cal program, and the Program of All-Inclusive Care for the Elderly (PACE).

2. If DHCS provides CalOptima Health with written notice of any problems or deficiencies related to the submittal of data to DHCS, or of any changes or clarifications related to CalOptima Health's Management Information System (MIS) system, RAC shall coordinate with impacted business areas to submit a Corrective Action Plan (CAP) response, with measurable benchmarks, within fifteen (15) calendar days from the date of DHCS' written notice to CalOptima Health. If DHCS requests revisions, CalOptima Health shall submit a revised CAP for DHCS' approval within fifteen (15) calendar days after receipt of the request.

3. RAC shall coordinate DHCS-required reports and filings with CalOptima Health business owners, as necessary.

4. RAC shall provide ad-hoc reports to DHCS, as requested. Such ad-hoc reports may include, but are not limited to, reports related to:

   a. Specific Member issues;

   b. New CalOptima Health programs or initiatives;

   c. New DHCS programs or initiatives;

   d. CalOptima Health issued CAP requests related to Medi-Cal, in accordance with CalOptima Health Policy HH.2005: Corrective Action Plan and DHCS All Plan Letter (APL) 23-006: Delegation and Subcontractor Network Certification; and

   e. Health Network issues.

C. Required reports and submissions to DMHC:

1. As applicable, RAC shall submit required reports and filings to DMHC, required by the Knox Keene Act and codified in Title 28, California Code of Regulations.

2. As applicable and requested, RAC shall provide ad-hoc reports to DMHC.

D. RAC shall provide a regulatory update to interested CalOptima Health parties at least once a month, as outlined in CalOptima Health Policy GA.7501: Regulatory Communications.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Compliance Plan
B. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Health PACE Program Agreement
E. CalOptima Health Policy GA.7501: Regulatory Communications
F. CalOptima Health Policy HH.2005: Corrective Action Plan
G. Department of Health Care Services (DHCS) All Plan Letter 23-006: Delegation and Subcontractor Network Certification (Supersedes APL 17-004)
H. Knox Keene Act of 1975
I. Title 28, California Code of Regulations (C.C.R)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
02/21/2024	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/2007	GA.7505	Regulatory Liaison Responsibilities	Administrative
Revised	04/01/2016	GA.7505	Regulatory Liaison Responsibilities	Administrative
Revised	04/01/2017	GA.7505	Regulatory Liaison Responsibilities	Administrative
Revised	09/01/2018	GA.7505	Regulatory Liaison Responsibilities	Administrative
Revised	07/01/2019	GA.7505	Regulatory Liaison Responsibilities	Administrative
Revised	11/01/2020	GA.7505	Regulatory Liaison Responsibilities	Administrative
Revised	10/01/2021	GA.7505	Regulatory Liaison Responsibilities	Administrative
Revised	12/31/2022	GA.7505	Regulatory Liaison Responsibilities	Administrative
Revised	09/01/2023	GA.7505	Regulatory Liaison Responsibilities	Administrative
Revised	02/01/2024	GA.7505	Regulatory Liaison Responsibilities	Administrative
Revised	11/07/2024	GA.7505	Regulatory Liaison Responsibilities	Administrative

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IX. GLOSSARY

Term	Definition
Centers for Medicare & Medicaid Services (CMS)	The federal agency within the United States Department of Health and Human Services (DHHS) that administers the Federal Medicare program and works in partnership with state governments to administer Medicaid programs.
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi-Cal Program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health related programs as provided by statute and/or regulation.
Department of Managed Health Care (DMHC)	The state Agency that is responsible for licensing and regulating health care services plans/health maintenance organizations in accordance with the Knox Keene Health Care Service Plan Act of 1975 and as subsequently amended.
Knox-Keene Health Care Services Plan Act of 1975 (Knox-Keene)	The law that regulates HMOs and is administrated by the Department of Managed Health Care (DMHC), commencing with Section 1340 of the California Health and Safety Code.

Policy:	HH.1105
Title:	**Fraud, Waste, and Abuse Detection**
Department:	Office of Compliance
Section:	Fraud, Waste, and Abuse – Special Investigations Unit
CEO Approval:	*/s/*
Effective Date:	06/01/1999
Revised Date:	11/07/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ PACE ☐ Administrative

I. PURPOSE

This policy establishes a process to detect suspected Fraud, Waste, or Abuse (FWA) in a CalOptima Health program by a Member, Provider or Prescribing Provider, Practitioner, a CalOptima Health Employee, First Tier, Downstream, and Related Entities (FDRs), Billing Intermediary, and CalOptima Health's Health Networks, in accordance with federal and state regulations.

II. POLICY

A. CalOptima Health maintains a zero-tolerance policy toward Fraud, Waste, and Abuse.

B. CalOptima Health shall follow the process for detecting suspected Fraud, Waste, or Abuse, outlined in this policy.

C. CalOptima Health and its First Tier, Downstream, and Related Entities (FDRs) shall comply with applicable statutory, regulatory, other requirements, sub-regulatory guidance, and contractual commitments related to the delivery of Covered Services, which include but are not limited to, federal and state False Claims Acts, Anti-Kickback statutes, prohibitions on inducements to beneficiaries, Health Insurance Portability and Accountability Act (HIPAA), and other applicable statutes.

D. CalOptima Health's Pharmacy Management Department shall identify Fraud and Abuse of controlled substances by Members, Prescribing Providers, and Pharmacies dispensing drugs to Members, by conducting drug claim reviews and monitoring utilization safety standards, to detect opioid related misuse, and refer cases to the Office of Compliance in accordance with CalOptima Health Policy GG.1428: Pharmacy Management Medi-Cal Rx Responsibilities.

E. CalOptima Health's Office of Compliance shall investigate, and report suspected Fraud, Waste, or Abuse, in accordance with CalOptima Health Policy HH.1107: Fraud, Waste, and Abuse Investigation and Reporting.

F. CalOptima Health shall provide regular training and information sessions to its Employees and FDRs regarding Fraud, Waste, and Abuse, and shall inform Members regarding Fraud, Waste, and Abuse and the provisions of this policy.

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G. CalOptima Health Employees and FDRs are expected and required to promptly report suspected violations of any statute, regulations, or guidelines applicable to any CalOptima Health program. CalOptima Health maintains a strict policy of non-retaliation and non-retribution toward Employees and its FDRs who make such reports in good faith. CalOptima Health shall treat the detection of suspected FWA in a confidential manner to the extent possible.

III. PROCEDURE

A. CalOptima Health may detect Fraud, Waste, or Abuse by a Member in circumstances that include, but are not limited to, the following:

MEMBER FRAUD OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
M01	Using (selling, loaning, or giving) another individual's identity or documentation of Medi-Cal eligibility to obtain Covered Services	Members with services or prescriptions obtained from multiple areas of service; Members who attempt more than one PCP
M03	Making an unsubstantiated declaration of eligibility	Members with multiple areas of service; Members who attempt more than one PCP; reports of Members who are hiding assets or income
M04	Using a Covered Service for purposes other than the purpose for which it was prescribed, or using a Covered Service inappropriately	Selling a covered wheelchair; selling medications; abusing prescription medications
M05	Failing to report other health coverage.	Payments by OHI
M06	Soliciting or receiving a kickback, bribe, or rebate as an inducement to receive or not receive Covered Services.	Hotline reports; internal reports; reports by Health Networks
M07	Other	Any source
M08	Member Pharmacy Utilization	PBM or prescription reports; data analytics; claims data; Encounter data; FWA software
M09	Doctor Shopping	PBM or prescription reports; data analytics; claims data; Encounter data; FWA software
M10	Altered Prescription	Provider report; DEA report; Pharmacy report; PBM reports; data analytics; claims data; Encounter data; FWA software

B. CalOptima Health may detect Fraud, Waste, or Abuse by an FDR (i.e., Provider, Vendor) in circumstances that include, but are not limited to, the following:

FDR FRAUD OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
P01	Unsubstantiated declaration of eligibility to participate in the CalOptima Health program	Provider information not able to be verified during credentialing or contracting process; Providers on the excluded Provider list

FDR FRAUD OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
P02	Submission of claims for Covered Services that are substantially and demonstrably in excess of any individual's usual charges for such Covered Services	PBM reports; data analytics; claims data; Encounter data; FWA software; coding edits
P03	Submission of claims for Covered Services that are not actually provided to the Member for which the claim is submitted	PBM or prescription reports; data analytics; claims data; Encounter data; FWA software; verification surveys; Hotline report; Member interviews
P04	Submission of claims for Covered Services that are in excess of the quantity that is Medically Necessary	PBM or prescription reports; data analytics; claims data; Encounter data; FWA software; Medical Record review
P05	Submission of claims for Covered Services that are that are billed using a code that would result in greater payment than the code that reflects the Covered Services	PBM or prescription reports; data analytics; claims data; Encounter data; FWA software; Medical Record review
P06	Submission of claims for Covered Services that is already included in the capitation rate	PBM or prescription reports; data analytics; claims data; Encounter data; FWA software
P07	Submission of claims for Covered Services that are submitted for payment to both CalOptima Health and another third-party payer without full disclosure	PBM or prescription reports; data analytics; claims data; Encounter data; FWA software; payment by OHI
P08	Charging a Member in excess of allowable co-payments and deductibles for Covered Services	Member report; Hotline report; oversight audits; Member interviews
P09	Billing a Member for Covered Services without obtaining written consent to bill for such service	Member report; Hotline report; oversight audits; Member interviews
P10	Failure to disclose conflict of interest	Hotline; credentialing or contracting process
P11	Receiving, soliciting, or offering a kickback, bribe or rebate to refer or fail to refer a Member	Hotline report; oversight report
P12	Failure to register billing intermediary with the Department of Health Care Services	Oversight audit; report by regulatory body; Hotline report
P13	False certification of Medical Necessity	Medical Record review; claims data; Encounter data; FWA software
P14	Attributing a diagnosis code to a Member that does not reflect the Member's medical condition for the purpose of obtaining higher reimbursement	Medical Record review; claims data; Encounter data; FWA software
P15	False or inaccurate Minimum Standards or credentialing information	Hotline report; credentialing or contracting process
P16	Submitting reports that contain unsubstantiated data, data that is inconsistent with clinical, Encounter or payment records, or has been altered in a manner that is inconsistent with policies, contracts, statutes, or regulations	Medical Record review; claims data; Encounter data; FWA software; Member interviews

FDR FRAUD OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
P17	Other	Any source
P18	Provider Pharmacy Utilization.	PBM or prescription reports; data analytics; claims data; encounter data; FWA software.
P19	Billing Medi-Cal member for services.	Member report; Hotline report; oversight Audits.
P20	Durable Medical Equipment- covered services that are not actually provided to a member.	Member report; Hotline report; oversight Audits; verification surveys.

C. CalOptima Health may detect Fraud, Waste, or Abuse by an Employee in circumstances that include, but are not limited to, the following:

EMPLOYEE FRAUD OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
E01	Use of a Member's identity or documentation of Medi-Cal eligibility to obtain services	Hotline report; Data analytics; Referrals to SIU
E02	Use of a Member's identity or documentation of Medi-Cal eligibility to obtain a gain	Hotline report, Referrals to SIU
E03	Employee assistance to Providers with the submission of false claims for Covered Services that are not actually provided to the Member for which the claim is submitted	Hotline report; Referrals to SIU
E04	Employee deceptively accessing company confidential information for purpose of a gain	Hotline report; Data analytics; Referrals to SIU

D. Training

1. CalOptima Health's Office of Compliance shall provide regular training and education to Employees and FDRs regarding the process for detecting suspected FWA, the specific provisions regarding FWA under the False Claims Act, and the protections afforded to those who report such concerns in good faith and in accordance with CalOptima Health Policy HH.5004: False Claims Act Education.

2. CalOptima Health shall provide regular FWA training and information sessions to:

   a. New Employees, upon hire;

   b. CalOptima Health Employees, on an annual basis; and

   c. Health Networks, on an annual basis.

3. CalOptima Health shall provide Members with information related to FWA through:

   a. The Member Handbook;

   b. Periodic communications; and

c. The CalOptima Health website.

E. Detection

1. CalOptima Health may receive Complaints of suspected FWA from sources, including but not limited to:

   a. CalOptima Health's Compliance and Ethics Hotline;

   b. Claims data history;

   c. Encounter data;

   d. Medical Records audits;

   e. Member and Provider Complaints, appeals, and grievance reviews;

   f. Utilization Management reports;

   g. Provider utilization profiles;

   h. Pharmacy data;

   i. Monitoring and auditing activities;

   j. Memorandums and resources from CMS;

   k. Referrals from DHCS;

   ~~j.~~l. Monitoring external health care FWA cases and determining if CalOptima Health's FWA Program can be strengthened with information gleaned from the case activity; and/or

   ~~k.~~m. Internal and external surveys, reviews, and audits.

2. The Office of Compliance shall provide oversight to the Health Networks' Compliance Programs to ensure that the programs are in place, are comprehensive, and in compliance with CalOptima Health contractual requirements.

3. CalOptima Health shall utilize "claims edits" in accordance with federal and state regulations, the DHCS Contract, and industry best practices, including but not limited to the National Correct Coding Initiative (NCCI).

4. CalOptima Health shall conduct data validation reviews by auditors within the Office of Compliance. ~~-~~These reviews are intended to detect any anomalies between items billed, items rendered, Medical Records, and all affiliated documentation related to the claims and Encounters.

5. CalOptima Health shall utilize data analytics including software to identify potential FWA cases. ~~-~~This data compares CalOptima Health claims and Encounters against national data to identify any suspected instances of FWA. ~~-~~These cases are forwarded to the Special Investigations Unit (SIU) for investigation.

6. CalOptima Health shall perform reviews on data samples to test for potential FWA through methods, including, but not limited to:

   a. Reviewing utilization by doctor, specialty, and geographic comparison;

   b. CalOptima Health's Pharmacy Department shall refer cases to the SIU for Members exhibiting drug seeking behavior or suspected of FWA issues related to Pharmacy services.

7. CalOptima Health shall implement a Service Verification Survey process to survey a sampling of Members as needed. The focus of these surveys will vary as decided by the SIU and/or the Office of Compliance designated staff. The focus may be on a specific code, Provider, Member category, geographic area, and DME description, reports by other agencies of potential FWA, and industry findings and best practices. The Service Verification process may be used to ensure that:

   a. Covered Services that were billed were received;

   b. Face-to-face, or telehealth, services were provided for services/equipment/medications requiring recent or regular face-to-face, or telehealth, appointments;

   c. Durable Medical Equipment (DME) that were billed were received; and

   d. Medications that were billed were received.

F. CalOptima Health shall attend and participate in DHCS's quarterly program integrity meetings, as scheduled.

G. Upon detection of suspected Fraud, Waste, and/or Abuse, the Office of Compliance shall review the suspected activity in accordance with CalOptima Health Policy HH.1107: Fraud, Waste, and Abuse Investigation and Reporting.

H. CalOptima Health shall treat the detection of suspected Fraud, Waste, or Abuse in a confidential manner, and shall not retaliate or make retribution against any CalOptima Health Employee, FDR, or Member for such detection, in accordance with CalOptima Health policy HH.3012: Non-Retaliation for Reporting Violations.

IV. ATTACHMENT(S)

A. Suspected Fraud or Abuse Referral Form (English)

V. REFERENCE(S)

A. California Government Code, §12650, California False Claims Act
B. CalOptima Health Contract for Health Care Services
C. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima Health Contract with Department of Health Care Services (DHCS) for Medi-Cal
E. CalOptima Health PACE Program Agreement
F. CalOptima Health Policy GG.1428: Pharmacy Management Medi-Cal Rx Responsibilities
G. CalOptima Health Policy HH.1107: Fraud, Waste and Abuse Investigation and Reporting
H. CalOptima Health Policy HH.3012: Non-Retaliation for Reporting Violations

I. CalOptima Health Policy HH.5004: False Claims Act Education
J. Department of Health Care Services All Plan Letter (APL) ~~19-012~~23-026: Federal ~~Drugs~~Drug Utilization Review Requirements Designed to Reduce Opioid Related Fraud, Misuse and Abuse (Supersedes APL 19-012)(Revised 02/20/2024)
K. Title 31, United States Code (U.S.C.), §3730(h)
L. Title 42, Code of Federal Regulations (C.F.R.), §§455.2 and 438.608
M. Welfare and Institutions Code, §§14026 and 14107.2
N. Welfare and Institutions Code, §14043.1(a)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/01/1999	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal
Revised	08/01/2000	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal
Revised	09/01/2004	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal
Revised	01/01/2007	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal
Revised	02/01/2013	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare
Revised	04/01/2014	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal
Revised	09/01/2015	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal
Revised	06/01/2016	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal
Revised	12/01/2016	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare OneCare Connect PACE
Revised	05/01/2018	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare OneCare Connect PACE

Action	Date	Policy	Policy Title	Program(s)
Revised	12/06/2018	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare PACE
Revised	09/01/2023	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare PACE
Revised	11/07/2024	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare PACE

IX. GLOSSARY

Term	Definition
Abuse	~~Actions that may, directly or indirectly,~~Medi-Cal: Practices that are inconsistent with sound fiscal and business practices or medical standards, and result in an unnecessary ~~costs~~cost to ~~a CalOptima Health Program, improper payment, payment~~the Medi-Cal program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards ~~of~~for health care~~, or services that are medically~~. It also includes Member practices that result in unnecessary~~. Abuse involves payment for items or services when there is no legal entitlement,~~ cost to ~~that payment and~~ the Medi-Cal program. OneCare: A Provider ~~has not knowingly and/~~practice that is inconsistent with sound fiscal, business, or ~~intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from Fraud, because the distinction between "Fraud"~~medical practice, and ~~"Abuse" depends on specific facts~~ results in an unnecessary cost to CalOptima Health and ~~circumstances, intent~~the OneCare program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to CalOptima Health and ~~prior knowledge, and available evidence, among other factors~~the OneCare program.
Centers for Medicare & Medicaid Services (CMS)	The federal agency within the United States Department of Health and Human Services (DHHS) that administers the Federal Medicare program and works in partnership with state governments to administer Medicaid programs.
Complaint	Medi-Cal: ~~An oral or written expression indicating dissatisfaction with any aspect of~~A complaint is the same as a Grievance. If CalOptima Health ~~program~~is unable to distinguish between a Grievance and an Inquiry, it must be considered a Grievance. OneCare: Any expression of dissatisfaction to CalOptima Health, a Provider, or the Quality Improvement Organization (QIO) by a Member made orally or in writing. A Complaint may also involve CalOptima Health's refusal to provide services to which a Member believes he or she is entitled. A Complaint may be a Grievance or an Appeal, or a single Complaint could include both.
Covered Service	~~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 Health's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Enhanced Care Management and Community Supports as part of the California Advancing and Innovating Medi-Cal (CalAIM) Initiative (as set~~

Term	Definition
	~~forth in the CalAIM 1115 Demonstration & 1915(b) Waiver, DHCS All Plan Letter (APL) 21-012: Enhanced Care Management Requirements and APL 21-017: Community Supports Requirements, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 5.51, beginning with section 14184.100), or other services as authorized by the CalOptima Health Board of Directors, which shall be covered for Members notwithstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.~~Medi-Cal: Those health care services, set forth in W&I sections 14000 et seq. and 14131 et seq., 22 CCR section 51301 et seq., 17 CCR section 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, the contract with DHCS for Medi-Cal, and DHCS APLs that are made the responsibility of CalOptima Health pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS. Covered Services do not include: 1. Home and Community-Based Services (HCBS) program as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsections 4.3.15 (Services for Persons with Developmental Disabilities), 4.3.20 (Home and Community-Based Services Programs) regarding waiver programs, 4.3.21 (In-Home Supportive Services), and Department of Developmental Services (DDS) Administered Medicaid Home and Community-Based Services Waiver. HCBS programs do not include services that are available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service, as described in 22 CCR sections 51184, 51340 and 51340.1. EPSDT services are covered under the DHCS contract for Medi-Cal, as specified in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services), Subsection F4 regarding services for Members less than twenty-one (21) years of age. CalOptima Health is financially responsible for the payment of all EPSDT services; 2. California Children's Services (CCS) as specified in Exhibit A, Attachment III, Subsection 4.3.14 (California Children's Services), except for Contractors providing Whole Child Model (WCM) services; 3. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (Mental Health Services); 4. Alcohol and SUD treatment services, and outpatient heroin and other opioid detoxification, except for medications for addiction treatment as specified in Exhibit A, Attachment III, Subsection 4.3.13 (Alcohol and Substance Use Disorder Treatment Services); 5. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members); 6. Direct Observed Therapy for Treatment of Tuberculosis (TB) as specified in Exhibit A, Attachment III, Subsection 4.3.18 (Direct Observed Therapy for Treatment of Tuberculosis); 7. Dental services as specified in W&I sections 14131.10, 14132(h), 14132.22, 14132.23, and 14132.88, and EPSDT dental services as described in 22 CCR section 51340.1(b). However, CalOptima Health is

Term	Definition
	responsible for all Covered Services as specified in Exhibit A, Attachment III, Subsection 4.3.17 (Dental) regarding dental services; 8. Prayer or spiritual healing as specified in 22 CCR section 51312; 9. Educationally Necessary Behavioral Health Services that are covered by a Local Education Agency (LEA) and provided pursuant to a Member's Individualized Education Plan (IEP) as set forth in Education Code section 56340 et seq., Individualized Family Service Plan (IFSP) as set forth in California Government Code (GC) section 95020, or Individualized Health and Support Plan (IHSP). However, CalOptima Health is responsible for all Medically Necessary Behavioral Health Services as specified in Exhibit A, Attachment III Subsection 4.3.16 (School-Based Services); 10. Laboratory services provided under the State serum alpha-feto-protein-testing program administered by the Genetic Disease Branch of California Department of Public Health (CDPH); 11. Pediatric Day Health Care, except for Contractors providing Whole Child Model (WCM) services; 12. State Supported Services; 13. Targeted Case Management (TCM) services as set forth in 42 USC section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR sections 51185 and 51351, and as described in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services). However, if Members less than twenty-one (21) years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, CalOptima Health must ensure access to comparable services under the EPSDT benefit in accordance with DHCS APL 23-005; 14. Childhood lead poisoning case management provided by county health departments; 15. Non-medical services provided by Regional Centers (RC) to individuals with Developmental Disabilities, including but not limited to respite, out-of-home placement, and supportive living; 16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and DHCS APL 16-006; and 17. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with DHCS APL 22-012. OneCare: Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Center of Medicare & Medicaid Services (CMS) Contract. PACE: Those services set for the in California Code of Regulations, title 22, chapter 3, article 4, beginning with section 51301, and title 17, division 1, chapter 4, subchapter 13, beginning with Section 6840, unless otherwise specifically excluded under the terms of the DHCS PACE Contract with CalOptima Health, or other services as authorized by the CalOptima Health Board of Directors.

Term	Definition
Department of Health Care Services (DHCS)	~~The California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.~~The single State department responsible for the administration of the Medi-Cal Program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health related programs as provided by statute and/or regulation.
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Health Program benefit, below the level of arrangement between CalOptima Health and a First Tier Entity. These written arrangements continue down to the level of the ultimate Provider of both health and administrative services.
Durable Medical Equipment (DME)	Medi-Cal: Medically Necessary medical equipment as defined by 22 CCR section 51160 that ~~is prescribed~~a Provider prescribes for a Member that the Member ~~by Provider and is used~~uses in the ~~Member's~~ home, in the community, or in ~~an institution~~a facility that is used as a home. ~~DME:~~ ~~1. Can withstand repeated use.~~ ~~2. Is used to serve a medical purpose.~~ ~~3. Is not useful to an individual in the absence of an illness, injury, functional impairment, or congenital anomaly.~~ ~~4. Is appropriate for use in or out of the patient's home.~~ OneCare & PACE: Durable medical equipment means equipment prescribed by a licensed practitioner to meet medical equipment needs of the Member that: 1. Can withstand repeated use. 2. Is used to serve a medical purpose. 3. Is not useful to an individual in the absence of an illness, injury, functional impairment, or congenital anomaly. 4. Is appropriate for use in or out of the patient's home.
Employee	For purposes of this policy, any and all Employees of CalOptima Health, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary Employees and volunteers.
Encounter	Medi-Cal: Any unit of Covered Services provided to a Member by a Health Network regardless of Health Network reimbursement methodology. ~~-~~Such Covered Services include any service provided to a Member regardless of the service location or Provider, including out-of-network services and sub-capitated and delegated Covered Services. OneCare: Any unit of Covered Service provided to a Member by a Health Network regardless of Health Network reimbursement methodology. These services include any Covered Services provided to a Member, regardless of the service location or Provider, including out-of-network Covered Services and sub-capitated and delegated Covered Services. Encounter data submitted to CalOptima Health should not include denied, adjusted, or duplicate claims.
First Tier, Downstream, and Related Entities (FDR)	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted Providers, Health Networks, physician groups, Physician Hospital Consortia, and Health Maintenance Organizations.

Term	Definition
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima Health to provide administrative services or health care services to a Member under a CalOptima Health Program.
Fraud	~~Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or Fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. § 1347).~~An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with Title 42 Code of Federal Regulations section 455.2, Welfare and Institutions Code section 14043.1(i).
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information as amended.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Medical Record	Medi-Cal: ~~Any single, complete~~The record ~~kept or required to be kept by any Provider that documents all the~~of a Member's medical ~~services received by the Member,~~information including~~,~~ but not limited to, ~~inpatient, outpatient~~medical history, care or treatments received, test results, diagnoses, and ~~emergency care, referral requests, authorizations, or other documentation as indicated by CalOptima Health policy.~~ prescribed medications. OneCare: A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal. PACE: Written documentary evidence of treatments rendered to plan Members.
Medically Necessary or Medical Necessity	Medi-Cal: Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of Medical Necessity set forth in Section 1396d(r)(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code

Term	Definition
	Section 14132(v). Without limitation, Medically Necessary services for Members under 21 years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima Health shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child. OneCare: ~~Necessary~~Reasonable and necessary medical services to protect life, to prevent significant illness or significant disability, or ~~to~~ alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services includes Medi-Cal Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. PACE: Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury.
Member	A beneficiary enrolled in a CalOptima Health Program.
Other Health Coverage (OHC)	Medi-Cal: ~~The responsibility of an Individual or~~Health coverage from another entity~~, other than CalOptima Health or a Member, for the~~ that is responsible for payment of the reasonable value of all or part of the health care ~~benefits~~services provided to a Member. ~~Such OHC may originate under any other state, federal, or local medical care program or under other contractual or legal entitlements, including but not limited to, a private group or indemnification program. This responsibility~~OHC may result from a health insurance policy or other contractual agreement or legal obligation to pay for health care services provided to a Member, excluding tort liability. OHC may originate under State (other than the Medi-Cal program), federal, or local medical care program, or under other contractual or legal entitlements. OneCare: Evidence of health coverage other than OneCare including, but not necessarily limited to: 1. The CalOptima Health Medi-Cal program; 2. Group health plans; 3. Federal Employee Health Benefits Program (FEHB); 4. Military coverage, including TRICARE; 5. Worker's Compensation; 6. Personal Injury Liability compensation; 7. Black Lung federal coverage; 8. Indian Health Service; 9. Federally qualified health centers (FQHC); 10. Rural health centers (RHC); and/or 11. Other health benefit plans or programs that provide coverage or financial assistance for the purchase or provision of Covered Part D Drugs on behalf of Part D eligible individuals as the Centers for Medicare & Medicaid Services (CMS) may specify.

Term	Definition
Personal Representative	Has the meaning given such term in section 164.502(g) of title 45, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of un-emancipated minors.
Pharmacy	An area, place, or premise licensed by the State Board of Pharmacy in which the profession of pharmacy is practiced and where Prescriptions are compounded and dispensed.
Pharmacy Benefit Manager (PBM)	Medi-Cal: The entity that performs certain functions and tasks including, but not limited to, Pharmacy credentialing, contracting, and claims processing in accordance with the terms and conditions of the PBM Services Agreement. OneCare: An entity that provides Pharmacy benefit management services, including contracting with a network of pharmacies; establishing payment levels for network pharmacies; negotiating rebate arrangements; developing and managing formularies, preferred drug lists, and Prior Authorization programs; maintaining patient compliance programs; performing drug utilization review; and operating disease management programs.
Practitioner	A licensed independent Practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
Prescribing Provider	The physician, osteopath, podiatrist, dentist, optometrist, or authorized mid-level medical Practitioner who prescribes a medication for a Member.
Prior Authorization	Medi-Cal: A formal process requiring a health care Provider to obtain advance approval of Medically Necessary Covered Services, including the amount, duration and scope of services, except in the case of an emergency. OneCare: A process through which a physician or other health care provider is required to obtain advance approval, from CalOptima Health and/or a delegated entity, that payment will be made for a service or item furnished to a Member. PACE: A formal process requiring a health care provider to obtain advance approval to provide specific services or procedures, or the process by which an IDT approves a member to receive a specific service or procedure.

Term	Definition
Provider	~~Medi-Cal: A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, or other person or institution that furnishes Covered Services.~~ Medi-Cal: Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so. OneCare: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B.
Related Entity	Any entity that is related to ~~CalOptima Health~~the Medicare Advantage organization by common ownership or control and ~~that: performs:~~ 1. Performs some of ~~CalOptima Health's~~the Medicare Advantage organization's management functions under contract or delegation; ~~furnishes~~ ~~1.~~2. Furnishes services to ~~Members~~Medicare enrollees under an oral or written agreement; or ~~leases~~ ~~2.~~3. Leases real property or sells materials to ~~CalOptima Health~~the Medicare Advantage organization at a cost of more than ~~$~~two-thousand five-hundred dollars ($2,500) during a contract period.
Waste	Medi-Cal: The overutilization or inappropriate utilization of services and misuse of resources. OneCare: The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Health Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

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Policy:	HH.1105
Title:	**Fraud, Waste, and Abuse Detection**
Department:	Office of Compliance
Section:	Fraud, Waste, and Abuse – Special Investigations Unit
CEO Approval:	*/s/*
Effective Date:	06/01/1999
Revised Date:	11/07/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ PACE ☐ Administrative

I. PURPOSE

This policy establishes a process to detect suspected Fraud, Waste, or Abuse (FWA) in a CalOptima Health program by a Member, Provider or Prescribing Provider, Practitioner, a CalOptima Health Employee, First Tier, Downstream, and Related Entities (FDRs), Billing Intermediary, and CalOptima Health's Health Networks, in accordance with federal and state regulations.

II. POLICY

A. CalOptima Health maintains a zero-tolerance policy toward Fraud, Waste, and Abuse.

B. CalOptima Health shall follow the process for detecting suspected Fraud, Waste, or Abuse, outlined in this policy.

C. CalOptima Health and its First Tier, Downstream, and Related Entities (FDRs) shall comply with applicable statutory, regulatory, other requirements, sub-regulatory guidance, and contractual commitments related to the delivery of Covered Services, which include but are not limited to, federal and state False Claims Acts, Anti-Kickback statutes, prohibitions on inducements to beneficiaries, Health Insurance Portability and Accountability Act (HIPAA), and other applicable statutes.

D. CalOptima Health's Pharmacy Management Department shall identify Fraud and Abuse of controlled substances by Members, Prescribing Providers, and Pharmacies dispensing drugs to Members, by conducting drug claim reviews and monitoring utilization safety standards, to detect opioid related misuse, and refer cases to the Office of Compliance in accordance with CalOptima Health Policy GG.1428: Pharmacy Management Medi-Cal Rx Responsibilities.

E. CalOptima Health's Office of Compliance shall investigate, and report suspected Fraud, Waste, or Abuse, in accordance with CalOptima Health Policy HH.1107: Fraud, Waste, and Abuse Investigation and Reporting.

F. CalOptima Health shall provide regular training and information sessions to its Employees and FDRs regarding Fraud, Waste, and Abuse, and shall inform Members regarding Fraud, Waste, and Abuse and the provisions of this policy.

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G. CalOptima Health Employees and FDRs are expected and required to promptly report suspected violations of any statute, regulations, or guidelines applicable to any CalOptima Health program. CalOptima Health maintains a strict policy of non-retaliation and non-retribution toward Employees and its FDRs who make such reports in good faith. CalOptima Health shall treat the detection of suspected FWA in a confidential manner to the extent possible.

III. PROCEDURE

A. CalOptima Health may detect Fraud, Waste, or Abuse by a Member in circumstances that include, but are not limited to, the following:

MEMBER FRAUD OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
M01	Using (selling, loaning, or giving) another individual's identity or documentation of Medi-Cal eligibility to obtain Covered Services	Members with services or prescriptions obtained from multiple areas of service; Members who attempt more than one PCP
M03	Making an unsubstantiated declaration of eligibility	Members with multiple areas of service; Members who attempt more than one PCP; reports of Members who are hiding assets or income
M04	Using a Covered Service for purposes other than the purpose for which it was prescribed, or using a Covered Service inappropriately	Selling a covered wheelchair; selling medications; abusing prescription medications
M05	Failing to report other health coverage.	Payments by OHI
M06	Soliciting or receiving a kickback, bribe, or rebate as an inducement to receive or not receive Covered Services.	Hotline reports; internal reports; reports by Health Networks
M07	Other	Any source
M08	Member Pharmacy Utilization	PBM or prescription reports; data analytics; claims data; Encounter data; FWA software
M09	Doctor Shopping	PBM or prescription reports; data analytics; claims data; Encounter data; FWA software
M10	Altered Prescription	Provider report; DEA report; Pharmacy report; PBM reports; data analytics; claims data; Encounter data; FWA software

B. CalOptima Health may detect Fraud, Waste, or Abuse by an FDR (i.e., Provider, Vendor) in circumstances that include, but are not limited to, the following:

FDR FRAUD OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
P01	Unsubstantiated declaration of eligibility to participate in the CalOptima Health program	Provider information not able to be verified during credentialing or contracting process; Providers on the excluded Provider list

FDR FRAUD OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
P02	Submission of claims for Covered Services that are substantially and demonstrably in excess of any individual's usual charges for such Covered Services	PBM reports; data analytics; claims data; Encounter data; FWA software; coding edits
P03	Submission of claims for Covered Services that are not actually provided to the Member for which the claim is submitted	PBM or prescription reports; data analytics; claims data; Encounter data; FWA software; verification surveys; Hotline report; Member interviews
P04	Submission of claims for Covered Services that are in excess of the quantity that is Medically Necessary	PBM or prescription reports; data analytics; claims data; Encounter data; FWA software; Medical Record review
P05	Submission of claims for Covered Services that are that are billed using a code that would result in greater payment than the code that reflects the Covered Services	PBM or prescription reports; data analytics; claims data; Encounter data; FWA software; Medical Record review
P06	Submission of claims for Covered Services that is already included in the capitation rate	PBM or prescription reports; data analytics; claims data; Encounter data; FWA software
P07	Submission of claims for Covered Services that are submitted for payment to both CalOptima Health and another third-party payer without full disclosure	PBM or prescription reports; data analytics; claims data; Encounter data; FWA software; payment by OHI
P08	Charging a Member in excess of allowable co-payments and deductibles for Covered Services	Member report; Hotline report; oversight audits; Member interviews
P09	Billing a Member for Covered Services without obtaining written consent to bill for such service	Member report; Hotline report; oversight audits; Member interviews
P10	Failure to disclose conflict of interest	Hotline; credentialing or contracting process
P11	Receiving, soliciting, or offering a kickback, bribe or rebate to refer or fail to refer a Member	Hotline report; oversight report
P12	Failure to register billing intermediary with the Department of Health Care Services	Oversight audit; report by regulatory body; Hotline report
P13	False certification of Medical Necessity	Medical Record review; claims data; Encounter data; FWA software
P14	Attributing a diagnosis code to a Member that does not reflect the Member's medical condition for the purpose of obtaining higher reimbursement	Medical Record review; claims data; Encounter data; FWA software
P15	False or inaccurate Minimum Standards or credentialing information	Hotline report; credentialing or contracting process
P16	Submitting reports that contain unsubstantiated data, data that is inconsistent with clinical, Encounter or payment records, or has been altered in a manner that is inconsistent with policies, contracts, statutes, or regulations	Medical Record review; claims data; Encounter data; FWA software; Member interviews

FDR FRAUD OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
P17	Other	Any source
P18	Provider Pharmacy Utilization.	PBM or prescription reports; data analytics; claims data; encounter data; FWA software.
P19	Billing Medi-Cal member for services.	Member report; Hotline report; oversight Audits.
P20	Durable Medical Equipment- covered services that are not actually provided to a member.	Member report; Hotline report; oversight Audits; verification surveys.

C. CalOptima Health may detect Fraud, Waste, or Abuse by an Employee in circumstances that include, but are not limited to, the following:

EMPLOYEE FRAUD OR PROGRAM ABUSE		DETECTION CRITERIA Including but not limited to:
E01	Use of a Member's identity or documentation of Medi-Cal eligibility to obtain services	Hotline report; Data analytics; Referrals to SIU
E02	Use of a Member's identity or documentation of Medi-Cal eligibility to obtain a gain	Hotline report, Referrals to SIU
E03	Employee assistance to Providers with the submission of false claims for Covered Services that are not actually provided to the Member for which the claim is submitted	Hotline report; Referrals to SIU
E04	Employee deceptively accessing company confidential information for purpose of a gain	Hotline report; Data analytics; Referrals to SIU

D. Training

1. CalOptima Health's Office of Compliance shall provide regular training and education to Employees and FDRs regarding the process for detecting suspected FWA, the specific provisions regarding FWA under the False Claims Act, and the protections afforded to those who report such concerns in good faith and in accordance with CalOptima Health Policy HH.5004: False Claims Act Education.

2. CalOptima Health shall provide regular FWA training and information sessions to:

   a. New Employees, upon hire;

   b. CalOptima Health Employees, on an annual basis; and

   c. Health Networks, on an annual basis.

3. CalOptima Health shall provide Members with information related to FWA through:

   a. The Member Handbook;

   b. Periodic communications; and

c. The CalOptima Health website.

E. Detection

1. CalOptima Health may receive Complaints of suspected FWA from sources, including but not limited to:

   a. CalOptima Health's Compliance and Ethics Hotline;

   b. Claims data history;

   c. Encounter data;

   d. Medical Records audits;

   e. Member and Provider Complaints, appeals, and grievance reviews;

   f. Utilization Management reports;

   g. Provider utilization profiles;

   h. Pharmacy data;

   i. Monitoring and auditing activities;

   j. Memorandums and resources from CMS;

   k. Referrals from DHCS;

   l. Monitoring external health care FWA cases and determining if CalOptima Health's FWA Program can be strengthened with information gleaned from the case activity; and/or

   m. Internal and external surveys, reviews, and audits.

2. The Office of Compliance shall provide oversight to the Health Networks' Compliance Programs to ensure that the programs are in place, are comprehensive, and in compliance with CalOptima Health contractual requirements.

3. CalOptima Health shall utilize "claims edits" in accordance with federal and state regulations, the DHCS Contract, and industry best practices, including but not limited to the National Correct Coding Initiative (NCCI).

4. CalOptima Health shall conduct data validation reviews by auditors within the Office of Compliance. These reviews are intended to detect any anomalies between items billed, items rendered, Medical Records, and all affiliated documentation related to the claims and Encounters.

5. CalOptima Health shall utilize data analytics including software to identify potential FWA cases. This data compares CalOptima Health claims and Encounters against national data to identify any suspected instances of FWA. These cases are forwarded to the Special Investigations Unit (SIU) for investigation.

6. CalOptima Health shall perform reviews on data samples to test for potential FWA through methods, including, but not limited to:

   a. Reviewing utilization by doctor, specialty, and geographic comparison;

   b. CalOptima Health's Pharmacy Department shall refer cases to the SIU for Members exhibiting drug seeking behavior or suspected of FWA issues related to Pharmacy services.

7. CalOptima Health shall implement a Service Verification Survey process to survey a sampling of Members as needed. The focus of these surveys will vary as decided by the SIU and/or the Office of Compliance designated staff. The focus may be on a specific code, Provider, Member category, geographic area, and DME description, reports by other agencies of potential FWA, and industry findings and best practices. The Service Verification process may be used to ensure that:

   a. Covered Services that were billed were received;

   b. Face-to-face, or telehealth, services were provided for services/equipment/medications requiring recent or regular face-to-face, or telehealth, appointments;

   c. Durable Medical Equipment (DME) that were billed were received; and

   d. Medications that were billed were received.

F. CalOptima Health shall attend and participate in DHCS's quarterly program integrity meetings, as scheduled.

G. Upon detection of suspected Fraud, Waste, and/or Abuse, the Office of Compliance shall review the suspected activity in accordance with CalOptima Health Policy HH.1107: Fraud, Waste, and Abuse Investigation and Reporting.

H. CalOptima Health shall treat the detection of suspected Fraud, Waste, or Abuse in a confidential manner, and shall not retaliate or make retribution against any CalOptima Health Employee, FDR, or Member for such detection, in accordance with CalOptima Health policy HH.3012: Non-Retaliation for Reporting Violations.

IV. ATTACHMENT(S)

A. Suspected Fraud or Abuse Referral Form (English)

V. REFERENCE(S)

A. California Government Code, §12650, California False Claims Act
B. CalOptima Health Contract for Health Care Services
C. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima Health Contract with Department of Health Care Services (DHCS) for Medi-Cal
E. CalOptima Health PACE Program Agreement
F. CalOptima Health Policy GG.1428: Pharmacy Management Medi-Cal Rx Responsibilities
G. CalOptima Health Policy HH.1107: Fraud, Waste and Abuse Investigation and Reporting
H. CalOptima Health Policy HH.3012: Non-Retaliation for Reporting Violations

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I. CalOptima Health Policy HH.5004: False Claims Act Education
J. Department of Health Care Services All Plan Letter (APL) 23-026: Federal Drug Utilization Review Requirements Designed to Reduce Opioid Related Fraud, Misuse and Abuse (Supersedes APL 19-012)(Revised 02/20/2024)
K. Title 31, United States Code (U.S.C.), §3730(h)
L. Title 42, Code of Federal Regulations (C.F.R.), §§455.2 and 438.608
M. Welfare and Institutions Code, §§14026 and 14107.2
N. Welfare and Institutions Code, §14043.1(a)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/01/1999	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal
Revised	08/01/2000	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal
Revised	09/01/2004	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal
Revised	01/01/2007	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal
Revised	02/01/2013	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare
Revised	04/01/2014	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal
Revised	09/01/2015	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal
Revised	06/01/2016	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal
Revised	12/01/2016	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare OneCare Connect PACE
Revised	05/01/2018	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare OneCare Connect PACE

Action	Date	Policy	Policy Title	Program(s)
Revised	12/06/2018	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare PACE
Revised	09/01/2023	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare PACE
Revised	11/07/2024	HH.1105	Fraud, Waste, and Abuse Detection	Medi-Cal OneCare PACE

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IX. GLOSSARY

Term	Definition
Abuse	Medi-Cal: Practices that are inconsistent with sound fiscal and business practices or medical standards, and result in an unnecessary cost to the Medi-Cal program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to the Medi-Cal program. OneCare: A Provider practice that is inconsistent with sound fiscal, business, or medical practice, and results in an unnecessary cost to CalOptima Health and the OneCare program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to CalOptima Health and the OneCare program.
Centers for Medicare & Medicaid Services (CMS)	The federal agency within the United States Department of Health and Human Services (DHHS) that administers the Federal Medicare program and works in partnership with state governments to administer Medicaid programs.
Complaint	Medi-Cal: A complaint is the same as a Grievance. If CalOptima Health is unable to distinguish between a Grievance and an Inquiry, it must be considered a Grievance. OneCare: Any expression of dissatisfaction to CalOptima Health, a Provider, or the Quality Improvement Organization (QIO) by a Member made orally or in writing. A Complaint may also involve CalOptima Health's refusal to provide services to which a Member believes he or she is entitled. A Complaint may be a Grievance or an Appeal, or a single Complaint could include both.
Covered Service	Medi-Cal: Those health care services, set forth in W&I sections 14000 et seq. and 14131 et seq., 22 CCR section 51301 et seq., 17 CCR section 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, the contract with DHCS for Medi-Cal, and DHCS APLs that are made the responsibility of CalOptima Health pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS. Covered Services do not include: 1. Home and Community-Based Services (HCBS) program as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsections 4.3.15 (Services for Persons with Developmental Disabilities), 4.3.20 (Home and Community-Based Services Programs) regarding waiver programs, 4.3.21 (In-Home Supportive Services), and Department of Developmental Services (DDS) Administered Medicaid Home and Community-Based Services Waiver. HCBS programs do not include services that are available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service, as described in 22 CCR sections 51184, 51340 and 51340.1. EPSDT services are covered under the DHCS contract for Medi-Cal, as specified in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services), Subsection F4

Term	Definition
	regarding services for Members less than twenty-one (21) years of age. CalOptima Health is financially responsible for the payment of all EPSDT services; 2. California Children's Services (CCS) as specified in Exhibit A, Attachment III, Subsection 4.3.14 (California Children's Services), except for Contractors providing Whole Child Model (WCM) services; 3. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (Mental Health Services); 4. Alcohol and SUD treatment services, and outpatient heroin and other opioid detoxification, except for medications for addiction treatment as specified in Exhibit A, Attachment III, Subsection 4.3.13 (Alcohol and Substance Use Disorder Treatment Services); 5. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members); 6. Direct Observed Therapy for Treatment of Tuberculosis (TB) as specified in Exhibit A, Attachment III, Subsection 4.3.18 (Direct Observed Therapy for Treatment of Tuberculosis); 7. Dental services as specified in W&I sections 14131.10, 14132(h), 14132.22, 14132.23, and 14132.88, and EPSDT dental services as described in 22 CCR section 51340.1(b). However, CalOptima Health is responsible for all Covered Services as specified in Exhibit A, Attachment III, Subsection 4.3.17 (Dental) regarding dental services; 8. Prayer or spiritual healing as specified in 22 CCR section 51312; 9. Educationally Necessary Behavioral Health Services that are covered by a Local Education Agency (LEA) and provided pursuant to a Member's Individualized Education Plan (IEP) as set forth in Education Code section 56340 et seq., Individualized Family Service Plan (IFSP) as set forth in California Government Code (GC) section 95020, or Individualized Health and Support Plan (IHSP). However, CalOptima Health is responsible for all Medically Necessary Behavioral Health Services as specified in Exhibit A, Attachment III Subsection 4.3.16 (School-Based Services); 10. Laboratory services provided under the State serum alpha-feto-protein-testing program administered by the Genetic Disease Branch of California Department of Public Health (CDPH); 11. Pediatric Day Health Care, except for Contractors providing Whole Child Model (WCM) services; 12. State Supported Services; 13. Targeted Case Management (TCM) services as set forth in 42 USC section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR sections 51185 and 51351, and as described in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services). However, if Members less than twenty-one (21) years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, CalOptima Health must ensure access to comparable services under the EPSDT benefit in accordance with DHCS APL 23-005; 14. Childhood lead poisoning case management provided by county health departments;

Term	Definition
	15. Non-medical services provided by Regional Centers (RC) to individuals with Developmental Disabilities, including but not limited to respite, out-of-home placement, and supportive living; 16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and DHCS APL 16-006; and 17. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with DHCS APL 22-012. OneCare: Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Center of Medicare & Medicaid Services (CMS) Contract. PACE: Those services set for the in California Code of Regulations, title 22, chapter 3, article 4, beginning with section 51301, and title 17, division 1, chapter 4, subchapter 13, beginning with Section 6840, unless otherwise specifically excluded under the terms of the DHCS PACE Contract with CalOptima Health, or other services as authorized by the CalOptima Health Board of Directors.
Department of Health Care Services (DHCS)	The single State department responsible for the administration of the Medi-Cal Program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health related programs as provided by statute and/or regulation.
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Health Program benefit, below the level of arrangement between CalOptima Health and a First Tier Entity. These written arrangements continue down to the level of the ultimate Provider of both health and administrative services.
Durable Medical Equipment (DME)	Medi-Cal: Medically Necessary medical equipment as defined by 22 CCR section 51160 that a Provider prescribes for a Member that the Member uses in the home, in the community, or in a facility that is used as a home. OneCare & PACE: Durable medical equipment means equipment prescribed by a licensed practitioner to meet medical equipment needs of the Member that: 1. Can withstand repeated use. 2. Is used to serve a medical purpose. 3. Is not useful to an individual in the absence of an illness, injury, functional impairment, or congenital anomaly. 4. Is appropriate for use in or out of the patient's home.
Employee	For purposes of this policy, any and all Employees of CalOptima Health, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary Employees and volunteers.
Encounter	Medi-Cal: Any unit of Covered Services provided to a Member by a Health Network regardless of Health Network reimbursement methodology. Such Covered Services include any service provided to a Member regardless of the service location or Provider, including out-of-network services and sub-capitated and delegated Covered Services. OneCare: Any unit of Covered Service provided to a Member by a Health Network regardless of Health Network reimbursement methodology. These

Term	Definition
	services include any Covered Services provided to a Member, regardless of the service location or Provider, including out-of-network Covered Services and sub-capitated and delegated Covered Services. Encounter data submitted to CalOptima Health should not include denied, adjusted, or duplicate claims.
First Tier, Downstream, and Related Entities (FDR)	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted Providers, Health Networks, physician groups, Physician Hospital Consortia, and Health Maintenance Organizations.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima Health to provide administrative services or health care services to a Member under a CalOptima Health Program.
Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with Title 42 Code of Federal Regulations section 455.2, Welfare and Institutions Code section 14043.1(i).
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information as amended.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Medical Record	Medi-Cal: The record of a Member's medical information including but not limited to, medical history, care or treatments received, test results, diagnoses, and prescribed medications. OneCare: A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal. PACE: Written documentary evidence of treatments rendered to plan Members.
Medically Necessary or Medical Necessity	Medi-Cal: Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of Medical Necessity set forth in Section 1396d(r)(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code

Term	Definition
	Section 14132(v). Without limitation, Medically Necessary services for Members under 21 years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima Health shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child. OneCare: Reasonable and necessary medical services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services includes Medi-Cal Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. PACE: Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury.
Member	A beneficiary enrolled in a CalOptima Health Program.
Other Health Coverage (OHC)	Medi-Cal: Health coverage from another entity that is responsible for payment of the reasonable value of all or part of the health care services provided to a Member. OHC may result from a health insurance policy or other contractual agreement or legal obligation to pay for health care services provided to a Member, excluding tort liability. OHC may originate under State (other than the Medi-Cal program), federal, or local medical care program, or under other contractual or legal entitlements. OneCare: Evidence of health coverage other than OneCare including, but not necessarily limited to: 1. The CalOptima Health Medi-Cal program; 2. Group health plans; 3. Federal Employee Health Benefits Program (FEHB); 4. Military coverage, including TRICARE; 5. Worker's Compensation; 6. Personal Injury Liability compensation; 7. Black Lung federal coverage; 8. Indian Health Service; 9. Federally qualified health centers (FQHC); 10. Rural health centers (RHC); and/or 11. Other health benefit plans or programs that provide coverage or financial assistance for the purchase or provision of Covered Part D Drugs on behalf of Part D eligible individuals as the Centers for Medicare & Medicaid Services (CMS) may specify.
Personal Representative	Has the meaning given such term in section 164.502(g) of title 45, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of un-emancipated minors.

Term	Definition
Pharmacy	An area, place, or premise licensed by the State Board of Pharmacy in which the profession of pharmacy is practiced and where Prescriptions are compounded and dispensed.
Pharmacy Benefit Manager (PBM)	Medi-Cal: The entity that performs certain functions and tasks including, but not limited to, Pharmacy credentialing, contracting, and claims processing in accordance with the terms and conditions of the PBM Services Agreement. OneCare: An entity that provides Pharmacy benefit management services, including contracting with a network of pharmacies; establishing payment levels for network pharmacies; negotiating rebate arrangements; developing and managing formularies, preferred drug lists, and Prior Authorization programs; maintaining patient compliance programs; performing drug utilization review; and operating disease management programs.
Practitioner	A licensed independent Practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
Prescribing Provider	The physician, osteopath, podiatrist, dentist, optometrist, or authorized mid-level medical Practitioner who prescribes a medication for a Member.
Prior Authorization	Medi-Cal: A formal process requiring a health care Provider to obtain advance approval of Medically Necessary Covered Services, including the amount, duration and scope of services, except in the case of an emergency. OneCare: A process through which a physician or other health care provider is required to obtain advance approval, from CalOptima Health and/or a delegated entity, that payment will be made for a service or item furnished to a Member. PACE: A formal process requiring a health care provider to obtain advance approval to provide specific services or procedures, or the process by which an IDT approves a member to receive a specific service or procedure.
Provider	Medi-Cal: Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so. OneCare: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B.

Term	Definition
Related Entity	Any entity that is related to the Medicare Advantage organization by common ownership or control and: 1. Performs some of the Medicare Advantage organization's management functions under contract or delegation; 2. Furnishes services to Medicare enrollees under an oral or written agreement; or 3. Leases real property or sells materials to the Medicare Advantage organization at a cost of more than two-thousand five-hundred dollars ($2,500) during a contract period.
Waste	Medi-Cal: The overutilization or inappropriate utilization of services and misuse of resources. OneCare: The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Health Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

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INSTRUCTIONS FOR COMPLETING A SUSPECTED FRAUD OR ABUSE REFERRAL FORM

To submit a request to investigate suspected fraud or abuse, please complete a CalOptima Health Suspected Fraud or Abuse Referral Form. Examples of "Member" or "Provider" fraud or abuse are listed on the form. These are examples only. The list does not represent every situation in which fraud or abuse can take place.

Complete all applicable sections of the form. It is very important to complete the entire form so we can effectively investigate the issue.

If desired, requestor may remain anonymous; however, if the requestor does not provide his/her name and phone number, the CalOptima Health Office of Compliance will be unable to contact him/her if there are any questions about the information submitted, which may prevent completion of the investigation.

Submit the completed form with supporting documents to CalOptima Health's Office of Compliance via one of the following methods:

1. Email: Fraud@CalOptima.org
2. U.S. Mail: CalOptima Health
   Office of Compliance — SIU
   505 City Parkway West
   Orange CA 92868
3. Fax: **1-714-481-6457**

MARK ALL CORRESPONDENCE AS "CONFIDENTIAL."

You may also report suspected fraud or abuse to CalOptima Health's Ethics and Compliance hotline, 24 hours a day, 7 days a week, toll-free at 1-855-507-1805. TDD/TTY users can call toll-free at 1-800-735-2929. We have staff that speak your language.

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SUSPECTED FRAUD OR ABUSE REFERRAL FORM

REFERRAL INFORMATION		
Date: _____		Notice involves suspected fraud or abuse by a:
Referred by: Name: _____	Title: _____	☐ Member
Dept.: _____	Phone#: _____	☐ Provider

MEMBER	PROVIDER
CalOptima Health Program: ☐ Medi-Cal ☐ OneCare ☐ PACE	Provider Name:
Member Name:	Type of provider:
Member ID:	Provider ID:
Address:	Address:
City: ZIP:	City: ZIP:
Date of service if applicable:	Date of service if applicable:
Member ID, if applicable:	If multiple members are involved, please attach a list.

Examples of suspected fraud or abuse:

- ☐ Using another individual's identity or documentation of Medi-Cal eligibility to obtain covered services and prescriptions (unless that person is an authorized representative who is presenting such information to obtain covered services on behalf of a member)
- ☐ Selling, loaning or giving a member's identity or documentation of eligibility to obtain covered services (other than to a family member to obtain covered services on behalf of a member)
- ☐ Falsely claiming eligibility
- ☐ Using a covered service for purposes other than the purposes for which it was prescribed, including use by an individual other than the member for whom the covered service was prescribed or provided
- ☐ Failing to report other health coverage
- ☐ Soliciting or receiving a kickback, bribe or rebate as an inducement to receive or not receive covered services
- ☐ Other (please specify) _____

Allegation of suspected fraud or abuse:

- ☐ Falsely claiming eligibility to participate in the CalOptima Health program.
- ☐ Submission of claims for covered services that are:
  - ☐ Substantially and demonstrably more than any individual's usual charges for such covered services
  - ☐ Not actually provided to the member for which the claim is submitted
  - ☐ More than the quantity that is medically necessary
  - ☐ Billed using a code that would result in greater payment than the code that reflects the covered service
  - ☐ Already included in capitation rate
  - ☐ Submitted for payment to both CalOptima Health and another third-party payer without full disclosure
- ☐ Charging a member in excess of allowable co-payments and deductibles for covered services
- ☐ Billing a member for covered services without obtaining written consent to bill for such services

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SUSPECTED FRAUD OR ABUSE REFERRAL FORM

	☐ Failure to disclose conflict of interest ☐ Receiving, soliciting or offering a kickback, bribe or rebate to refer or fail to refer a member ☐ Failure to register billing intermediary with the Department of Health Care Services (DHCS) ☐ False certification of medical necessity ☐ Attributing a diagnosis code to a member that does not reflect the member's medical condition to obtain higher reimbursement ☐ False or inaccurate Minimum Standards or credentialing information ☐ Submitting reports that contain unsubstantiated data, data that is inconsistent with records or has been altered in a manner that is inconsistent with policies, contracts, statutes or regulations. ☐ Other (please specify) _____

DOCUMENTATION (PLEASE ATTACH):
☐ Claims data ☐ Medical records ☐ Complaint, appeal or grievance ☐ UM reports ☐ Audit ☐ Other (please specify) _____ **Please provide a brief explanation of how the documentation provided supports concerns of fraudulent activity:** _____ **Please provide the root cause of this suspected fraudulent activity:** _____

OTHER RELEVANT INFORMATION (PLEASE ATTACH):
Are there any prior suspected fraud or abuse issues by this member, provider, pharmacy, other: _____ 1. ☐ No ☐ Yes. Please describe:
2. If yes, what was the outcome?

Please submit this form with all pertinent documentation to the OFFICE OF COMPLIANCE SPECIAL INVESTIGATIONS UNIT (SIU). The Office of Compliance SIU shall report as appropriate to local and state entities. If you do not receive an acknowledgement of receipt of this form within five (5) working days, please send an email to Fraud@CalOptima.org.

Policy:	HH.2005
Title:	**Corrective Action Plan**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	*/s/*
Effective Date:	11/01/1998
Revised Date:	11/07/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ PACE ☐ Administrative

I. PURPOSE

This policy defines the requirements for CalOptima Health and its First Tier, Downstream, and Related Entities (FDRs) for development and submission of an Immediate Corrective Action Plan (ICAP) or Corrective Action Plan (CAP) for areas of non-compliant performance, as identified by CalOptima Health's Office of Compliance.

CalOptima Health's Office of Compliance recognizes that issues of non-compliant performance may be identified by internal departments and FDRs that are outside of the Auditing, and operational Monitoring and investigations conducted by the Office of Compliance. This policy does not restrict the internal departments and FDRs from performing their own routine monitoring, investigation and corrective action process. As an example, refer to CalOptima Health Policy GG.1615: Corrective Action Plan for Practitioners and Organizational Providers.

II. POLICY

A. CalOptima Health's Office of Compliance shall conduct Auditing, ~~operational~~ Monitoring, and investigations of internal CalOptima Health departments and its FDRs to ensure compliance with statutory, regulatory, contractual, CalOptima Health policy, and other requirements related to CalOptima Health programs.

B. CalOptima Health's Office of Compliance may require that an internal department or FDR develop an ICAP or CAP response based on the identified area(s) of non-compliance.

C. CalOptima Health's Office of Compliance shall require CalOptima Health internal departments and FDRs to bring their operations into full compliance with statutory, regulatory, contractual, CalOptima Health policy, and other requirements, which CalOptima Health or its regulators have identified as non-compliant, within time frames established by CalOptima Health's Office of Compliance.

D. An internal department or FDR shall develop, submit, and take corrective action under an approved ICAP or CAP response in the time and manner required by CalOptima Health's Office of Compliance.

1. Failure by the internal department to respond accurately, timely, and in compliance with statutory, regulatory, contractual, CalOptima Health policy, or other requirements to CalOptima Health's Office of Compliance's ICAP or CAP request may lead to further action.

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2. Failure by an FDR to respond accurately, timely, and in compliance with statutory, regulatory, contractual, CalOptima Health policy, or other requirements to CalOptima Health's Office of Compliance's ICAP, or CAP, request may lead to further action. CalOptima Health may impose Sanctions for the underlying non-compliant performance that gave rise to the ICAP or CAP request, or the failure to develop, submit, and meet the requirements of the ICAP or CAP request, in accordance with CalOptima Health Policy HH.2002: Sanctions.

III. PROCEDURE

A. Basis for an ICAP or CAP

1. CalOptima Health's Office of Compliance shall routinely Monitor performance metrics, conduct routine, or focused, Audits, and conduct ongoing Monitoring and investigations of reported non-compliance for internal departments, or FDRs, through a variety of mechanisms.

   a. CalOptima Health's Office of Compliance may issue an ICAP/CAP request as a result of Audits conducted by federal and state regulatory agencies, including, but not limited to the Department of Health Care Services (DHCS), the Centers for Medicare & Medicaid Services (CMS), and the Department of Managed Health Care (DMHC).

   b. CalOptima Health's Office of Compliance may issue an ICAP/CAP request as a result of an ICAP/CAP request, or other corrective action, that CalOptima Health receives from a federal or state regulatory agency that is directly related to the operations of an internal department or FDR.

2. In the event that CalOptima Health's Office of Compliance determines an internal department, or FDR, has failed to comply with statutory, regulatory, contractual, CalOptima Health policy, or other requirements, the Office of Compliance may issue an ICAP, or CAP request, to address the problem. CalOptima Health's Office of Compliance shall coordinate its efforts with CalOptima Health's Human Resources Department in the event that an ICAP or CAP potentially warrants Employee disciplinary action.

B. ICAP and CAP Issuance and Requirements

1. CalOptima Health's Office of Compliance shall utilize a standardized ICAP and CAP request template.

2. Non-compliance with specific requirements that have the potential to cause significant Member harm, or place CalOptima Health's accreditation, participation, and/or contractual status with regulatory agencies in jeopardy will require an ICAP response.

   a. If the finding requires an ICAP request, as determined by CalOptima Health's Office of Compliance, the internal department or FDR must immediately take all reasonable action to stop or prevent further non-compliance. The internal department or FDR will have five (5) business days from the formal ICAP request to provide a plan, in writing, to address or remediate the deficiency.

   b. The internal department or FDR shall provide a written response within five (5) business days of receiving an ICAP request, detailing how it will mitigate and prevent further non-compliance. Following the acceptance of the ICAP response, the internal department or FDR is required to resolve the issue in a manner and time frame deemed appropriate by CalOptima Health's Office of Compliance.

3. A CAP request is the result of material non-compliance with specific requirements that does not rise to the level of an ICAP request.

    a. The internal department or FDR is required to respond to the CAP request within ten (10) business days. CalOptima Health's Chief Compliance Officer or Designee may authorize extensions to this timeline on a case-by-case basis. Following the acceptance of the CAP response, the internal department or FDR is required to resolve the issue in a manner and time frame deemed appropriate by CalOptima Health's Office of Compliance.

4. An ICAP or CAP response shall include the following elements:

    a. A root cause analysis of the deficiency which may include a description of the policies and procedures, staffing, training, and systems that failed;

    b. Steps taken to resolve the deficiency;

    c. Steps taken to avoid reoccurrence;

    d. Method for implementation and completion of ICAP response or CAP response;

    e. Individual(s) responsible for implementation of the ICAP response or CAP response;

    f. An attestation by the internal ~~department or FDR~~department's Executive Officer responsible for the area subject to the CAP, or their Designee, or FDR, conveying a plan to remedy its identified deficiencies; and

    g. ICAP response or CAP response completion date(s), as applicable.

C. Unacceptable Resolution to an ICAP or CAP

1. If the resolution to the deficiency is unacceptable or the internal department or FDR fails to respond, CalOptima Health's Office of Compliance shall issue a written notice to the internal department or the FDR, which shall include:

    a. A summary of previous outreach and required action(s);

    b. An explanation of why that the resolution was not acceptable, or why a response was not received;

    c. A revised response timeline of two (2) business days for an ICAP;

        i. Extensions to this timeline may be authorized on a case-by-case basis by CalOptima Health's Chief Compliance Officer or Designee.

    d. A revised response timeline of five (5) business days for a CAP;

        i. Extensions to this timeline may be authorized on a case-by-case basis by CalOptima Health's Chief Compliance Officer or Designee.

    e. Explain the possible consequences, specific to the nature of the issue and degree of completeness in accordance with CalOptima Health Policy HH.2002: Sanctions;

    f. Possibility of escalating to the department's Chief, or the FDR's Chief Executive Officer (CEO) or their Designee; and

g. Possibility of referral to the Delegation Oversight Committee (DOC) and the Compliance Committee.

D. Acceptable Resolution with ICAP or CAP Requirements

1. A response may be accepted once all requirements outlined in Section III.B.4. of this Policy are fulfilled. If an ICAP or CAP response requires Monitoring or a focused Audit, the ICAP or CAP response shall not be closed until the remediation(s) implemented have been validated by the Office of Compliance and demonstrate that the issue will not recur.

   a. A response may be accepted and closed simultaneously if Monitoring or a focused Audit is not required.

2. If the resolution to the deficiency is deemed acceptable by CalOptima Health's Chief Compliance Officer or Designee, CalOptima Health's Office of Compliance may issue a written notification of acceptance, which shall include:

   a. An acknowledgement of acceptance;

   b. A description of follow up actions which shall include, but is not limited to:

      i. Submission of finalized documentation; and/or

      ii. Focused Audit, as described in Section III.E. of this Policy; and/or

      iii. Monitoring, as deemed appropriate by CalOptima Health's Office of Compliance, and as described in Section III.F. of this Policy.

3. If the resolution to the deficiency is accepted and deemed sufficient by CalOptima Health's Chief Compliance Officer or Designee, CalOptima Health's Office of Compliance shall issue a written notification of closure, which shall include:

   a. An acknowledgement of closure;

   b. The effective date of closure; and

   c. Consequences of repeat deficiencies.

E. Focused Audits

1. CalOptima Health's Office of Compliance may conduct a focused Audit of an internal department or FDR to confirm implementation of the accepted ICAP or CAP response.

2. CalOptima Health's Office of Compliance shall notify the internal department or FDR of the scope, Audit period, and Audit deliverables that shall be required to complete the focused Audit.

3. CalOptima Health's Office of Compliance may continue to Monitor and/or Audit an internal department or FDR for performance of issues and/or functions related to the ICAP or CAP request.

F. Monitoring Period

1. CalOptima Health's Office of Compliance may conduct Monitoring of the internal department's or FDR's resolution to confirm implementation of the accepted ICAP or CAP response.

2. CalOptima Health's Office of Compliance shall Monitor the resolution for a predetermined time frame for example, not more than 90 days after a "cure" has been affected to ensure ongoing compliance, as established by CalOptima Health's Office of Compliance.

3. CalOptima Health's Office of Compliance shall notify the internal department, or FDR, of the scope, Monitoring period, and deliverables that shall be required to complete the Monitoring.

4. CalOptima Health's Office of Compliance may continue to Monitor and/or Audit an internal department's or FDR's performance of issues and/or functions related to the ICAP or CAP request.

G. Failure to Maintain Adequate Resolution

1. If during the Monitoring period or the focused Audit the internal department or FDR fails to maintain the remedies in place, CalOptima Health's Office of Compliance may issue the internal department or FDR an ICAP or CAP request, as appropriate.

2. If an ICAP request is issued, the internal department or FDR shall be required to resolve the issue within two (2) business days from the re-issuance of the finding.

   a. Extensions to this timeline may be authorized on a case-by-case basis by the Chief Compliance Officer, or Designee.

3. The ICAP request shall require the information as described in Section III.B.4. of this Policy.

H. ICAP and CAP Tracking and Reporting

1. CalOptima Health's Office of Compliance shall track all CAP and ICAP requests issued utilizing a standardized tool.

2. CalOptima Health's Office of Compliance shall report the status of all CAP/ICAP requests to the DOC and the Compliance Committee.

3. In the event that CalOptima Health's Office of Compliance makes a determination to self-disclose the ICAP or significant incident of noncompliance with respect to the CalOptima Health Medi-Cal or Medicare Program, the Regulatory Affairs & Compliance Department shall report the issue to CalOptima Health's DHCS Contract Manager and/or CMS Account Manager.

   a. The Office of Compliance will submit the Self-Disclosure report to the Chief Compliance Officer for review and sign off.

   b. Once the above step has been completed, and an accepted CAP (if applicable) has been submitted, the Chief Compliance Officer, or Designee, will submit the non-compliance incident to DHCS and/or CMS, including any steps taken to correct the non-compliance, immediately, but no later than the referenced time frame for Medicare in accordance with CalOptima Health Policy MA.9124: CMS Self-Disclosure, and three (3) business days for Medi-Cal ICAPs.

c. CalOptima shall report the incident to DHCS and/or CMS as soon as possible after its discovery.

4. If CalOptima Health's internal department, or FDR, has repeated deficiencies, the issue(s) shall be reported to the DOC and the Compliance Committee by the Office of Compliance for further action.

I. On a quarterly basis, CalOptima Health's Office of Compliance shall make publicly available, a report containing CAP status and actions taken to close out the findings.

IV. ATTACHMENT(S)

A. ICAP/CAP Request Template

V. REFERENCE(S)

A. CalOptima Health Compliance Plan
B. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Health PACE Program Agreement
E. CalOptima Health Policy GG.1615: Corrective Action Plan for Practitioners and Organizational Providers
F. CalOptima Health Policy HH.2002: Sanctions
G. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-006: Delegation and Subcontractor Network Certification (Supersedes APL 17-004)
H. Medicare Managed Care Manual, Chapter 21
I. Medicare Prescription Drug Benefit Manual, Chapter 9
J. Title 22, California Code of Regulations (CCR), §51301 et. seq.

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
06/08/2022	Department of Health Care Services (DHCS)	File and Use
10/23/2023	Department of Health Care Services (DHCS)	File and Use
02/21/2024	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
08/02/2018	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
05/05/2022	Regular Meeting of the CalOptima Board of Directors
12/01/2022	Regular Meeting of the CalOptima Health Board of Directors
10/05/2023	Regular Meeting of the CalOptima Health Board of Directors
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	11/01/1998	HH.2005	Health Network Corrective Action Plan	Medi-Cal
Revised	10/01/2002	HH.2005	Health Network Corrective Action Plan	Medi-Cal
Revised	06/01/2007	HH.2005	Health Network Corrective Action Plan	Medi-Cal
Revised	04/01/2013	HH.2005	Corrective Action Plan	Medi-Cal OneCare
Revised	09/01/2015	HH.2005	Corrective Action Plan	Medi-Cal
Revised	12/01/2016	HH.2005	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.2005	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised	08/02/2018	HH.2005	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.2005	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.2005	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.2005	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.2005	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised	05/05/2022	HH.2005	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	HH.2005	Corrective Action Plan	Medi-Cal OneCare PACE
Revised	09/01/2023	HH.2005	Corrective Action Plan	Medi-Cal OneCare PACE
Revised	02/01/2024	HH.2005	Corrective Action Plan	Medi-Cal OneCare PACE
Revised	11/07/2024	HH.2005	Corrective Action Plan	Medi-Cal OneCare PACE

IX. GLOSSARY

Term	Definition
Audit	A formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being audited and normally performed by individuals with one of several acknowledged certifications.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima Health, the Centers for Medicare & Medicaid Services (CMS), or designated representatives. First Tier Entities and/or CalOptima Health departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima Health and its regulators.
Delegation Oversight Committee (DOC)	Medi-Cal: A subcommittee of the Compliance Committee chaired by the Director(s) of Delegation Oversight to oversee CalOptima Health's delegated functions. The composition of the DOC includes representatives from CalOptima Health's departments as provided for in CalOptima Health Policy HH.4001: Delegation Oversight Committee. OneCare: A subcommittee of the Compliance Committee chaired by the Director of the Delegation Oversight department to oversee CalOptima Health's delegated functions. The composition of the DOC includes representatives from CalOptima Health's operational departments.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Downstream Entity	Medi-Cal: Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Health Program benefit, below the level of ~~the~~ arrangement between CalOptima Health and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services. OneCare: Any party that enters into an acceptable written arrangement below the level of the arrangement between a Medicare Advantage (MA) organization (and contract applicant) and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.
Employee	For purposes of this policy, any and all employees of CalOptima Health, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.
First Tier, Downstream, and Related Entities (FDRs)	Means First Tier, Downstream or Related Entity, as separately defined herein.

Term	Definition
First Tier Entity	Medi-Cal: Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima Health to provide administrative services or health care services to a Member under a CalOptima Health Program. OneCare: Any party that enters into a written arrangement, acceptable to CMS, with an MAO or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare eligible individual under the MA program or Part D program.
Immediate Corrective Action Plan (ICAP)	An ICAP is the result of non-compliance with specific requirements that has the potential to cause significant member harm. Significant member harm exists if the non-compliance resulted in the failure to provide medical items, services or prescription drugs, causing financial distress, or posing a threat to member's health and safety due to non-existent or inadequate policies and procedures, systems, operations or staffing.
Immediate Corrective Action Plan (ICAP) Request	The result of non-compliance with specific requirements that has the potential to cause significant Member harm. Significant Member harm exists if the noncompliance resulted in the failure to provide medical services or prescription drugs, causing financial distress, or posing a threat to Member's health and safety due to non-existent or inadequate policies and procedures, systems, operations or staffing.
Member	A beneficiary ~~who is~~ enrolled in a CalOptima Health ~~Program~~program.
Monitoring	Regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.
Related Entity	Any entity that is related to ~~CalOptima Health~~the Medicare Advantage organization by common ownership or control and ~~that: performs~~: 1. Performs some of ~~CalOptima Health's~~the Medicare Advantage organization's management functions under contract or delegation; ~~furnishes~~ 2. Furnishes services to ~~Members~~Medicare enrollees under an oral or written agreement; or ~~leases~~ ~~1.~~3. Leases real property or sells materials to ~~CalOptima Health~~the Medicare Advantage organization at a cost of more than two thousand five hundred dollars ($2,500) during a contract period.
Sanction	An action taken by CalOptima Health, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on a First Tier Entity's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima Health Programs.

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Policy:	HH.2005
Title:	**Corrective Action Plan**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	*/s/*
Effective Date:	11/01/1998
Revised Date:	11/07/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ PACE ☐ Administrative

I. PURPOSE

This policy defines the requirements for CalOptima Health and its First Tier, Downstream, and Related Entities (FDRs) for development and submission of an Immediate Corrective Action Plan (ICAP) or Corrective Action Plan (CAP) for areas of non-compliant performance, as identified by CalOptima Health's Office of Compliance.

CalOptima Health's Office of Compliance recognizes that issues of non-compliant performance may be identified by internal departments and FDRs that are outside of the Auditing, and operational Monitoring and investigations conducted by the Office of Compliance. This policy does not restrict the internal departments and FDRs from performing their own routine monitoring, investigation and corrective action process. As an example, refer to CalOptima Health Policy GG.1615: Corrective Action Plan for Practitioners and Organizational Providers.

II. POLICY

A. CalOptima Health's Office of Compliance shall conduct Auditing, Monitoring, and investigations of internal CalOptima Health departments and its FDRs to ensure compliance with statutory, regulatory, contractual, CalOptima Health policy, and other requirements related to CalOptima Health programs.

B. CalOptima Health's Office of Compliance may require that an internal department or FDR develop an ICAP or CAP response based on the identified area(s) of non-compliance.

C. CalOptima Health's Office of Compliance shall require CalOptima Health internal departments and FDRs to bring their operations into full compliance with statutory, regulatory, contractual, CalOptima Health policy, and other requirements, which CalOptima Health or its regulators have identified as non-compliant, within time frames established by CalOptima Health's Office of Compliance.

D. An internal department or FDR shall develop, submit, and take corrective action under an approved ICAP or CAP response in the time and manner required by CalOptima Health's Office of Compliance.

1. Failure by the internal department to respond accurately, timely, and in compliance with statutory, regulatory, contractual, CalOptima Health policy, or other requirements to CalOptima Health's Office of Compliance's ICAP or CAP request may lead to further action.

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2. Failure by an FDR to respond accurately, timely, and in compliance with statutory, regulatory, contractual, CalOptima Health policy, or other requirements to CalOptima Health's Office of Compliance's ICAP, or CAP, request may lead to further action. CalOptima Health may impose Sanctions for the underlying non-compliant performance that gave rise to the ICAP or CAP request, or the failure to develop, submit, and meet the requirements of the ICAP or CAP request, in accordance with CalOptima Health Policy HH.2002: Sanctions.

III. PROCEDURE

A. Basis for an ICAP or CAP

1. CalOptima Health's Office of Compliance shall routinely Monitor performance metrics, conduct routine, or focused, Audits, and conduct ongoing Monitoring and investigations of reported non-compliance for internal departments, or FDRs, through a variety of mechanisms.

   a. CalOptima Health's Office of Compliance may issue an ICAP/CAP request as a result of Audits conducted by federal and state regulatory agencies, including, but not limited to the Department of Health Care Services (DHCS), the Centers for Medicare & Medicaid Services (CMS), and the Department of Managed Health Care (DMHC).

   b. CalOptima Health's Office of Compliance may issue an ICAP/CAP request as a result of an ICAP/CAP request, or other corrective action, that CalOptima Health receives from a federal or state regulatory agency that is directly related to the operations of an internal department or FDR.

2. In the event that CalOptima Health's Office of Compliance determines an internal department, or FDR, has failed to comply with statutory, regulatory, contractual, CalOptima Health policy, or other requirements, the Office of Compliance may issue an ICAP, or CAP request, to address the problem. CalOptima Health's Office of Compliance shall coordinate its efforts with CalOptima Health's Human Resources Department in the event that an ICAP or CAP potentially warrants Employee disciplinary action.

B. ICAP and CAP Issuance and Requirements

1. CalOptima Health's Office of Compliance shall utilize a standardized ICAP and CAP request template.

2. Non-compliance with specific requirements that have the potential to cause significant Member harm, or place CalOptima Health's accreditation, participation, and/or contractual status with regulatory agencies in jeopardy will require an ICAP response.

   a. If the finding requires an ICAP request, as determined by CalOptima Health's Office of Compliance, the internal department or FDR must immediately take all reasonable action to stop or prevent further non-compliance. The internal department or FDR will have five (5) business days from the formal ICAP request to provide a plan, in writing, to address or remediate the deficiency.

   b. The internal department or FDR shall provide a written response within five (5) business days of receiving an ICAP request, detailing how it will mitigate and prevent further non-compliance. Following the acceptance of the ICAP response, the internal department or FDR is required to resolve the issue in a manner and time frame deemed appropriate by CalOptima Health's Office of Compliance.

3. A CAP request is the result of material non-compliance with specific requirements that does not rise to the level of an ICAP request.

    a. The internal department or FDR is required to respond to the CAP request within ten (10) business days. CalOptima Health's Chief Compliance Officer or Designee may authorize extensions to this timeline on a case-by-case basis. Following the acceptance of the CAP response, the internal department or FDR is required to resolve the issue in a manner and time frame deemed appropriate by CalOptima Health's Office of Compliance.

4. An ICAP or CAP response shall include the following elements:

    a. A root cause analysis of the deficiency which may include a description of the policies and procedures, staffing, training, and systems that failed;

    b. Steps taken to resolve the deficiency;

    c. Steps taken to avoid reoccurrence;

    d. Method for implementation and completion of ICAP response or CAP response;

    e. Individual(s) responsible for implementation of the ICAP response or CAP response;

    f. An attestation by the internal department's Executive Officer responsible for the area subject to the CAP, or their Designee, or FDR, conveying a plan to remedy its identified deficiencies; and

    g. ICAP response or CAP response completion date(s), as applicable.

C. Unacceptable Resolution to an ICAP or CAP

1. If the resolution to the deficiency is unacceptable or the internal department or FDR fails to respond, CalOptima Health's Office of Compliance shall issue a written notice to the internal department or the FDR, which shall include:

    a. A summary of previous outreach and required action(s);

    b. An explanation of why that the resolution was not acceptable, or why a response was not received;

    c. A revised response timeline of two (2) business days for an ICAP;

        i. Extensions to this timeline may be authorized on a case-by-case basis by CalOptima Health's Chief Compliance Officer or Designee.

    d. A revised response timeline of five (5) business days for a CAP;

        i. Extensions to this timeline may be authorized on a case-by-case basis by CalOptima Health's Chief Compliance Officer or Designee.

    e. Explain the possible consequences, specific to the nature of the issue and degree of completeness in accordance with CalOptima Health Policy HH.2002: Sanctions;

    f. Possibility of escalating to the department's Chief, or the FDR's Chief Executive Officer (CEO) or their Designee; and

g. Possibility of referral to the Delegation Oversight Committee (DOC) and the Compliance Committee.

D. Acceptable Resolution with ICAP or CAP Requirements

1. A response may be accepted once all requirements outlined in Section III.B.4. of this Policy are fulfilled. If an ICAP or CAP response requires Monitoring or a focused Audit, the ICAP or CAP response shall not be closed until the remediation(s) implemented have been validated by the Office of Compliance and demonstrate that the issue will not recur.

   a. A response may be accepted and closed simultaneously if Monitoring or a focused Audit is not required.

2. If the resolution to the deficiency is deemed acceptable by CalOptima Health's Chief Compliance Officer or Designee, CalOptima Health's Office of Compliance may issue a written notification of acceptance, which shall include:

   a. An acknowledgement of acceptance;

   b. A description of follow up actions which shall include, but is not limited to:

      i. Submission of finalized documentation; and/or

      ii. Focused Audit, as described in Section III.E. of this Policy; and/or

      iii. Monitoring, as deemed appropriate by CalOptima Health's Office of Compliance, and as described in Section III.F. of this Policy.

3. If the resolution to the deficiency is accepted and deemed sufficient by CalOptima Health's Chief Compliance Officer or Designee, CalOptima Health's Office of Compliance shall issue a written notification of closure, which shall include:

   a. An acknowledgement of closure;

   b. The effective date of closure; and

   c. Consequences of repeat deficiencies.

E. Focused Audits

1. CalOptima Health's Office of Compliance may conduct a focused Audit of an internal department or FDR to confirm implementation of the accepted ICAP or CAP response.

2. CalOptima Health's Office of Compliance shall notify the internal department or FDR of the scope, Audit period, and Audit deliverables that shall be required to complete the focused Audit.

3. CalOptima Health's Office of Compliance may continue to Monitor and/or Audit an internal department or FDR for performance of issues and/or functions related to the ICAP or CAP request.

F. Monitoring Period

1. CalOptima Health's Office of Compliance may conduct Monitoring of the internal department's or FDR's resolution to confirm implementation of the accepted ICAP or CAP response.

2. CalOptima Health's Office of Compliance shall Monitor the resolution for a predetermined time frame for example, not more than 90 days after a "cure" has been affected to ensure ongoing compliance, as established by CalOptima Health's Office of Compliance.

3. CalOptima Health's Office of Compliance shall notify the internal department, or FDR, of the scope, Monitoring period, and deliverables that shall be required to complete the Monitoring.

4. CalOptima Health's Office of Compliance may continue to Monitor and/or Audit an internal department's or FDR's performance of issues and/or functions related to the ICAP or CAP request.

G. Failure to Maintain Adequate Resolution

1. If during the Monitoring period or the focused Audit the internal department or FDR fails to maintain the remedies in place, CalOptima Health's Office of Compliance may issue the internal department or FDR an ICAP or CAP request, as appropriate.

2. If an ICAP request is issued, the internal department or FDR shall be required to resolve the issue within two (2) business days from the re-issuance of the finding.

   a. Extensions to this timeline may be authorized on a case-by-case basis by the Chief Compliance Officer, or Designee.

3. The ICAP request shall require the information as described in Section III.B.4. of this Policy.

H. ICAP and CAP Tracking and Reporting

1. CalOptima Health's Office of Compliance shall track all CAP and ICAP requests issued utilizing a standardized tool.

2. CalOptima Health's Office of Compliance shall report the status of all CAP/ICAP requests to the DOC and the Compliance Committee.

3. In the event that CalOptima Health's Office of Compliance makes a determination to self-disclose the ICAP or significant incident of noncompliance with respect to the CalOptima Health Medi-Cal or Medicare Program, the Regulatory Affairs & Compliance Department shall report the issue to CalOptima Health's DHCS Contract Manager and/or CMS Account Manager.

   a. The Office of Compliance will submit the Self-Disclosure report to the Chief Compliance Officer for review and sign off.

   b. Once the above step has been completed, and an accepted CAP (if applicable) has been submitted, the Chief Compliance Officer, or Designee, will submit the non-compliance incident to DHCS and/or CMS, including any steps taken to correct the non-compliance, immediately, but no later than the referenced time frame for Medicare in accordance with CalOptima Health Policy MA.9124: CMS Self-Disclosure, and three (3) business days for Medi-Cal ICAPs.

   c. CalOptima shall report the incident to DHCS and/or CMS as soon as possible after its discovery.

4. If CalOptima Health's internal department, or FDR, has repeated deficiencies, the issue(s) shall be reported to the DOC and the Compliance Committee by the Office of Compliance for further action.

I. On a quarterly basis, CalOptima Health's Office of Compliance shall make publicly available, a report containing CAP status and actions taken to close out the findings.

IV. ATTACHMENT(S)

A. ICAP/CAP Request Template

V. REFERENCE(S)

A. CalOptima Health Compliance Plan
B. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Health PACE Program Agreement
E. CalOptima Health Policy GG.1615: Corrective Action Plan for Practitioners and Organizational Providers
F. CalOptima Health Policy HH.2002: Sanctions
G. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-006: Delegation and Subcontractor Network Certification (Supersedes APL 17-004)
H. Medicare Managed Care Manual, Chapter 21
I. Medicare Prescription Drug Benefit Manual, Chapter 9
J. Title 22, California Code of Regulations (CCR), §51301 et. seq.

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
06/08/2022	Department of Health Care Services (DHCS)	File and Use
10/23/2023	Department of Health Care Services (DHCS)	File and Use
02/21/2024	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
08/02/2018	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
05/05/2022	Regular Meeting of the CalOptima Board of Directors
12/01/2022	Regular Meeting of the CalOptima Health Board of Directors
10/05/2023	Regular Meeting of the CalOptima Health Board of Directors
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	11/01/1998	HH.2005	Health Network Corrective Action Plan	Medi-Cal
Revised	10/01/2002	HH.2005	Health Network Corrective Action Plan	Medi-Cal
Revised	06/01/2007	HH.2005	Health Network Corrective Action Plan	Medi-Cal
Revised	04/01/2013	HH.2005	Corrective Action Plan	Medi-Cal OneCare
Revised	09/01/2015	HH.2005	Corrective Action Plan	Medi-Cal
Revised	12/01/2016	HH.2005	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
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Revised	12/05/2019	HH.2005	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
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Revised	12/20/2021	HH.2005	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
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Revised	09/01/2023	HH.2005	Corrective Action Plan	Medi-Cal OneCare PACE
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IX. GLOSSARY

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Audit	A formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being audited and normally performed by individuals with one of several acknowledged certifications.
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Employee	For purposes of this policy, any and all employees of CalOptima Health, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.
First Tier, Downstream, and Related Entities (FDRs)	Means First Tier, Downstream or Related Entity, as separately defined herein.

Term	Definition
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Immediate Corrective Action Plan (ICAP) Request	The result of non-compliance with specific requirements that has the potential to cause significant Member harm. Significant Member harm exists if the noncompliance resulted in the failure to provide medical services or prescription drugs, causing financial distress, or posing a threat to Member's health and safety due to non-existent or inadequate policies and procedures, systems, operations or staffing.
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Related Entity	Any entity that is related to the Medicare Advantage organization by common ownership or control and: 1. Performs some of the Medicare Advantage organization's management functions under contract or delegation; 2. Furnishes services to Medicare enrollees under an oral or written agreement; or 3. Leases real property or sells materials to the Medicare Advantage organization at a cost of more than two thousand five hundred dollars ($2,500) during a contract period.
Sanction	An action taken by CalOptima Health, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on a First Tier Entity's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima Health Programs.

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Corrective Action Plan (CAP):
Non-Compliance Investigations

Instructions: The Responsible Party (CalOptima Health or Delegated Entity) must provide a response to all cells in white, including: (1) a response (in black font) to each of the four questions under CAP Response (2) Identification of the responsible person including all contact information, (3) Implementation date, actual or planned, and (4) CAP Attestation.

CalOptima Health's Office of Compliance is responsible for completing all cells in blue.

Responsible Party (CalOptima Health or Delegated Entity)		**Case #**	
		CAP Type: Immediate (ICAP) or Standard (CAP)	
Department (if applicable)		**Date CAP Sent by CalOptima Health**	
Date of Incident		**Date CAP Due to CalOptima Health**	
Investigator Name		**CAP Submitted By**	
Line of Business		**Date CAP Submitted**	

CAP #	Background/Deficiency	CAP Response (Responsible Party: Black, CalOptima Health: Red)	Responsible Person/Contact Information	Implementation Date (Actual or Planned)	CAP Status
1	**Background:** **Applicable References and Standards:** **Findings and Actions:**	**1a) Indicate the root cause(s) of the deficiency, by utilizing the check box(es) below.** ☐ Lack of established protocols (e.g., P&Ps, DTPs) ☐ Non-adherence to established protocols ☐ Inadequate or ineffective staff/delegate training ☐ Inadequate oversight of process/system ☐ Incorrect interpretation or application of requirement ☐ Other: Please specify **1b) Please provide additional details on each root cause(s) selected above:**			

Corrective Action Plan (CAP):
Non-Compliance Investigations

Instructions: The Responsible Party (CalOptima Health or Delegated Entity) must provide a response to all cells in white, including: (1) a response (in black font) to each of the four questions under CAP Response (2) Identification of the responsible person including all contact information, (3) Implementation date, actual or planned, and (4) CAP Attestation.

CalOptima Health's Office of Compliance is responsible for completing all cells in blue.

		~~2)~~ **What step(s) have been taken to resolve *each* root cause of the deficiency?** ~~3)~~2)			
		~~4)~~3) **What control(s) have been implemented for *each* root cause to ensure this deficiency does not reoccur?**			
		~~5)~~4) **How will the responsible party measure and monitor *each* implemented control to ensure continued effectiveness/compliance of the CAP?**			
Office of Compliance Monitoring Method(s) and Result				**Monitoring Status**	

Corrective Action Plan (CAP):
Non-Compliance Investigations

Instructions: The Responsible Party (CalOptima Health or Delegated Entity) must provide a response to all cells in white, including: (1) a response (in black font) to each of the four questions under CAP Response (2) Identification of the responsible person including all contact information, (3) Implementation date, actual or planned, and (4) CAP Attestation.

CalOptima Health's Office of Compliance is responsible for completing all cells in blue.

CAP #	Background/Deficiency	CAP Response (Responsible Party: Black, CalOptima Health: Red)	Responsible Person/Contact Information	Implementation Date (Actual or Planned)	CAP Status
2	**Background:** **Applicable References and Standards:** **Findings and Actions:**	**1a) Indicate the root cause(s) of the deficiency, by utilizing the check box(es) below.** ☐ Lack of established protocols (e.g., P&Ps, DTPs) ☐ Non-adherence to established protocols ☐ Inadequate or ineffective staff/delegate training ☐ Inadequate oversight of process/system ☐ Incorrect interpretation or application of requirement ☐ Other: Please specify **1b) Please provide additional details on each root cause(s) selected above:**			
		2) What step(s) have been taken to resolve *each* root cause of the deficiency?			
		3) What control(s) have been implemented for *each* root cause to ensure this deficiency does not reoccur?			

Corrective Action Plan (CAP):
Non-Compliance Investigations

Instructions: The Responsible Party (CalOptima Health or Delegated Entity) must provide a response to all cells in white, including: (1) a response (in black font) to each of the four questions under CAP Response (2) Identification of the responsible person including all contact information, (3) Implementation date, actual or planned, and (4) CAP Attestation.

CalOptima Health's Office of Compliance is responsible for completing all cells in blue.

		4) How will the responsible party measure and monitor *each* implemented control to ensure continued effectiveness/compliance of the CAP?			
Office of Compliance Monitoring Method(s) and Result				**Monitoring Status**	

CAP Attestation:

I, _____ [NAME/TITLE] hereby have the authority to attest that the CAP(s), and subsequent remediation, as stated above, accurately reflect _____ [BUSINESS OWNER/DELEGATE] plan to remediate and execute the above referenced area(s) of non-compliance.

Generated by: (Responsible Party, must be Executive Officer or his/her Designee)	Name, Title	Signature	Date
Approved by: (CalOptima Health ~~Office of Compliance~~, Chief Compliance Officer or his/her Designee)	Name, Title	Signature	Date

Corrective Action Plan (CAP):
Non-Compliance Investigations

Instructions: The Responsible Party (CalOptima Health or Delegated Entity) must provide a response to all cells in white, including: (1) a response (in black font) to each of the four questions under CAP Response (2) Identification of the responsible person including all contact information, (3) Implementation date, actual or planned, and (4) CAP Attestation.

CalOptima Health's Office of Compliance is responsible for completing all cells in blue.

Responsible Party (CalOptima Health or Delegated Entity)		**Case #**	
		CAP Type: Immediate (ICAP) or Standard (CAP)	
Department (if applicable)		**Date CAP Sent by CalOptima Health**	
Date of Incident		**Date CAP Due to CalOptima Health**	
Investigator Name		**CAP Submitted By**	
Line of Business		**Date CAP Submitted**	

CAP #	Background/Deficiency	CAP Response (Responsible Party: Black, CalOptima Health: Red)	Responsible Person/Contact Information	Implementation Date (Actual or Planned)	CAP Status
1	**Background:** **Applicable References and Standards:** **Findings and Actions:**	**1a) Indicate the root cause(s) of the deficiency, by utilizing the check box(es) below.** ☐ Lack of established protocols (e.g., P&Ps, DTPs) ☐ Non-adherence to established protocols ☐ Inadequate or ineffective staff/delegate training ☐ Inadequate oversight of process/system ☐ Incorrect interpretation or application of requirement ☐ Other: Please specify **1b) Please provide additional details on each root cause(s) selected above:**			

Corrective Action Plan (CAP):
Non-Compliance Investigations

Instructions: The Responsible Party (CalOptima Health or Delegated Entity) must provide a response to all cells in white, including: (1) a response (in black font) to each of the four questions under CAP Response (2) Identification of the responsible person including all contact information, (3) Implementation date, actual or planned, and (4) CAP Attestation.

CalOptima Health's Office of Compliance is responsible for completing all cells in blue.

		2) What step(s) have been taken to resolve *each* root cause of the deficiency?			
		3) What control(s) have been implemented for *each* root cause to ensure this deficiency does not reoccur?			
		4) How will the responsible party measure and monitor *each* implemented control to ensure continued effectiveness/compliance of the CAP?			
Office of Compliance Monitoring Method(s) and Result				**Monitoring Status**	

CAP #	Background/Deficiency	CAP Response (Responsible Party: Black, CalOptima Health: Red)	Responsible Person/Contact Information	Implementation Date (Actual or Planned)	CAP Status

Corrective Action Plan (CAP):
Non-Compliance Investigations

Instructions: The Responsible Party (CalOptima Health or Delegated Entity) must provide a response to all cells in white, including: (1) a response (in black font) to each of the four questions under CAP Response (2) Identification of the responsible person including all contact information, (3) Implementation date, actual or planned, and (4) CAP Attestation.

CalOptima Health's Office of Compliance is responsible for completing all cells in blue.

2	**Background:** **Applicable References and Standards:** **Findings and Actions:**	**1a) Indicate the root cause(s) of the deficiency, by utilizing the check box(es) below.** ☐ Lack of established protocols (e.g., P&Ps, DTPs) ☐ Non-adherence to established protocols ☐ Inadequate or ineffective staff/delegate training ☐ Inadequate oversight of process/system ☐ Incorrect interpretation or application of requirement ☐ Other: Please specify **1b) Please provide additional details on each root cause(s) selected above:**			
		2) What step(s) have been taken to resolve *each* root cause of the deficiency?			
		3) What control(s) have been implemented for *each* root cause to ensure this deficiency does not reoccur?			

Corrective Action Plan (CAP):
Non-Compliance Investigations

Instructions: The Responsible Party (CalOptima Health or Delegated Entity) must provide a response to all cells in white, including: (1) a response (in black font) to each of the four questions under CAP Response (2) Identification of the responsible person including all contact information, (3) Implementation date, actual or planned, and (4) CAP Attestation.

CalOptima Health's Office of Compliance is responsible for completing all cells in blue.

		4) How will the responsible party measure and monitor *each* implemented control to ensure continued effectiveness/compliance of the CAP?			
Office of Compliance Monitoring Method(s) and Result				**Monitoring Status**	

CAP Attestation:

I, _____ [NAME/TITLE] hereby have the authority to attest that the CAP(s), and subsequent remediation, as stated above, accurately reflect _____ [BUSINESS OWNER/DELEGATE] plan to remediate and execute the above referenced area(s) of non-compliance.

Generated by: (Responsible Party, must be Executive Officer or his/her Designee)	_____ Name, Title	_____ Signature	_____ Date
Approved by: (CalOptima Health, Chief Compliance Officer or his/her Designee)	_____ Name, Title	_____ Signature	_____ Date

Policy:	HH.2007
Title:	**Compliance Committee**
Department:	Office of Compliance
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	09/01/2015
Revised Date:	11/07/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ PACE ☐ Administrative

I. PURPOSE

This policy describes the role and responsibility of CalOptima Health's Compliance Committee in ensuring and enforcing compliance with ethical standards, regulatory requirements, contractual obligations, the Compliance Program, including the Fraud, Waste, and Abuse (FWA) Plan and Code of Conduct, and CalOptima Health policies and procedures.

II. POLICY

A. For the purpose of CalOptima Health's Medi-Cal program, the Compliance Committee shall also serve as the Regulatory Compliance and Oversight Committee and will herein only be referred to as the Compliance Committee.

~~A.~~B. The Compliance Committee shall oversee compliance efforts in accordance with the Compliance Program, including the Compliance Plan, Fraud, Waste, and Abuse (FWA) Plan, Code of Conduct, all applicable state and federal regulations, policies and procedures, and federal and state contracts.

~~B.~~C. The Compliance Committee shall recommend and monitor, in collaboration with the Office of Compliance, the development of internal processes and procedures to implement and support the Compliance Plan, Code of Conduct, the FWA Plan, and adherence to relevant statutory, regulatory, and contractual obligations.

D. The Compliance Committee shall review the Compliance Plan on an annual basis.

~~C.~~E. The Office of Compliance shall provide summary updates of all issued Corrective Action Plan(s) (CAPs) to the Delegation Oversight Committee (DOC) and the Compliance Committee for review. The Compliance Committee shall Monitor and report on the effectiveness of issued CAPs.

III. PROCEDURE

A. Compliance Committee Organization

1. The Chief Compliance Officer shall serve as chairperson of the Compliance Committee.

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2. The Directors of Medicare Regulatory Affairs & Compliance and Medi-Cal Regulatory Affairs & Compliance shall serve as co-vice chairpersons and are considered the chairperson's Designees.

3. Members of the Compliance Committee are designated and/or selected from their senior level executives representing the various functional areas of the organization. The Compliance Committee shall consist of Executive staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Chief Compliance Officer; and Chief Human Resources Officer.

~~3.~~4. Each member of the Compliance Committee is a voting member. Voting members may appoint a Designee, when deemed appropriate. The Designee may serve as a subject matter expert at the Compliance Committee meeting; however, the Designee will not have voting rights unless approved in advance by the Chief Compliance Officer.

~~4.~~5. At the request of the chairperson of the Compliance Committee, CalOptima Health Employees may be requested to attend a Compliance Committee meeting on an ad-hoc basis. Attendance may be warranted to support discussion items at the Compliance Committee meeting and/or to provide clarification for the voting members.

~~5.~~6. Activities of the Compliance Committee, to the extent not deemed privileged and confidential, shall be disclosable.

B. Compliance Committee Meetings

1. The Compliance Committee shall meet at least on a quarterly basis, or more frequently, as significant non-compliant and/or FWA issues are identified outside of the quarterly time period, as determined by the Compliance Officer. Annually, Compliance Committee members shall receive a calendar of meetings for the calendar year as well as a reporting matrix which includes all planned reports to be presented during scheduled Compliance Committee meetings.

2. A committee binder is distributed to all meeting attendees, electronically, prior to the Compliance Committee meeting. The committee binder shall include, but is not limited to:

   a. Current meeting agenda;

   b. Final draft meeting minutes from the previous Compliance Committee for approval;

   c. Listing of open action items;

   d. Submitted Compliance Committee reports;

   e. Scheduled audit reports;

   f. CAP monitoring;

   g. Notices of Non-Compliance; and

   h. Special reports, which may include, but not limited to, any reports not regularly presented to the Compliance Committee that may be of interest or concern or is intermittent in nature.

3. Minutes of Compliance Committee meetings shall be maintained, electronically, by the Office of Compliance in the normal course of business.

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4. Ad-hoc Compliance Committee meetings may be held at the discretion of the chairperson, as deemed appropriate.

C. Compliance Committee Responsibilities

1. The Compliance Committee responsibilities include, but are not limited to:

a. Determine the appropriate strategy and/or approach to promote compliance; to prevent, detect, and correct potential violations; and to advise the Chief Compliance Officer accordingly;

b. Review and approve training related to compliance and FWA and ensure that training and education are effective and appropriately completed;

c. Assist with the creation and implementation of the Office of Compliance Annual Risk Assessment and of the compliance Monitoring and Auditing work plan;

d. Review and Monitor the effectiveness of the Compliance Program, including Monitoring key performance reports and metrics, evaluating business and administrative operations, and overseeing the creation, implementation, and development of corrective and preventive action(s) to ensure they are prompt and effective;

e. Maintain and update the Compliance Plan and Code of Conduct consistent with regulatory requirements and/or operational changes, subject to the ultimate approval by the CalOptima Health Board of Directors;

~~e.~~f. Review overall effectiveness of the internal controls designed to ensure compliance with applicable regulations in daily operations;

~~f.~~g. Receive reports from the Chief Compliance Officer, on at least a quarterly basis, concerning the Compliance Program;

~~g.~~h. Review and approve recommendations of appropriate actions to ensure CalOptima Health is complying with the applicable laws, regulations, and ethical standards;

~~h.~~i. Ensure legal counsel is consulted as appropriate and all applicable rights are preserved, including the attorney-client privilege;

~~i.~~j. Ensure CalOptima Health has a Compliance & Ethics Hotline and an Office of Compliance email address for CalOptima Health Members, members of the Governing Body, Employees, and FDRs to ask compliance questions and report potential issues regarding any CalOptima Health program. Inquiries may include, but are not limited to, non-compliance and potential FWA. Information presented shall be handled confidentially (to the extent permitted by applicable law and circumstances) and may be submitted anonymously, if desired by the informant, without fear of retaliation, in accordance with CalOptima Health Policy HH.3012: Non-Retaliation for Reporting Violations;

~~j.~~k. Ensure CalOptima Health has appropriate and current compliance policies and procedures;

~~k.~~l. Review and address reports of Monitoring and Auditing of areas in which CalOptima Health is at risk of program non-compliance and/or potential FWA, and ensure CAPs and ICAPs are implemented and Monitored for effectiveness;

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~~l.~~m. Provide regular and ad-hoc status reports of compliance with recommendations to the CalOptima Health Board of Directors;

n. Maintain written notes, records, correspondence, or minutes (as appropriate) of Compliance Committee meetings reflecting reports made to the Compliance Committee and the Compliance Committee's decisions on the issues raised (subject to all applicable privileges).

~~m.~~o. Analyze applicable federal and state programs, including contractual, legal, and regulatory requirements, along with areas of risk, and coordinate with the Chief Compliance Officer to ensure the adequacy of the Compliance Program; and

~~n.~~p. Review the Office of Compliance's process for soliciting, evaluating, and responding to reports and disclosures within the Compliance Program.

2. In accordance with CalOptima Health Policy HH.2005: Corrective Action Plan, the Compliance Committee, in cooperation with Delegation Oversight Committee (DOC), shall determine Sanctions in accordance with CalOptima Health Policy HH.2002: Sanctions, or other remedial actions, as appropriate, to ensure compliance.

3. The Compliance Committee, in collaboration with the DOC, shall evaluate the effectiveness of such corrective actions in collaboration with the appropriate CalOptima Health departments and shall make recommendations regarding ongoing Monitoring activities to ensure continuing compliance.

D. The Compliance Committee chairperson shall report to the CalOptima Health Board of Directors on at least a quarterly basis. The report shall include a summary of compliance issues taken before the Compliance Committee, remedial action taken, and outcomes of such actions.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Code of Conduct
B. CalOptima Health Compliance Plan
C. CalOptima Health Compliance Committee Charter
D. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
E. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
F. CalOptima Health PACE Program Agreement
G. CalOptima Health Policy HH.2005: Corrective Action Plan
H. CalOptima Health Policy HH.2002: Sanctions
I. CalOptima Health Policy HH.3012: Non-Retaliation for Reporting Violations
K. Medicare Managed Care Manual, Chapter 21
L. Medicare Prescription Drug Benefit Manual, Chapter 9
M. Title 42, Code of Federal Regulations (CFR), §455.2
N. Welfare and Institutions Code, §14043.1(a)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	09/01/2015	HH.2007	Compliance Committee	Medi-Cal
Revised	12/01/2016	HH.2007	Compliance Committee	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.2007	Compliance Committee	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.2007	Compliance Committee	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.2007	Compliance Committee	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.2007	Compliance Committee	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.2007	Compliance Committee	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	HH.2007	Compliance Committee	Medi-Cal OneCare PACE
Revised	09/01/2023	HH.2007	Compliance Committee	Medi-Cal OneCare PACE
Revised	11/07/2024	HH.2007	Compliance Committee	Medi-Cal OneCare PACE

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IX. GLOSSARY

Term	Definition
Abuse	~~Actions that may, directly or indirectly,~~Medi-Cal: Practices that are inconsistent with sound fiscal and business practices or medical standards, and result in~~:~~ an unnecessary ~~costs~~cost to ~~a CalOptima Health Program, improper payment, payment~~the Medi-Cal program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards ~~of~~for health care~~, or services that are medically~~. It also includes Member practices that result in unnecessary~~. Abuse involves payment for items or services when there is no legal entitlement~~ cost to ~~that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because~~ the ~~distinction between "fraud"~~Medi-Cal program. OneCare: A Provider practice that is inconsistent with sound fiscal, business, or medical practice, and ~~"abuse" depends on specific facts~~ results in an unnecessary cost to CalOptima Health and ~~circumstances, intent~~the OneCare program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to CalOptima Health and ~~prior knowledge, and available evidence, among other factors~~the OneCare program.
Audit	A formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being audited and normally performed by individuals with one of several acknowledged certifications.
Code of Conduct	The statement setting forth the principles and standards governing CalOptima Health's activities to which Board Members, Employees, FDRs, and agents of CalOptima Health are expected to adhere.
Compliance Committee	~~The committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out provisions of this Compliance Plan. The composition of the Compliance Committee shall consist of Executive staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Chief Compliance Officer; and Chief Human Resources Officer.~~This CalOptima Health committee consists of executive officers, managers of key operating divisions, and legal counsel and oversees the implementation of CalOptima Health's Compliance Program.
Compliance Program	Medi-Cal: The program ~~(~~including, without limitation, the Compliance Plan, Code of Conduct, and ~~Policies and Procedures)~~CalOptima Health policies, developed and adopted by CalOptima Health to promote, monitor, and ensure that CalOptima Health's operations and practices and the practices of its Board Members, ~~Employees~~employees, contractors, and ~~FDRs~~providers comply with applicable law and ethical standards. OneCare: A comprehensive program that incorporates the fundamental elements identified by the state and federal governments and CalOptima Health as necessary to prevent and detect violations of ethical standards,

Term	Definition
	contractual obligations, and applicable laws and the involvement of CalOptima Health's governing body and executive staff. Elements of the Compliance Program include standards, oversight, training, reporting, monitoring, enforcement, and remediation. The Compliance Program applies to CalOptima Health's Board of Directors, employees, and contractors including delegated entities, providers, and suppliers.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima Health, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima Health departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima Health and its regulators.
Delegation Oversight Committee (DOC)	Medi-Cal: A subcommittee of the Compliance Committee chaired by the Director(s) of Delegation Oversight to oversee CalOptima Health's delegated functions. The composition of the DOC includes representatives from CalOptima Health's departments as provided for in CalOptima Health Policy HH.4001: Delegation Oversight Committee. OneCare: A subcommittee of the Compliance Committee chaired by the Director of the Delegation Oversight department to oversee CalOptima Health's delegated functions. -The composition of the DOC includes representatives from CalOptima Health's operational departments.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Downstream Entity	Medi-Cal: Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Health Program benefit, below the level of arrangement between CalOptima Health and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services. OneCare: Any party that enters into an acceptable written arrangement below the level of the arrangement between a Medicare Advantage (MA) organization (and contract applicant) and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.
Employee	For purposes of this policy, any and all employees of CalOptima Health, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.
First Tier, Downstream, and Related Entities (FDR)	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, Health Maintenance Organizations, suppliers and consultants, including those that contract with CalOptima Health as well as those that are Downstream or Related Entities.

Term	Definition
First Tier Entity	Medi-Cal: Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima Health to provide administrative services or health care services to a Member under a CalOptima Health Program. OneCare: Any party that enters into a written arrangement, acceptable to CMS, with an MAO or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare eligible individual under the MA program or Part D program.
Fraud	~~Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C Section 1347).~~An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with Title 42 Code of Federal Regulations section 455.2, Welfare and Institutions Code section 14043.1(i).
Governing Body	The Board of Directors of CalOptima Health.
Monitoring	Regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.
Related Entity	Any entity that is related to ~~CalOptima Health~~the Medicare Advantage organization by common ownership or control and ~~that: performs~~: 1. Performs some of ~~CalOptima Health's~~the Medicare Advantage organization's management functions under contract or delegation; ~~furnishes~~ 2. Furnishes services to ~~Members~~Medicare enrollees under an oral or written agreement; or ~~leases~~ ~~1.~~3. Leases real property or sells materials to ~~CalOptima Health~~the Medicare Advantage organization at a cost of more than two thousand five hundred dollars ($2,500) during a contract period.
Waste	Medi-Cal: The overutilization or inappropriate utilization of services and misuse of resources. OneCare: The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Health Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

1

Policy:	HH.2007
Title:	**Compliance Committee**
Department:	Office of Compliance
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	09/01/2015
Revised Date:	11/07/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ PACE ☐ Administrative

I. PURPOSE

This policy describes the role and responsibility of CalOptima Health's Compliance Committee in ensuring and enforcing compliance with ethical standards, regulatory requirements, contractual obligations, the Compliance Program, including the Fraud, Waste, and Abuse (FWA) Plan and Code of Conduct, and CalOptima Health policies and procedures.

II. POLICY

A. For the purpose of CalOptima Health's Medi-Cal program, the Compliance Committee shall also serve as the Regulatory Compliance and Oversight Committee and will herein only be referred to as the Compliance Committee.

B. The Compliance Committee shall oversee compliance efforts in accordance with the Compliance Program, including the Compliance Plan, Fraud, Waste, and Abuse (FWA) Plan, Code of Conduct, all applicable state and federal regulations, policies and procedures, and federal and state contracts.

C. The Compliance Committee shall recommend and monitor, in collaboration with the Office of Compliance, the development of internal processes and procedures to implement and support the Compliance Plan, Code of Conduct, the FWA Plan, and adherence to relevant statutory, regulatory, and contractual obligations.

D. The Compliance Committee shall review the Compliance Plan on an annual basis.

E. The Office of Compliance shall provide summary updates of all issued Corrective Action Plan(s) (CAPs) to the Delegation Oversight Committee (DOC) and the Compliance Committee for review. The Compliance Committee shall Monitor and report on the effectiveness of issued CAPs.

III. PROCEDURE

A. Compliance Committee Organization

1. The Chief Compliance Officer shall serve as chairperson of the Compliance Committee.

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2. The Directors of Medicare Regulatory Affairs & Compliance and Medi-Cal Regulatory Affairs & Compliance shall serve as co-vice chairpersons and are considered the chairperson's Designees.

3. Members of the Compliance Committee are designated and/or selected from their senior level executives representing the various functional areas of the organization. The Compliance Committee shall consist of Executive staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Chief Compliance Officer; and Chief Human Resources Officer.

4. Each member of the Compliance Committee is a voting member. Voting members may appoint a Designee, when deemed appropriate. The Designee may serve as a subject matter expert at the Compliance Committee meeting; however, the Designee will not have voting rights unless approved in advance by the Chief Compliance Officer.

5. At the request of the chairperson of the Compliance Committee, CalOptima Health Employees may be requested to attend a Compliance Committee meeting on an ad-hoc basis. Attendance may be warranted to support discussion items at the Compliance Committee meeting and/or to provide clarification for the voting members.

6. Activities of the Compliance Committee, to the extent not deemed privileged and confidential, shall be disclosable.

B. Compliance Committee Meetings

1. The Compliance Committee shall meet at least on a quarterly basis, or more frequently, as significant non-compliant and/or FWA issues are identified outside of the quarterly time period, as determined by the Compliance Officer. Annually, Compliance Committee members shall receive a calendar of meetings for the calendar year as well as a reporting matrix which includes all planned reports to be presented during scheduled Compliance Committee meetings.

2. A committee binder is distributed to all meeting attendees, electronically, prior to the Compliance Committee meeting. The committee binder shall include, but is not limited to:

   a. Current meeting agenda;

   b. Final draft meeting minutes from the previous Compliance Committee for approval;

   c. Listing of open action items;

   d. Submitted Compliance Committee reports;

   e. Scheduled audit reports;

   f. CAP monitoring;

   g. Notices of Non-Compliance; and

   h. Special reports, which may include, but not limited to, any reports not regularly presented to the Compliance Committee that may be of interest or concern or is intermittent in nature.

3. Minutes of Compliance Committee meetings shall be maintained, electronically, by the Office of Compliance in the normal course of business.

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4. Ad-hoc Compliance Committee meetings may be held at the discretion of the chairperson, as deemed appropriate.

C. Compliance Committee Responsibilities

1. The Compliance Committee responsibilities include, but are not limited to:

a. Determine the appropriate strategy and/or approach to promote compliance; to prevent, detect, and correct potential violations; and to advise the Chief Compliance Officer accordingly;

b. Review and approve training related to compliance and FWA and ensure that training and education are effective and appropriately completed;

c. Assist with the creation and implementation of the Office of Compliance Annual Risk Assessment and of the compliance Monitoring and Auditing work plan;

d. Review and Monitor the effectiveness of the Compliance Program, including Monitoring key performance reports and metrics, evaluating business and administrative operations, and overseeing the creation, implementation, and development of corrective and preventive action(s) to ensure they are prompt and effective;

e. Maintain and update the Compliance Plan and Code of Conduct consistent with regulatory requirements and/or operational changes, subject to the ultimate approval by the CalOptima Health Board of Directors;

f. Review overall effectiveness of the internal controls designed to ensure compliance with applicable regulations in daily operations;

g. Receive reports from the Chief Compliance Officer, on at least a quarterly basis, concerning the Compliance Program;

h. Review and approve recommendations of appropriate actions to ensure CalOptima Health is complying with the applicable laws, regulations, and ethical standards;

i. Ensure legal counsel is consulted as appropriate and all applicable rights are preserved, including the attorney-client privilege;

j. Ensure CalOptima Health has a Compliance & Ethics Hotline and an Office of Compliance email address for CalOptima Health Members, members of the Governing Body, Employees, and FDRs to ask compliance questions and report potential issues regarding any CalOptima Health program. Inquiries may include, but are not limited to, non-compliance and potential FWA. Information presented shall be handled confidentially (to the extent permitted by applicable law and circumstances) and may be submitted anonymously, if desired by the informant, without fear of retaliation, in accordance with CalOptima Health Policy HH.3012: Non-Retaliation for Reporting Violations;

k. Ensure CalOptima Health has appropriate and current compliance policies and procedures;

l. Review and address reports of Monitoring and Auditing of areas in which CalOptima Health is at risk of program non-compliance and/or potential FWA, and ensure CAPs and ICAPs are implemented and Monitored for effectiveness;

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m. Provide regular and ad-hoc status reports of compliance with recommendations to the CalOptima Health Board of Directors;

n. Maintain written notes, records, correspondence, or minutes (as appropriate) of Compliance Committee meetings reflecting reports made to the Compliance Committee and the Compliance Committee's decisions on the issues raised (subject to all applicable privileges).

o. Analyze applicable federal and state programs, including contractual, legal, and regulatory requirements, along with areas of risk, and coordinate with the Chief Compliance Officer to ensure the adequacy of the Compliance Program; and

p. Review the Office of Compliance's process for soliciting, evaluating, and responding to reports and disclosures within the Compliance Program.

2. In accordance with CalOptima Health Policy HH.2005: Corrective Action Plan, the Compliance Committee, in cooperation with Delegation Oversight Committee (DOC), shall determine Sanctions in accordance with CalOptima Health Policy HH.2002: Sanctions, or other remedial actions, as appropriate, to ensure compliance.

3. The Compliance Committee, in collaboration with the DOC, shall evaluate the effectiveness of such corrective actions in collaboration with the appropriate CalOptima Health departments and shall make recommendations regarding ongoing Monitoring activities to ensure continuing compliance.

D. The Compliance Committee chairperson shall report to the CalOptima Health Board of Directors on at least a quarterly basis. The report shall include a summary of compliance issues taken before the Compliance Committee, remedial action taken, and outcomes of such actions.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Code of Conduct
B. CalOptima Health Compliance Plan
C. CalOptima Health Compliance Committee Charter
D. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
E. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
F. CalOptima Health PACE Program Agreement
G. CalOptima Health Policy HH.2005: Corrective Action Plan
H. CalOptima Health Policy HH.2002: Sanctions
I. CalOptima Health Policy HH.3012: Non-Retaliation for Reporting Violations
K. Medicare Managed Care Manual, Chapter 21
L. Medicare Prescription Drug Benefit Manual, Chapter 9
M. Title 42, Code of Federal Regulations (CFR), §455.2
N. Welfare and Institutions Code, §14043.1(a)

VI. REGULATORY AGENCY APPROVAL(S)

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None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	09/01/2015	HH.2007	Compliance Committee	Medi-Cal
Revised	12/01/2016	HH.2007	Compliance Committee	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.2007	Compliance Committee	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.2007	Compliance Committee	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.2007	Compliance Committee	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.2007	Compliance Committee	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.2007	Compliance Committee	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	HH.2007	Compliance Committee	Medi-Cal OneCare PACE
Revised	09/01/2023	HH.2007	Compliance Committee	Medi-Cal OneCare PACE
Revised	11/07/2024	HH.2007	Compliance Committee	Medi-Cal OneCare PACE

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IX. GLOSSARY

Term	Definition
Abuse	Medi-Cal: Practices that are inconsistent with sound fiscal and business practices or medical standards, and result in an unnecessary cost to the Medi-Cal program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to the Medi-Cal program. OneCare: A Provider practice that is inconsistent with sound fiscal, business, or medical practice, and results in an unnecessary cost to CalOptima Health and the OneCare program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to CalOptima Health and the OneCare program.
Audit	A formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being audited and normally performed by individuals with one of several acknowledged certifications.
Code of Conduct	The statement setting forth the principles and standards governing CalOptima Health's activities to which Board Members, Employees, FDRs, and agents of CalOptima Health are expected to adhere.
Compliance Committee	This CalOptima Health committee consists of executive officers, managers of key operating divisions, and legal counsel and oversees the implementation of CalOptima Health's Compliance Program.
Compliance Program	Medi-Cal: The program including, without limitation, the Compliance Plan, Code of Conduct, and CalOptima Health policies, developed and adopted by CalOptima Health to promote, monitor, and ensure that CalOptima Health's operations and practices and the practices of its Board Members, employees, contractors, and providers comply with applicable law and ethical standards. OneCare: A comprehensive program that incorporates the fundamental elements identified by the state and federal governments and CalOptima Health as necessary to prevent and detect violations of ethical standards, contractual obligations, and applicable laws and the involvement of CalOptima Health's governing body and executive staff. Elements of the Compliance Program include standards, oversight, training, reporting, monitoring, enforcement, and remediation. The Compliance Program applies to CalOptima Health's Board of Directors, employees, and contractors including delegated entities, providers, and suppliers.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima Health, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima Health departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima Health and its regulators.

Term	Definition
Delegation Oversight Committee (DOC)	Medi-Cal: A subcommittee of the Compliance Committee chaired by the Director(s) of Delegation Oversight to oversee CalOptima Health's delegated functions. The composition of the DOC includes representatives from CalOptima Health's departments as provided for in CalOptima Health Policy HH.4001: Delegation Oversight Committee. OneCare: A subcommittee of the Compliance Committee chaired by the Director of the Delegation Oversight department to oversee CalOptima Health's delegated functions. The composition of the DOC includes representatives from CalOptima Health's operational departments.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Downstream Entity	Medi-Cal: Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Health Program benefit, below the level of arrangement between CalOptima Health and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services. OneCare: Any party that enters into an acceptable written arrangement below the level of the arrangement between a Medicare Advantage (MA) organization (and contract applicant) and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.
Employee	For purposes of this policy, any and all employees of CalOptima Health, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.
First Tier, Downstream, and Related Entities (FDR)	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, Health Maintenance Organizations, suppliers and consultants, including those that contract with CalOptima Health as well as those that are Downstream or Related Entities.
First Tier Entity	Medi-Cal: Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima Health to provide administrative services or health care services to a Member under a CalOptima Health Program. OneCare: Any party that enters into a written arrangement, acceptable to CMS, with an MAO or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare eligible individual under the MA program or Part D program.
Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with Title 42 Code of Federal Regulations section 455.2, Welfare and Institutions Code section 14043.1(i).
Governing Body	The Board of Directors of CalOptima Health.
Monitoring	Regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.

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Term	Definition
Related Entity	Any entity that is related to the Medicare Advantage organization by common ownership or control and: 1. Performs some of the Medicare Advantage organization's management functions under contract or delegation; 2. Furnishes services to Medicare enrollees under an oral or written agreement; or 3. Leases real property or sells materials to the Medicare Advantage organization at a cost of more than two thousand five hundred dollars ($2,500) during a contract period.
Waste	Medi-Cal: The overutilization or inappropriate utilization of services and misuse of resources. OneCare: The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Health Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

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Policy:	HH.2014
Title:	**Compliance Program**
Department:	Office of Compliance
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	08/01/2008
Revised Date:	11/07/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ PACE ☒ Administrative

I. PURPOSE

This policy establishes a Compliance Program to ensure and enforce compliance with ethical standards, contractual requirements, applicable federal and state statutes and regulations, and CalOptima Health policies.

II. POLICY

A. CalOptima Health shall establish a written Compliance Program, in accordance with applicable regulatory and contractual requirements.

B. CalOptima Health's First Tier, Downstream, and Related Entities (FDRs) shall, at a minimum, develop a written Compliance Program, in accordance with this Policy.

C. CalOptima Health shall ~~revise~~review and update the Compliance Program, including the Compliance Plan, Code of Conduct, Anti-Fraud, Waste and Abuse Plan, HIPAA Privacy and Security Program and all applicable CalOptima Health policies, no less than annually and as necessary for compliance with changes ~~occur in~~to CalOptima ~~Health's~~Health needs, regulatory requirements, ~~and~~or applicable laws.

D. The CalOptima Health Board of Directors is responsible for overseeing the implementation and effectiveness of the Compliance Program and approving the Compliance Plan and Code of Conduct.

a. The Board of Directors review and approve the Compliance Program, including the Compliance Plan, Code of Conduct, Anti-Fraud, Waste and Abuse Plan, HIPAA Privacy and Security Program and all applicable CalOptima Health policies, no less than annually.

E. The Compliance Officer, in conjunction with the Compliance Committee, shall provide oversight, analysis, and continuous monitoring of compliance activities and shall provide a summary of such activities to the Board of Directors on a periodic basis.

a. The Compliance Officer is responsible for developing, implementing, and ensuring compliance with the requirements and standards under the Department of Health Care Services (DHCS) contract and shall report directly to the Chief Executive Officer (CEO) and the Board of Directors (BOD).

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b. The Compliance Officer is a full-time employee of CalOptima Health and is considered independent, which means they do not serve in both a compliance and operational role.

c. Criteria for selecting a Compliance Officer, including job descriptions, responsibilities and authority of the position is outlined in the applicable job description. Selection and hiring of the Compliance Officer shall be in adherence with CalOptima Health Policy GA.8060: Recruitment, Selection, and Hiring.

F. The Compliance Officer, in conjunction with the Compliance Committee, may update and make minor, non-substantive revisions to the Compliance Plan without the need to obtain Board of Directors approval.

G. CalOptima Health Employees, members of the Governing Body, and FDRs, shall comply with the Compliance Program.

H. The Compliance Plan shall be publicly posted on CalOptima Health's website.

III. PROCEDURE

A. The Office of Compliance shall recommend revisions to the Compliance Plan, Code of Conduct, Anti-Fraud, Waste and Abuse Plan, and/or the HIPAA Privacy and Security Program and/or related policies and procedures, as necessary, to maintain compliance with contractual requirements, applicable state and federal statutes and regulations, and CalOptima Health operations, or as otherwise indicated to meet the needs of Members.

B. The Compliance Officer shall submit recommended revisions to the Compliance Plan, Code of Conduct, Anti-Fraud, Waste and Abuse Plan, and/or the HIPAA Privacy and Security Program to the Compliance Committee for review and approval.

C. Upon the Compliance Committee's approval, the Compliance Officer shall present substantive revisions to the Compliance Plan, Code of Conduct, Anti-Fraud, Waste and Abuse Plan, and/or the HIPAA Privacy and Security Program to the Board of Directors for approval and adoption into the Compliance Program. ~~Minor non-substantive revisions, specifically the correction of typographical or formatting errors, may be implemented without the need to obtain Board of Directors approval.~~

IV. ATTACHMENT(S)

~~A. FDR Compliance Attestation~~
Not Applicable

V. REFERENCE(S)

A. CalOptima Health Code of Conduct
B. CalOptima Health Compliance Plan
C. CalOptima Health Anti-Fraud, Waste and Abuse Plan
D. CalOptima Health HIPAA Privacy and Security Program
E. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
F. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
G. CalOptima Health PACE Program Agreement
H. Medicare Managed Care Manual, Chapter 21
I. Medicare Prescription Drug Benefit Manual, Chapter 9

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J. Office of Inspector General Guidelines for Operating an Effective Compliance Program
K. Title 42, Code of Federal Regulations (CFR.), §§422.503, 423.504
L. Title 42, Code of Federal Regulations (CFR), §438.608(a)(1)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
07/12/2013	Department of Health Care Services (DHCS)	Approved as Submitted
10/23/2023	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
10/05/2023	Regular Meeting of the CalOptima Health Board of Directors
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	08/01/2008	HH.2014	Compliance Program	Medi-Cal
Revised	06/01/2013	HH.2014	Compliance Program	Medi-Cal Healthy Families OneCare
Revised	09/01/2014	HH.2014	Compliance Program	Medi-Cal
Revised	09/01/2015	HH.2014	Compliance Program	Medi-Cal
Revised	12/01/2016	HH.2014	Compliance Program	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.2014	Compliance Program	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.2014	Compliance Program	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.2014	Compliance Program	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.2014	Compliance Program	Medi-Cal OneCare OneCare Connect PACE

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Action	Date	Policy	Policy Title	Program(s)
Revised	12/20/2021	HH.2014	Compliance Program	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	HH.2014	Compliance Program	Medi-Cal OneCare PACE
Revised	09/01/2023	HH.2014	Compliance Program	Medi-Cal OneCare PACE
Revised	11/07/2024	HH.2014	Compliance Program	Medi-Cal OneCare PACE

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IX. GLOSSARY

Term	Definition
Code of Conduct	The statement setting forth the principles and standards governing CalOptima Health's activities to which CalOptima Health's Board of Directors, employees, contractors, and agents are required to adhere.
Compliance Committee	The committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out the provisions of this Compliance Plan. The composition of the Compliance Committee shall consist of Executive staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Compliance Officer; and Chief Human Resources Officer.
Compliance Program	Medi-Cal: The program (including, without limitation, the Compliance Plan, Code of Conduct, and CalOptima Health policies and procedures), developed and adopted by CalOptima Health to promote, monitor, and ensure that CalOptima Health's operations and practices and the practices of its Board Members, Employeesemployees, contractors, and FDRsproviders comply with applicable law and ethical standards. OneCare: A comprehensive program that incorporates the fundamental elements identified by the state and federal governments and CalOptima Health as necessary to prevent and detect violations of ethical standards, contractual obligations, and applicable laws and the involvement of CalOptima Health's governing body and executive staff. Elements of the Compliance Program include standards, oversight, training, reporting, monitoring, enforcement, and remediation. The Compliance Program applies to CalOptima Health's Board of Directors, employees, and contractors including delegated entities, providers, and suppliers.
Downstream Entity	Medi-Cal: Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Health Program benefit, below the level of arrangement between CalOptima Health and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services. OneCare: Any party that enters into an acceptable written arrangement below the level of the arrangement between a Medicare Advantage (MA) organization (and contract applicant) and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.
Employee	Any and all employees of CalOptima Health, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.

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Term	Definition
First Tier Entity	Medi-Cal: Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima Health to provide administrative services or health care services to a Member under a CalOptima Health Program. OneCare: Any party that enters into a written arrangement, acceptable to CMS, with an MAO or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare eligible individual under the MA program or Part D program.
First Tier, Downstream, and Related Entities (FDR)	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, Health Maintenance Organizations, suppliers and consultants, including those that directly contract with CalOptima Health as well as those that are Downstream or Related Entities.
Governing Body	The Board of Directors of CalOptima Health.
Related Entity	Any entity that is related to ~~CalOptima Health~~the Medicare Advantage organization by common ownership or control and ~~that: performs~~: 1. Performs some of ~~CalOptima Health's~~the Medicare Advantage organization's management functions under contract or delegation; ~~furnishes~~ 2. Furnishes services to ~~Members~~Medicare enrollees under an oral or written agreement; or ~~leases~~ ~~1.~~3. Leases real property or sells materials to ~~CalOptima Health~~the Medicare Advantage organization at a cost of more than two thousand five hundred dollars ($2,500) during a contract period.

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Policy:	HH.2014
Title:	**Compliance Program**
Department:	Office of Compliance
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	08/01/2008
Revised Date:	11/07/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ PACE ☒ Administrative

I. PURPOSE

This policy establishes a Compliance Program to ensure and enforce compliance with ethical standards, contractual requirements, applicable federal and state statutes and regulations, and CalOptima Health policies.

II. POLICY

A. CalOptima Health shall establish a written Compliance Program, in accordance with applicable regulatory and contractual requirements.

B. CalOptima Health's First Tier, Downstream, and Related Entities (FDRs) shall, at a minimum, develop a written Compliance Program, in accordance with this Policy.

C. CalOptima Health shall review and update the Compliance Program, including the Compliance Plan, Code of Conduct, Anti-Fraud, Waste and Abuse Plan, HIPAA Privacy and Security Program and all applicable CalOptima Health policies, no less than annually and as necessary for compliance with changes to CalOptima Health needs, regulatory requirements, or applicable laws.

D. The CalOptima Health Board of Directors is responsible for overseeing the implementation and effectiveness of the Compliance Program and approving the Compliance Plan and Code of Conduct.

a. The Board of Directors review and approve the Compliance Program, including the Compliance Plan, Code of Conduct, Anti-Fraud, Waste and Abuse Plan, HIPAA Privacy and Security Program and all applicable CalOptima Health policies, no less than annually.

E. The Compliance Officer, in conjunction with the Compliance Committee, shall provide oversight, analysis, and continuous monitoring of compliance activities and shall provide a summary of such activities to the Board of Directors on a periodic basis.

a. The Compliance Officer is responsible for developing, implementing, and ensuring compliance with the requirements and standards under the Department of Health Care Services (DHCS) contract and shall report directly to the Chief Executive Officer (CEO) and the Board of Directors (BOD).

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b. The Compliance Officer is a full-time employee of CalOptima Health and is considered independent, which means they do not serve in both a compliance and operational role.

c. Criteria for selecting a Compliance Officer, including job descriptions, responsibilities and authority of the position is outlined in the applicable job description. Selection and hiring of the Compliance Officer shall be in adherence with CalOptima Health Policy GA.8060: Recruitment, Selection, and Hiring.

F. The Compliance Officer, in conjunction with the Compliance Committee, may update and make minor, non-substantive revisions to the Compliance Plan without the need to obtain Board of Directors approval.

G. CalOptima Health Employees, members of the Governing Body, and FDRs, shall comply with the Compliance Program.

H. The Compliance Plan shall be publicly posted on CalOptima Health's website.

III. PROCEDURE

A. The Office of Compliance shall recommend revisions to the Compliance Plan, Code of Conduct, Anti-Fraud, Waste and Abuse Plan, and/or the HIPAA Privacy and Security Program and/or related policies and procedures, as necessary, to maintain compliance with contractual requirements, applicable state and federal statutes and regulations, and CalOptima Health operations, or as otherwise indicated to meet the needs of Members.

B. The Compliance Officer shall submit recommended revisions to the Compliance Plan, Code of Conduct, Anti-Fraud, Waste and Abuse Plan, and/or the HIPAA Privacy and Security Program to the Compliance Committee for review and approval.

C. Upon the Compliance Committee's approval, the Compliance Officer shall present substantive revisions to the Compliance Plan, Code of Conduct, Anti-Fraud, Waste and Abuse Plan, and/or the HIPAA Privacy and Security Program to the Board of Directors for approval and adoption into the Compliance Program.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Code of Conduct
B. CalOptima Health Compliance Plan
C. CalOptima Health Anti-Fraud, Waste and Abuse Plan
D. CalOptima Health HIPAA Privacy and Security Program
E. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
F. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
G. CalOptima Health PACE Program Agreement
H. Medicare Managed Care Manual, Chapter 21
I. Medicare Prescription Drug Benefit Manual, Chapter 9
J. Office of Inspector General Guidelines for Operating an Effective Compliance Program
K. Title 42, Code of Federal Regulations (CFR.), §§422.503, 423.504

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L. Title 42, Code of Federal Regulations (CFR), §438.608(a)(1)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
07/12/2013	Department of Health Care Services (DHCS)	Approved as Submitted
10/23/2023	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
10/05/2023	Regular Meeting of the CalOptima Health Board of Directors
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	08/01/2008	HH.2014	Compliance Program	Medi-Cal
Revised	06/01/2013	HH.2014	Compliance Program	Medi-Cal Healthy Families OneCare
Revised	09/01/2014	HH.2014	Compliance Program	Medi-Cal
Revised	09/01/2015	HH.2014	Compliance Program	Medi-Cal
Revised	12/01/2016	HH.2014	Compliance Program	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.2014	Compliance Program	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.2014	Compliance Program	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.2014	Compliance Program	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.2014	Compliance Program	Medi-Cal OneCare OneCare Connect PACE

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Action	Date	Policy	Policy Title	Program(s)
Revised	12/20/2021	HH.2014	Compliance Program	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	HH.2014	Compliance Program	Medi-Cal OneCare PACE
Revised	09/01/2023	HH.2014	Compliance Program	Medi-Cal OneCare PACE
Revised	11/07/2024	HH.2014	Compliance Program	Medi-Cal OneCare PACE

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IX. GLOSSARY

Term	Definition
Code of Conduct	The statement setting forth the principles and standards governing CalOptima Health's activities to which CalOptima Health's Board of Directors, employees, contractors, and agents are required to adhere.
Compliance Committee	The committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out the provisions of this Compliance Plan. The composition of the Compliance Committee shall consist of Executive staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Compliance Officer; and Chief Human Resources Officer.
Compliance Program	Medi-Cal: The program including, without limitation, the Compliance Plan, Code of Conduct, and CalOptima Health policies, developed and adopted by CalOptima Health to promote, monitor, and ensure that CalOptima Health's operations and practices and the practices of its Board Members, employees, contractors, and providers comply with applicable law and ethical standards. OneCare: A comprehensive program that incorporates the fundamental elements identified by the state and federal governments and CalOptima Health as necessary to prevent and detect violations of ethical standards, contractual obligations, and applicable laws and the involvement of CalOptima Health's governing body and executive staff. Elements of the Compliance Program include standards, oversight, training, reporting, monitoring, enforcement, and remediation. The Compliance Program applies to CalOptima Health's Board of Directors, employees, and contractors including delegated entities, providers, and suppliers.
Downstream Entity	Medi-Cal: Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Health Program benefit, below the level of arrangement between CalOptima Health and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services. OneCare: Any party that enters into an acceptable written arrangement below the level of the arrangement between a Medicare Advantage (MA) organization (and contract applicant) and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.
Employee	Any and all employees of CalOptima Health, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.
First Tier Entity	Medi-Cal: Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima Health to provide administrative services or health care services to a Member under a CalOptima Health Program. OneCare: Any party that enters into a written arrangement, acceptable to CMS, with an MAO or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare eligible individual under the MA program or Part D program.

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Term	Definition
First Tier, Downstream, and Related Entities (FDR)	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, Health Maintenance Organizations, suppliers and consultants, including those that directly contract with CalOptima Health as well as those that are Downstream or Related Entities.
Governing Body	The Board of Directors of CalOptima Health.
Related Entity	Any entity that is related to the Medicare Advantage organization by common ownership or control and: 1. Performs some of the Medicare Advantage organization's management functions under contract or delegation; 2. Furnishes services to Medicare enrollees under an oral or written agreement; or 3. Leases real property or sells materials to the Medicare Advantage organization at a cost of more than two thousand five hundred dollars ($2,500) during a contract period.

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Policy:	HH.2022
Title:	**Record Retention and Access**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	*/s/*
Effective Date:	06/01/2013
Revised Date:	11/07/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ PACE ☐ Administrative

I. PURPOSE

This policy establishes the requirements for CalOptima Health and its First Tier, Downstream, and Related Entities (FDRs) to retain and make available premises, contracts, books, documents, records, financial statements, equipment, computers, or other electronic systems, in accordance with federal and state regulations for the purpose of any audit, or investigation, of a CalOptima Health program.

II. POLICY

A. CalOptima Health and its FDRs shall retain and make available contracts, books, documents, records, and financial statements, in accordance with the provisions of this Policy. These documents include, but are not limited to, the following:

1. Data relating to Medicare utilization and costs;
2. Reinsurance costs;
3. Low-income subsidy payments;
4. Risk corridor costs;
5. Bid calculations;
6. Rebate information;
7. Medical Records;
8. Medical charts and prescription files;
9. Records related to/supporting Health Network Medical Loss Ratio (MLR) calculations;
10. Hierarchical Condition Categories (HCC) and risk adjustment records;
11. Encounter data;
12. Member Grievance and Appeal records;

13. Base data as defined in Title 42, Code of Federal Regulations (C.F.R.), Section 438.5(c);

14. Data, information, and documentation specified in Title 42, C.F.R., Sections 438.604, 606, 608, and 610; and

15. Other documentation pertaining to medical and non-medical services rendered to Members.

16. Documentation of disciplinary actions for a period of ten (10) years at a minimum, including date of and description of violation, date of investigation, findings and date and description of disciplinary action.

B. An FDR shall retain and make available all of its premises, facilities, equipment, contracts, books, documents, records, encounter data (for a period of at least ten (10) years), computers and other electronic systems pertaining to the goods and services provided to Members, available to CalOptima Health and any authorized state and federal agencies or contractors, as described in Section II.C. 1-9 of this Policy, or their designees, for inspections, evaluations, examinations, copying, monitoring and auditing.

1. If DHCS, CMS, or the HHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the HHS Inspector General may inspect, evaluate, and audit an FDR at any time.

2. Upon resolution of a full investigation of Fraud, DHCS reserves the right to suspend or terminate the FDR from participation in the Medi-Cal program; seek recovery of payments made to the FDR; impose other Sanctions provided under the State Plan, and direct CalOptima Health to terminate its agreement with the FDR due to Fraud.

C. Authorized state and federal agencies reserve the right to monitor all aspects of CalOptima Health's operations, including its FDRs, for compliance with the provisions of the CalOptima Health Contract with DHCS for Medi-Cal and applicable federal and state laws and regulations. Monitoring activities will include, but are not limited to, inspection and auditing of facilities, management systems and procedures, and books and records as deemed appropriate by the Director of DHCS, at any time, pursuant to 42 CFR 438.3(h). The monitoring activities will be either announced or unannounced.

III. PROCEDURE

A. CalOptima Health and its FDRs shall provide an authorized entity with the requested and required access to premises, contracts, books, documents, records, financial statements, equipment, computers, or other electronic systems at any time during normal business hours for audit, monitoring, and other investigative activities.

B. CalOptima Health and its FDRs shall maintain and make available all records and documents for a minimum of ten (10) years from the final date of the Contract Period, or from completion of any audit or investigation, whichever is later.

1. If there is a termination, dispute, or allegation of Fraud, or similar fault, document retention requirements for CalOptima Health and its FDRs may be extended to ten (10) years from the date of any resulting final resolution of the termination, dispute, or allegation of Fraud, or similar fault.

C. CalOptima Health shall retain and make available all of its premises, facilities, equipment, contracts, books, documents, records, encounter data (for a period of at least ten (10) years and in

accordance with CalOptima Health's Document Retention Schedule), computers and other electronic systems pertaining to the goods and services provided to Members, ~~available~~ to any authorized state and federal agencies or contractors for inspections, evaluations, examinations or copying, monitoring and auditing including, but not limited to:

a. Centers for Medicare & Medicaid Services (CMS);

b. Department of Managed Health Care (DMHC);

c. Department of Health Care Services (DHCS);

d. The U.S. Department of Health and Human Services (HHS) Office of the Inspector General ;

e. The Bureau of Medi-Cal Fraud

f. The Comptroller General;

g. Department of Justice;

h. The U.S. Government Accountability Office (GAO)

i. Authorized State agencies, or their duly authorized representatives or designees, including DHCS's External Quality Review Organization (EQRO) contractor; and

j. Any Quality Improvement Organization (QIO) or accrediting organizations, including NCQA, their designees and other representatives of regulatory or accrediting organizations.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Compliance Plan
B. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Health's Document Retention Schedule
~~D.~~ CalOptima Health PACE Program ~~Agreement~~
E. ~~Department~~Agreement Department of Health Care Services (DHCS) All Plan Letter ~~17-004: Subcontractual Relationships and~~ (APL) 23-006: Delegation and Subcontractor Network Certification
F. Medicare Managed Care Manual, Chapter 21
G. Medicare Prescription Drug Benefit Manual, Chapter 9
H. Title 42, Code of Federal Regulations (C.F.R.), §422.504(d)(2), §438.230(c), §438.3(h), §438.604, §606, §608, §438.3(u); and §610

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
07/12/2013	Department of Health Care Services (DHCS)	Approved as Submitted
01/19/2022	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/01/2013	HH.2022	Record Retention and Access	Medi-Cal OneCare
Revised	09/01/2015	HH.2022	Record Retention and Access	Medi-Cal
Revised	12/01/2016	HH.2022	Record Retention and Access	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.2022	Record Retention and Access	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.2022	Record Retention and Access	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.2022	Record Retention and Access	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.2022	Record Retention and Access	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.2022	Record Retention and Access	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	HH.2022	Record Retention and Access	Medi-Cal OneCare PACE
Revised	09/01/2023	HH.2022	Record Retention and Access	Medi-Cal OneCare PACE
Revised	11/07/2024	HH.2022	Record Retention and Access	Medi-Cal OneCare PACE

IX. GLOSSARY

Term	Definition
Appeal	Medi-Cal: A review by CalOptima Health of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the timeframes provided in 42 CFR 438.408(b). OneCare: ~~Any of~~As defined at 42 CFR §422.561 and §423.560, the procedures that deal with the review of ~~an~~ adverse initial ~~determination~~determinations made by ~~CalOptima Health~~ the plan on health care services or benefits under Part C or D the ~~Member~~enrollee believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the ~~Member),~~enrollee) or on any amounts the ~~Member~~enrollee must pay for a service or drug as defined in 42 CFR §422.566(b) and §423.566(b). These appeal procedures include a plan reconsideration or redetermination ~~by CalOptima Health,~~(also referred to as a level 1 appeal), a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (~~MAC~~Council), and judicial review. PACE: A Member's action taken with respect to the PACE organization's noncoverage of, modification of, or nonpayment for, a service including denials, reductions or termination of services, as defined by federal PACE regulation 42 CFR Section 460.122. ~~For purposes of this definition, "Member" means any eligible Medi-Cal beneficiary who has enrolled in CalOptima Health PACE's plan in accordance with the provisions of California Code of Regulations title 22, section 53420.~~
Contract Period	For purposes of this policy, this timeframe is the First Tier, Downstream, and Related Entities' (FDR's) contract duration with the Department of Health Care Services (DHCS).
Covered Service	~~Medi-Cal: Those 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 Health'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

Term	Definition
	~~Enhanced Care Management and Community Supports as part of the California Advancing and Innovating Medi-Cal (CalAIM) Initiative (as set forth in the CalAIM 1115 Demonstration & 1915(b) Waiver, DHCS All Plan Letter (APL) 21-012: Enhanced Care Management Requirements and APL 21-017: Community Supports Requirements, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 5.51, beginning with section 14184.100), or other services as authorized by the CalOptima Health Board of Directors, which shall be covered for Members notwithstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.~~ Medi-Cal: Those health care services, set forth in W&I sections 14000 et seq. and 14131 et seq., 22 CCR section 51301 et seq., 17 CCR section 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, the contract with DHCS for Medi-Cal, and DHCS APLs that are made the responsibility of CalOptima Health pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS. Covered Services do not include: 1. Home and Community-Based Services (HCBS) program as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsections 4.3.15 (Services for Persons with Developmental Disabilities), 4.3.20 (Home and Community-Based Services Programs) regarding waiver programs, 4.3.21 (In-Home Supportive Services), and Department of Developmental Services (DDS) Administered Medicaid Home and Community-Based Services Waiver. HCBS programs do not include services that are available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service, as described in 22 CCR sections 51184, 51340 and 51340.1. EPSDT services are covered under the DHCS contract for Medi-Cal, as specified in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services), Subsection F4 regarding services for Members less than twenty-one (21) years of age. CalOptima Health is financially responsible for the payment of all EPSDT services; 2. California Children's Services (CCS) as specified in Exhibit A, Attachment III, Subsection 4.3.14 (California Children's Services), except for Contractors providing Whole Child Model (WCM) services; 3. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (Mental Health Services); 4. Alcohol and SUD treatment services, and outpatient heroin and other opioid detoxification, except for medications for addiction treatment as specified in Exhibit A, Attachment III, Subsection 4.3.13 (Alcohol and Substance Use Disorder Treatment Services); 5. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members); 6. Direct Observed Therapy for Treatment of Tuberculosis (TB) as specified in Exhibit A, Attachment III, Subsection 4.3.18 (Direct Observed Therapy for Treatment of Tuberculosis); 7. Dental services as specified in W&I sections 14131.10, 14132(h), 14132.22, 14132.23, and 14132.88, and EPSDT dental services as

Term	Definition
	described in 22 CCR section 51340.1(b). However, CalOptima Health is responsible for all Covered Services as specified in Exhibit A, Attachment III, Subsection 4.3.17 (Dental) regarding dental services; 8. Prayer or spiritual healing as specified in 22 CCR section 51312; 9. Educationally Necessary Behavioral Health Services that are covered by a Local Education Agency (LEA) and provided pursuant to a Member's Individualized Education Plan (IEP) as set forth in Education Code section 56340 et seq., Individualized Family Service Plan (IFSP) as set forth in California Government Code (GC) section 95020, or Individualized Health and Support Plan (IHSP). However, CalOptima Health is responsible for all Medically Necessary Behavioral Health Services as specified in Exhibit A, Attachment III Subsection 4.3.16 (School-Based Services); 10. Laboratory services provided under the State serum alpha-feto-protein-testing program administered by the Genetic Disease Branch of California Department of Public Health (CDPH); 11. Pediatric Day Health Care, except for Contractors providing Whole Child Model (WCM) services; 12. State Supported Services; 13. Targeted Case Management (TCM) services as set forth in 42 USC section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR sections 51185 and 51351, and as described in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services). However, if Members less than twenty-one (21) years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, CalOptima Health must ensure access to comparable services under the EPSDT benefit in accordance with DHCS APL 23-005; 14. Childhood lead poisoning case management provided by county health departments; 15. Non-medical services provided by Regional Centers (RC) to individuals with Developmental Disabilities, including but not limited to respite, out-of-home placement, and supportive living; 16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and DHCS APL 16-006; and 17. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with DHCS APL 22-012. OneCare: Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract~~.~~, or Care Coordination, or Coordination of Care as defined in the state Medicaid Agency Contract. PACE: Those items and services provided by CalOptima Health under the provisions of Welfare and Institutions Code, section 14132 and the California State Plan, except those services specifically excluded under Exhibit E, Attachment 1 of the CalOptima Health PACE contract, state law, or the California State Plan.

Term	Definition
Department of Health Care Services (DHCS)	Medi-Cal: The single State department responsible for the administration of the Medi-Cal Program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health related programs as provided by statute and/or regulation. OneCare: The single State Department ~~of~~ responsible for administration of the Medi-Cal program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health ~~Care Services, the State agency that oversees California's~~and Disabilities Prevention (CHDP), and other health related programs. PACE: The single State Department responsible for administration of the federal Medicaid ~~program, known~~(referred to as Medi-Cal in California) Program.
Department of Managed Health Care (DMHC)	~~The California Department of Managed Health Care that oversees California's managed care system. DMHC regulates health maintenance organizations licensed under the Knox-Keene Act, Health & Safety Code, Sections 1340 *et seq*.~~The State agency responsible for administering the Knox-Keene Health Care Service Plan Act of 1975.
Downstream Entity	Medi-Cal: Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Health Program benefit, below the level of arrangement between CalOptima Health and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services. OneCare: Any party that enters into an acceptable written arrangement below the level of the arrangement between a Medicare Advantage (MA) organization (and contract applicant) and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.
External Quality Review	The analysis and review by the External Quality Review ~~means an analysis and evaluation by the~~ Organization (EQRO) of aggregated information on quality, timeliness, and access to the ~~Covered Services~~health care services that CalOptima Health, its Subcontractor, its Downstream Subcontractor, or its ~~subcontractors furnish~~Network Provider furnishes to Members~~, as referenced for related activities in Exhibit A, Attachment 4 of the CalOptima Health Contract with DHCS for Medi-Cal~~.
External Quality Review Organization (EQRO)	~~A Peer Review Organization (PRO), PRO-like entity, or accrediting body that is an expert in the scientific review of the quality of health care provided to Medicaid beneficiaries in a State's Medicaid managed care plans,~~An organization that meets the competence and independence requirements set forth in 42 CFR section 438.354, and ~~is contracted with DHCS to perform External Quality Reviews~~performs EQR and other EQR–related activities ~~per~~ as set forth in 42 CFR section 438.358 pursuant to its contract with DHCS.
First Tier, Downstream, and Related Entities (FDR)	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.

Term	Definition
First Tier Entity	Medi-Cal: Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima Health to provide administrative services or health care services to a Member under a CalOptima Health Program. OneCare: Any party that enters into a written arrangement, acceptable to CMS, with an MAO or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare eligible individual under the MA program or Part D program.
Fraud	~~Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or Fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. § 1347).~~An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with Title 42 Code of Federal Regulations section 455.2, Welfare and Institutions Code section 14043.1(i).
Grievance	Medi-Cal: ~~An oral or written~~Any expression of dissatisfaction about any matter other than an ~~action that is an adverse benefit determination, as identified within the definition of an Appeal,~~Adverse Benefit Determination (ABD), and may include, but is not limited to~~:~~ the ~~quality~~Quality of ~~care~~Care or services provided, aspects of interpersonal relationships with a ~~provider~~Provider or CalOptima Health's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima Health to make an authorization decision. A complaint is the same as Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other CalOptima Health processes. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, it must be considered a Grievance. OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. A grievance does not include, and is distinct from, a dispute of the appeal of an organization determination or coverage determination or an LEP determination. PACE: A complaint, either written or oral, expressing dissatisfaction with service delivery or the quality of care furnished, as defined by the federal PACE regulation 42 CFR Section 460.120.
Hierarchical Coding Categories (HCC)	A risk-adjusted model developed by CMS to adjust Medicare payments to health care plans for the health expenditure risk of Members.

Term	Definition
Medical Loss Ratio (MLR)	Medi-Cal: The percentage calculated by dividing the Health Network's total medical costs paid on behalf of CalOptima Health Members by the total revenue received from CalOptima Health. Health Network medical costs would include payments to physicians (i.e., capitation, fee-for-service, or salary), medical groups/Independent Practice Associations (IPAs), hospitals, labs, ambulance companies, and other providers of service. PACE: The Allowed Medical Expenses for the covered services provided to enrollees under the Contract divided by the amount of Medi-Cal managed care Net Capitation Payments or revenues recorded by CalOptima Health PACE, by county.
Medically Necessary or Medical Necessity	Medi-Cal: Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. ~~OneCare: The services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.~~ For Members under twenty-one (21) years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of medical necessity set forth in Section 1396d(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under twenty-one (21) years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima Health shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child. OneCare: Reasonable and necessary medical services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services includes Medi-Cal Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. PACE: Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.

Term	Definition
Medical Record	Medi-Cal: ~~Any single, complete~~The record ~~kept or required to be kept by any Provider that documents all the~~of a Member's medical ~~services received by the Member,~~information including~~,~~ but not limited to, ~~inpatient, outpatient~~medical history, care or treatments received, test results, diagnoses, and ~~emergency care, referral requests, authorizations, or other documentation as indicated by CalOptima Health policy~~prescribed medications. OneCare: A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal. PACE: Written documentary evidence of treatments rendered to plan Members.
Member	Medi-Cal: A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Health program. OneCare: A beneficiary enrolled in a CalOptima Health ~~program.~~OneCare Program. PACE: Any Eligible Medi-Cal Beneficiary who has enrolled in CalOptima Health PACE's plan in accordance with the provisions of California Code of Regulations title 22, section 53420.
National Committee for Quality Assurance (NCQA)	Medi-Cal: An organization responsible for the accreditation of managed care plans and other health care entities and for developing and managing health care measures that assess the Quality of Care and services that Members receive. OneCare: An independent, not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans, managed behavioral healthcare organizations, preferred provider organizations, new health plans, physician organizations, credentials verification organizations, disease management programs and other health-related programs. PACE: A non-profit organization committed to evaluating and publicly reporting on the quality of managed care plans.
Quality Improvement Organization (QIO)	An organization comprised of practicing doctors and other health care experts under contract to the federal government to monitor and improve the care given to Medicare enrollees. A QIO reviews Complaints raised by enrollees about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare managed care plans, and ambulatory surgical centers. A QIO also reviews continued stay denials for enrollees receiving care in acute inpatient hospital facilities as well as coverage terminations in Skilled Nursing Facilities, Home Health Agencies, and Comprehensive Outpatient Rehabilitation Facilities.

Term	Definition
Related Entity	Any entity that is related to ~~CalOptima Health~~the Medicare Advantage organization by common ownership or control and~~ that: performs~~: 1. Performs some of ~~CalOptima Health's~~the Medicare Advantage organization's management functions under contract or delegation; ~~furnishes~~ 2. Furnishes services to ~~Members~~Medicare enrollees under an oral or written agreement; or ~~leases~~ ~~1.~~3. Leases real property or sells materials to ~~CalOptima Health~~the Medicare Advantage organization at a cost of more than two thousand five hundred dollars ($2,500) during a contract period.

1

Policy:	HH.2022
Title:	**Record Retention and Access**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	*/s/*
Effective Date:	06/01/2013
Revised Date:	11/07/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ PACE ☐ Administrative

I. PURPOSE

This policy establishes the requirements for CalOptima Health and its First Tier, Downstream, and Related Entities (FDRs) to retain and make available premises, contracts, books, documents, records, financial statements, equipment, computers, or other electronic systems, in accordance with federal and state regulations for the purpose of any audit, or investigation, of a CalOptima Health program.

II. POLICY

A. CalOptima Health and its FDRs shall retain and make available contracts, books, documents, records, and financial statements, in accordance with the provisions of this Policy. These documents include, but are not limited to, the following:

1. Data relating to Medicare utilization and costs;
2. Reinsurance costs;
3. Low-income subsidy payments;
4. Risk corridor costs;
5. Bid calculations;
6. Rebate information;
7. Medical Records;
8. Medical charts and prescription files;
9. Records related to/supporting Health Network Medical Loss Ratio (MLR) calculations;
10. Hierarchical Condition Categories (HCC) and risk adjustment records;
11. Encounter data;
12. Member Grievance and Appeal records;

13. Base data as defined in Title 42, Code of Federal Regulations (C.F.R.), Section 438.5(c);

14. Data, information, and documentation specified in Title 42, C.F.R., Sections 438.604, 606, 608, and 610; and

15. Other documentation pertaining to medical and non-medical services rendered to Members.

16. Documentation of disciplinary actions for a period of ten (10) years at a minimum, including date of and description of violation, date of investigation, findings and date and description of disciplinary action.

B. An FDR shall retain and make available all of its premises, facilities, equipment, contracts, books, documents, records, encounter data (for a period of at least ten (10) years), computers and other electronic systems pertaining to the goods and services provided to Members, available to CalOptima Health and any authorized state and federal agencies or contractors, as described in Section II.C. 1-9 of this Policy, or their designees, for inspections, evaluations, examinations, copying, monitoring and auditing.

1. If DHCS, CMS, or the HHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the HHS Inspector General may inspect, evaluate, and audit an FDR at any time.

2. Upon resolution of a full investigation of Fraud, DHCS reserves the right to suspend or terminate the FDR from participation in the Medi-Cal program; seek recovery of payments made to the FDR; impose other Sanctions provided under the State Plan, and direct CalOptima Health to terminate its agreement with the FDR due to Fraud.

C. Authorized state and federal agencies reserve the right to monitor all aspects of CalOptima Health's operations, including its FDRs, for compliance with the provisions of the CalOptima Health Contract with DHCS for Medi-Cal and applicable federal and state laws and regulations. Monitoring activities will include, but are not limited to, inspection and auditing of facilities, management systems and procedures, and books and records as deemed appropriate by the Director of DHCS, at any time, pursuant to 42 CFR 438.3(h). The monitoring activities will be either announced or unannounced.

III. PROCEDURE

A. CalOptima Health and its FDRs shall provide an authorized entity with the requested and required access to premises, contracts, books, documents, records, financial statements, equipment, computers, or other electronic systems at any time during normal business hours for audit, monitoring, and other investigative activities.

B. CalOptima Health and its FDRs shall maintain and make available all records and documents for a minimum of ten (10) years from the final date of the Contract Period, or from completion of any audit or investigation, whichever is later.

1. If there is a termination, dispute, or allegation of Fraud, or similar fault, document retention requirements for CalOptima Health and its FDRs may be extended to ten (10) years from the date of any resulting final resolution of the termination, dispute, or allegation of Fraud, or similar fault.

C. CalOptima Health shall retain and make available all of its premises, facilities, equipment, contracts, books, documents, records, encounter data (for a period of at least ten (10) years and in

accordance with CalOptima Health's Document Retention Schedule), computers and other electronic systems pertaining to the goods and services provided to Members, to any authorized state and federal agencies or contractors for inspections, evaluations, examinations or copying, monitoring and auditing including, but not limited to:

a. Centers for Medicare & Medicaid Services (CMS);

b. Department of Managed Health Care (DMHC);

c. Department of Health Care Services (DHCS);

d. The U.S. Department of Health and Human Services (HHS) Office of the Inspector General ;

e. The Bureau of Medi-Cal Fraud

f. The Comptroller General;

g. Department of Justice;

h. The U.S. Government Accountability Office (GAO)

i. Authorized State agencies, or their duly authorized representatives or designees, including DHCS's External Quality Review Organization (EQRO) contractor; and

j. Any Quality Improvement Organization (QIO) or accrediting organizations, including NCQA, their designees and other representatives of regulatory or accrediting organizations.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Compliance Plan
B. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Health's Document Retention Schedule
E. CalOptima Health PACE Program Agreement Department of Health Care Services (DHCS) All Plan Letter (APL) 23-006: Delegation and Subcontractor Network Certification
F. Medicare Managed Care Manual, Chapter 21
G. Medicare Prescription Drug Benefit Manual, Chapter 9
H. Title 42, Code of Federal Regulations (C.F.R.), §422.504(d)(2), §438.230(c), §438.3(h), §438.604, §606, §608, §438.3(u); and §610

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
07/12/2013	Department of Health Care Services (DHCS)	Approved as Submitted
01/19/2022	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/01/2013	HH.2022	Record Retention and Access	Medi-Cal OneCare
Revised	09/01/2015	HH.2022	Record Retention and Access	Medi-Cal
Revised	12/01/2016	HH.2022	Record Retention and Access	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.2022	Record Retention and Access	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.2022	Record Retention and Access	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.2022	Record Retention and Access	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.2022	Record Retention and Access	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.2022	Record Retention and Access	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	HH.2022	Record Retention and Access	Medi-Cal OneCare PACE
Revised	09/01/2023	HH.2022	Record Retention and Access	Medi-Cal OneCare PACE
Revised	11/07/2024	HH.2022	Record Retention and Access	Medi-Cal OneCare PACE

IX. GLOSSARY

Term	Definition
Appeal	Medi-Cal: A review by CalOptima Health of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the timeframes provided in 42 CFR 438.408(b). OneCare: As defined at 42 CFR §422.561 and §423.560, the procedures that deal with the review of adverse initial determinations made by the plan on health care services or benefits under Part C or D the enrollee believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the enrollee) or on any amounts the enrollee must pay for a service or drug as defined in 42 CFR §422.566(b) and §423.566(b). These appeal procedures include a plan reconsideration or redetermination (also referred to as a level 1 appeal), a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (Council), and judicial review. PACE: A Member's action taken with respect to the PACE organization's noncoverage of, modification of, or nonpayment for, a service including denials, reductions or termination of services, as defined by federal PACE regulation 42 CFR Section 460.122.
Contract Period	For purposes of this policy, this timeframe is the First Tier, Downstream, and Related Entities' (FDR's) contract duration with the Department of Health Care Services (DHCS).
Covered Service	Medi-Cal: Those health care services, set forth in W&I sections 14000 et seq. and 14131 et seq., 22 CCR section 51301 et seq., 17 CCR section 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, the contract with DHCS for Medi-Cal, and DHCS APLs that are made the responsibility of CalOptima Health pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS. Covered Services do not include: 1. Home and Community-Based Services (HCBS) program as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsections 4.3.15 (Services for Persons with Developmental Disabilities), 4.3.20 (Home and Community-Based Services Programs) regarding waiver programs, 4.3.21 (In-Home Supportive Services), and Department of Developmental Services (DDS) Administered Medicaid Home and

Term	Definition
	Community-Based Services Waiver. HCBS programs do not include services that are available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service, as described in 22 CCR sections 51184, 51340 and 51340.1. EPSDT services are covered under the DHCS contract for Medi-Cal, as specified in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services), Subsection F4 regarding services for Members less than twenty-one (21) years of age. CalOptima Health is financially responsible for the payment of all EPSDT services; 2. California Children's Services (CCS) as specified in Exhibit A, Attachment III, Subsection 4.3.14 (California Children's Services), except for Contractors providing Whole Child Model (WCM) services; 3. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (Mental Health Services); 4. Alcohol and SUD treatment services, and outpatient heroin and other opioid detoxification, except for medications for addiction treatment as specified in Exhibit A, Attachment III, Subsection 4.3.13 (Alcohol and Substance Use Disorder Treatment Services); 5. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members); 6. Direct Observed Therapy for Treatment of Tuberculosis (TB) as specified in Exhibit A, Attachment III, Subsection 4.3.18 (Direct Observed Therapy for Treatment of Tuberculosis); 7. Dental services as specified in W&I sections 14131.10, 14132(h), 14132.22, 14132.23, and 14132.88, and EPSDT dental services as described in 22 CCR section 51340.1(b). However, CalOptima Health is responsible for all Covered Services as specified in Exhibit A, Attachment III, Subsection 4.3.17 (Dental) regarding dental services; 8. Prayer or spiritual healing as specified in 22 CCR section 51312; 9. Educationally Necessary Behavioral Health Services that are covered by a Local Education Agency (LEA) and provided pursuant to a Member's Individualized Education Plan (IEP) as set forth in Education Code section 56340 et seq., Individualized Family Service Plan (IFSP) as set forth in California Government Code (GC) section 95020, or Individualized Health and Support Plan (IHSP). However, CalOptima Health is responsible for all Medically Necessary Behavioral Health Services as specified in Exhibit A, Attachment III Subsection 4.3.16 (School-Based Services); 10. Laboratory services provided under the State serum alpha-feto-protein-testing program administered by the Genetic Disease Branch of California Department of Public Health (CDPH); 11. Pediatric Day Health Care, except for Contractors providing Whole Child Model (WCM) services; 12. State Supported Services; 13. Targeted Case Management (TCM) services as set forth in 42 USC section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR sections 51185 and 51351, and as described in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services). However, if Members less than twenty-one (21) years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, CalOptima Health must ensure access to

Term	Definition
	comparable services under the EPSDT benefit in accordance with DHCS APL 23-005; 14. Childhood lead poisoning case management provided by county health departments; 15. Non-medical services provided by Regional Centers (RC) to individuals with Developmental Disabilities, including but not limited to respite, out-of-home placement, and supportive living; 16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and DHCS APL 16-006; and 17. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with DHCS APL 22-012. OneCare: Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract, or Care Coordination, or Coordination of Care as defined in the state Medicaid Agency Contract. PACE: Those items and services provided by CalOptima Health under the provisions of Welfare and Institutions Code, section 14132 and the California State Plan, except those services specifically excluded under Exhibit E, Attachment 1 of the CalOptima Health PACE contract, state law, or the California State Plan.
Department of Health Care Services (DHCS)	Medi-Cal: The single State department responsible for the administration of the Medi-Cal Program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health related programs as provided by statute and/or regulation. OneCare: The single State Department responsible for administration of the Medi-Cal program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs. PACE: The single State Department responsible for administration of the federal Medicaid (referred to as Medi-Cal in California) Program.
Department of Managed Health Care (DMHC)	The State agency responsible for administering the Knox-Keene Health Care Service Plan Act of 1975.
Downstream Entity	Medi-Cal: Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Health Program benefit, below the level of arrangement between CalOptima Health and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services. OneCare: Any party that enters into an acceptable written arrangement below the level of the arrangement between a Medicare Advantage (MA) organization (and contract applicant) and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.

Term	Definition
External Quality Review	The analysis and review by the External Quality Review Organization (EQRO) of aggregated information on quality, timeliness, and access to the health care services that CalOptima Health, its Subcontractor, its Downstream Subcontractor, or its Network Provider furnishes to Members.
External Quality Review Organization (EQRO)	An organization that meets the competence and independence requirements set forth in 42 CFR section 438.354, and performs EQR and other EQR–related activities as set forth in 42 CFR section 438.358 pursuant to its contract with DHCS.
First Tier, Downstream, and Related Entities (FDR)	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
First Tier Entity	Medi-Cal: Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima Health to provide administrative services or health care services to a Member under a CalOptima Health Program. OneCare: Any party that enters into a written arrangement, acceptable to CMS, with an MAO or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare eligible individual under the MA program or Part D program.
Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with Title 42 Code of Federal Regulations section 455.2, Welfare and Institutions Code section 14043.1(i).
Grievance	Medi-Cal: Any expression of dissatisfaction about any matter other than an Adverse Benefit Determination (ABD), and may include, but is not limited to the Quality of Care or services provided, aspects of interpersonal relationships with a Provider or CalOptima Health's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima Health to make an authorization decision. A complaint is the same as Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other CalOptima Health processes. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, it must be considered a Grievance. OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. A grievance does not include, and is distinct from, a dispute of the appeal of an organization determination or coverage determination or an LEP determination. PACE: A complaint, either written or oral, expressing dissatisfaction with service delivery or the quality of care furnished, as defined by the federal PACE regulation 42 CFR Section 460.120.
Hierarchical Coding Categories (HCC)	A risk-adjusted model developed by CMS to adjust Medicare payments to health care plans for the health expenditure risk of Members.

Term	Definition
Medical Loss Ratio (MLR)	Medi-Cal: The percentage calculated by dividing the Health Network's total medical costs paid on behalf of CalOptima Health Members by the total revenue received from CalOptima Health. Health Network medical costs would include payments to physicians (i.e., capitation, fee-for-service, or salary), medical groups/Independent Practice Associations (IPAs), hospitals, labs, ambulance companies, and other providers of service. PACE: The Allowed Medical Expenses for the covered services provided to enrollees under the Contract divided by the amount of Medi-Cal managed care Net Capitation Payments or revenues recorded by CalOptima Health PACE, by county.
Medically Necessary or Medical Necessity	Medi-Cal: Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under twenty-one (21) years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of medical necessity set forth in Section 1396dI(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under twenty-one (21) years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima Health shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child. OneCare: Reasonable and necessary medical services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services includes Medi-Cal Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. PACE: Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.

Term	Definition
Medical Record	Medi-Cal: The record of a Member's medical information including but not limited to, medical history, care or treatments received, test results, diagnoses, and prescribed medications. OneCare: A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal. PACE: Written documentary evidence of treatments rendered to plan Members.
Member	Medi-Cal: A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Health program. OneCare: A beneficiary enrolled in a CalOptima Health OneCare Program. PACE: Any Eligible Medi-Cal Beneficiary who has enrolled in CalOptima Health PACE's plan in accordance with the provisions of California Code of Regulations title 22, section 53420.
National Committee for Quality Assurance (NCQA)	Medi-Cal: An organization responsible for the accreditation of managed care plans and other health care entities and for developing and managing health care measures that assess the Quality of Care and services that Members receive. OneCare: An independent, not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans, managed behavioral healthcare organizations, preferred provider organizations, new health plans, physician organizations, credentials verification organizations, disease management programs and other health-related programs. PACE: A non-profit organization committed to evaluating and publicly reporting on the quality of managed care plans.
Quality Improvement Organization (QIO)	An organization comprised of practicing doctors and other health care experts under contract to the federal government to monitor and improve the care given to Medicare enrollees. A QIO reviews Complaints raised by enrollees about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare managed care plans, and ambulatory surgical centers. A QIO also reviews continued stay denials for enrollees receiving care in acute inpatient hospital facilities as well as coverage terminations in Skilled Nursing Facilities, Home Health Agencies, and Comprehensive Outpatient Rehabilitation Facilities.

Term	Definition
Related Entity	Any entity that is related to the Medicare Advantage organization by common ownership or control and: 1. Performs some of the Medicare Advantage organization's management functions under contract or delegation; 2. Furnishes services to Medicare enrollees under an oral or written agreement; or 3. Leases real property or sells materials to the Medicare Advantage organization at a cost of more than two thousand five hundred dollars ($2,500) during a contract period.

1

Policy:	HH.2023
Title:	**Compliance Training**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	*/s/*
Effective Date:	09/01/2015
Revised Date:	11/07/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ PACE ☐ Administrative

I. PURPOSE

This policy describes CalOptima Health's ~~compliance~~annual Compliance Training and education including, but not limited to, Anti-Fraud, Waste~~,~~ and Abuse (FWA~~) education~~), Code of Conduct, Compliance Plan, Health Insurance Portability and ~~training requirements~~Accountability Act (HIPAA), and CalOptima Health Policies and Procedures for Employees, members of the Governing Body, and First Tier, Downstream, and Related Entities (FDRs).

II. POLICY

A. All CalOptima Health Employees, members of the Governing Body, and FDRs must successfully complete the required annual Compliance ~~and FWA~~ Training ~~Program~~ within ninety (90) calendar days of hire, or contracting, and annually thereafter.

B. All CalOptima Health Employees and members of the Governing Body shall complete the knowledge verification for the applicable annual Compliance ~~and FWA~~ Training ~~Program~~ with a score of eighty percent (80%) or greater.

C. When reviewing and establishing the content of the annual Compliance ~~and FWA~~ Training ~~Program~~, the Chief Compliance Officer may consider applicable statutes, regulations, regulator contractual requirements, and regulatory guidance. The following are examples of topics the ~~general~~annual Compliance ~~and FWA~~ Training ~~Program~~ shall communicate:

1. A description of the Compliance Program, including a review of compliance policies and procedures, the Code of Conduct, and CalOptima Health's commitment to business ethics and compliance with all CalOptima Health program requirements;

2. An overview of how to ask compliance questions, request compliance clarification, or report suspected, or detected, non-compliance. Training should emphasize Confidentiality, anonymity, and non-Retaliation for reporting compliance related questions, or reports of suspected, or detected, non-compliance, or potential ~~FWA;~~Fraud, Waste and Abuse (FWA);

3. The requirement to report to CalOptima Health actual or suspected program non-compliance, or potential FWA;

4. Scenarios of reportable non-compliance that an Employee might observe;

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5. A review of the disciplinary guidelines for non-compliant or fraudulent behavior. The guidelines will communicate how such behavior can result in mandatory retraining and may result in disciplinary action, including possible termination when such behavior is serious or repeated, or when knowledge of a possible violation is not reported;

6. Discussion of attendance and participation in the annual Compliance ~~and FWA~~ Training ~~Programs~~ as a condition of continued employment and a criterion to be included in Employee evaluations;

7. A review of policies related to contracting with the government, such as the laws addressing gifts and gratuities for government Employees;

8. A review of potential conflicts of interest and CalOptima Health's system for disclosure of conflicts of interest;

9. An overview of HIPAA/Health Information Technology for Economic and Clinical Health Act (HITECH), the CMS Data Use Agreement (if applicable), and the importance of maintaining the Confidentiality of Protected Health Information~~:~~ (PHI);

10. An overview of the Monitoring and Auditing process; and

11. A review of the laws that govern Employee conduct in the CalOptima Health programs.

D. CalOptima Health Employees, members of the Governing Body, as well as FDR Employees who have involvement in the administration or delivery of Parts C and D benefits must, at a minimum, receive ~~FWA training~~Compliance Training within ninety (90) calendar days of initial hiring (or contracting in the case of FDRs), and annually thereafter. Additionally, specialized or refresher training may be provided on issues posing FWA risks based on the individual's job function (e.g., pharmacist, statistician, customer service, etc.). Training may be provided:

1. Upon appointment to a new job function;

2. When requirements change;

3. When Employees are found to be non-compliant;

4. As a corrective action to address a non-compliance issue; and

5. When an Employee works in an area implicated in past FWA.

E. Topics that may be addressed in ~~FWA training~~Compliance Training include, but are not limited to:

1. Laws and regulations related to Medicare Part C and Part D FWA (i.e., False Claims Act, Anti-Kickback statute, HIPAA/HITECH, etc.);

2. Obligations of FDRs to have appropriate policies and procedures to address FWA;

3. Processes for CalOptima Health Employees, members of the Governing Body, FDRs, and FDR Employees to report suspected FWA to CalOptima Health (or, for FDR Employees, either to CalOptima Health directly, or to their employers who then must report it to CalOptima Health);

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4. Protections for CalOptima Health and FDR Employees who report suspected FWA; and

5. Types of FWA that can occur in the settings in which CalOptima Health and FDR Employees work. ~~-~~All CalOptima Health FDRs shall receive CalOptima Health Compliance ~~and FWA~~ Training ~~Program and CalOptima Health's Code of Conduct training~~ upon contracting. Additionally, training modules are provided through the CalOptima Health vendor and Provider website with updates provided to FDRs and annually thereafter.

F. FDRs who have met the FWA (as per Chapter 21, Section 50.3 of the Medicare Managed Care Manual) training and education certification requirements through enrollment into Parts A or B of the Medicare program, or through accreditation as a supplier of Durable Medical Equipment, Prosthetics/Orthotics, and Supplies (DMEPOS), are NOT exempt from the ~~general compliance training~~annual Compliance Training requirement.

G. ~~Documentation of~~ Compliance ~~with~~ Training Documentation

1. CalOptima Health Employees, members of the Governing Body, FDRs, and FDR Employees, who are performing services on behalf of CalOptima Health shall successfully complete all required Compliance ~~training~~Training modules.

2. Failure to successfully complete all required Compliance ~~training~~Training may lead to disciplinary action (up to and including termination), Corrective Action Plan requirements, and/or Sanctions, in accordance with CalOptima Health Policies HH.2002: Sanctions and HH.2005: Corrective Action Plan. CalOptima Health Employees, members of the Governing Body, and FDRs are expected to inform CalOptima Health immediately in the event of any failure to comply with training requirements. ~~-~~For CalOptima Health Employees and members of the Governing Body, the Human Resources (HR) Training Unit has a systematic indicator that identifies those who fail to comply within the mandated timeframes; non-compliance will result in revoking CalOptima Health system access.

3. The Office of Compliance is responsible for Monitoring and Auditing the compliance of Employees, members of the Governing Body, and FDRs with ~~the~~annual Compliance ~~and FWA training and education~~Training requirements.

4. FDRs shall provide annual attestations confirming completion of all Compliance ~~training~~Training as stated in this policy. Failure to provide timely attestation ~~will~~may lead to ~~further~~ corrective actions.

H. Training Document Retention.

1. CalOptima Health and FDRs shall maintain all evidence of Compliance-related training completion for at least ten (10) years. ~~-~~Such materials include, but are not limited to:

a. Attendance;

b. Topic;

c. Certificates of Completion;

d. FDR Attestations;

e. Test scores; and

f. Tests administered to Employees.

III. PROCEDURE

A. Distributing Compliance Training for Existing Employees and Members of the Governing Body

1. On an annual basis, the HR Training Unit shall communicate to all Employees and members of the Governing Body that an updated Compliance ~~training~~Training is available and must be successfully completed within sixty (60) calendar days.

2. Upon completion, Employees and members of the Governing Body can access a learner transcript confirming successful completion. ~~-~~The transcript will include the training title and completion date.~~-~~ HR, via the HR Training Unit, is responsible for retaining evidence of an Employee's and members of the Governing Body's successful completion of all Compliance ~~training~~Training modules.

B. Distributing Compliance Training for New Employees and Members of the Governing Body

1. Upon hire, the HR Training Unit shall provide each new Employee and member(s) of the Governing Body with instructions to complete ~~the~~ Compliance Training.

2. The HR Training Unit shall create a system generated report that identifies those who fail to comply within the mandated time frames. ~~-~~Non-compliance will result in revoking system access.

C. Distributing Compliance Training to FDRs

1. The Office of Compliance shall ensure the training is uploaded and available on the CalOptima Health vendor and Provider website.

2. Upon contracting, the Office of Compliance shall distribute an FDR Compliance Package composed of compliance documents, including the CalOptima Health Compliance ~~and FWA~~ Training, ~~CalOptima Health's Code of Conduct, FWA Plan,~~ and an FDR Attestation that confirms the required Compliance ~~training~~Training is completed by FDRs and their Employees within ninety (90) calendar days of hire and at least annually thereafter.

3. Annually, the Office of Compliance shall distribute and Monitor receipt of updated attestation to all FDRs for execution.

4. When there are updates to ~~compliance training~~Compliance Training materials and/or related policies and procedures, the Office of Compliance shall communicate updates to all FDRs with instructions to access the CalOptima Health vendor and Provider website to retrieve them.

IV. ATTACHMENT(S)

A. FDR Compliance Attestation

V. REFERENCE(S)

A. CalOptima Health Compliance Plan

B. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Health Contract with Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Health PACE Program Agreement
E. CalOptima Health Policy HH.2002: Sanctions
F. CalOptima Health Policy HH.2005: Corrective Action Plan
G. CalOptima Health Policy HH.2028: Code of Conduct
H. Medicare Managed Care Manual, Chapter 21
I. Medicare Prescription Drug Benefit Manual, Chapter 9
J. Title 42, Code of Federal Regulations (C.F.R.), §§422.503(b)(4)(vi)(A) and (D)
K. Title 42, Code of Federal Regulations (C.F.R.), §§423.504(b)(4)(vi)(A) and (D)
L. Title 42, Code of Federal Regulations (C.F.R.), §438.608
M. Title 42, Code of Federal Regulations (C.F.R.), §455.2
N. "Update—Reducing the Burden of the Compliance Program Training Requirements," Health Plan Management System (HPMS) Memorandum, Issued 7/17/2015
O. "Additional Guidance -- Compliance Program Training Requirements and Audit Process Update," Health Management System (HPMS) Memorandum, Issued 2/10/2016.
P. Welfare and Institutions Code, §14043.1(a)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVIEW/REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	09/01/2015	HH.2023	Compliance Training	Medi-Cal
Revised	12/07/2017	HH.2023	Compliance Training	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.2023	Compliance Training	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.2023	Compliance ~~and FWA~~ Training	Medi-Cal OneCare OneCare Connect PACE

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Action	Date	Policy	Policy Title	Program(s)
Revised	12/03/2020	HH.2023	Compliance ~~and FWA~~ Training	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.2023	Compliance ~~and FWA~~ Training	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	HH.2023	Compliance ~~and FWA~~ Training	Medi-Cal OneCare PACE
Revised	09/01/2023	HH.2023	Compliance ~~and FWA~~ Training	Medi-Cal OneCare PACE
Revised	11/07/2024	HH.2023	Compliance Training	Medi-Cal OneCare PACE

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IX. GLOSSARY

Term	Definition
Abuse	~~Actions that may, directly or indirectly,~~Medi-Cal: Practices that are inconsistent with sound fiscal and business practices or medical standards, and result in~~;~~ an unnecessary ~~costs~~cost to ~~a CalOptima Health Program, improper payment, payment~~the Medi-Cal program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards ~~of~~for health care~~, or services that are medically~~. It also includes Member practices that result in unnecessary~~. Abuse involves payment for items or services when there is no legal entitlement~~ cost to ~~that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because~~ the ~~distinction between "fraud"~~Medi-Cal program. OneCare: A Provider practice that is inconsistent with sound fiscal, business, or medical practice, and ~~"abuse" depends on specific facts~~ results in an unnecessary cost to CalOptima Health and ~~circumstances, intent~~the OneCare program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to CalOptima Health and ~~prior knowledge, and available evidence, among other factors~~the OneCare program.
Audit	A formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being audited and normally performed by individuals with one of several acknowledged certifications.
Code of Conduct	The statement setting forth the principles and standards governing CalOptima Health's activities to which CalOptima Health's Board of Directors, Employees, contractors, and agents are required to adhere.
Compliance Program	The program (including, without limitation, this Compliance Plan, Code of Conduct and Policies and Procedures and Procedures) developed and adopted by CalOptima Health to promote, monitor and ensure that CalOptima Health's operations and practices and the practices of its Board Member, Employees and FDRs comply with applicable law and ethical standards.
Compliance Training	Annually required, this includes, but is not limited to, training and education for the Anti-Fraud, Waste and Abuse (FWA) Plan, Code of Conduct, CalOptima Health's (or an approved FDR version) Compliance Plan, Health Insurance Portability and Accountability Act (HIPAA), and CalOptima Health Policies and Procedures.

Term	Definition
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima Health, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. ~~-~~FDRs and/or CalOptima Health departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima Health and its regulators.
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 Health's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Enhanced Care Management and Community Supports as part of the California Advancing and Innovating Medi-Cal (CalAIM) Initiative (as set forth in the CalAIM 1115 Demonstration & 1915(b) Waiver, DHCS All Plan Letter (APL) 21-012: Enhanced Care Management Requirements and APL 21-017: Community Supports Requirements, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 5.51, beginning with section 14184.100), or other services as authorized by the CalOptima Health Board of Directors, which shall be covered for Members notwithstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.~~ Medi-Cal: Those health care services, set forth in W&I sections 14000 et seq. and 14131 et seq., 22 CCR section 51301 et seq., 17 CCR section 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, the contract with DHCS for Medi-Cal, and DHCS APLs that are made the responsibility of CalOptima Health pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS. Covered Services do not include: 1. Home and Community-Based Services (HCBS) program as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsections 4.3.15 (Services for Persons with Developmental Disabilities), 4.3.20 (Home and Community-Based Services Programs) regarding waiver programs, 4.3.21 (In-Home Supportive Services), and Department of Developmental Services (DDS)

Term	Definition
	Administered Medicaid Home and Community-Based Services Waiver. HCBS programs do not include services that are available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service, as described in 22 CCR sections 51184, 51340 and 51340.1. EPSDT services are covered under the DHCS contract for Medi-Cal, as specified in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services), Subsection F4 regarding services for Members less than twenty-one (21) years of age. CalOptima Health is financially responsible for the payment of all EPSDT services; 2. California Children's Services (CCS) as specified in Exhibit A, Attachment III, Subsection 4.3.14 (California Children's Services), except for Contractors providing Whole Child Model (WCM) services; 3. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (Mental Health Services); 4. Alcohol and SUD treatment services, and outpatient heroin and other opioid detoxification, except for medications for addiction treatment as specified in Exhibit A, Attachment III, Subsection 4.3.13 (Alcohol and Substance Use Disorder Treatment Services); 5. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members); 6. Direct Observed Therapy for Treatment of Tuberculosis (TB) as specified in Exhibit A, Attachment III, Subsection 4.3.18 (Direct Observed Therapy for Treatment of Tuberculosis); 7. Dental services as specified in W&I sections 14131.10, 14132(h), 14132.22, 14132.23, and 14132.88, and EPSDT dental services as described in 22 CCR section 51340.1(b). However, CalOptima Health is responsible for all Covered Services as specified in Exhibit A, Attachment III, Subsection 4.3.17 (Dental) regarding dental services; 8. Prayer or spiritual healing as specified in 22 CCR section 51312; 9. Educationally Necessary Behavioral Health Services that are covered by a Local Education Agency (LEA) and provided pursuant to a Member's Individualized Education Plan (IEP) as set forth in Education Code section 56340 et seq., Individualized Family Service Plan (IFSP) as set forth in California Government Code (GC) section 95020, or Individualized Health and Support Plan (IHSP). However, CalOptima Health is responsible for all Medically Necessary Behavioral Health Services as specified in Exhibit A, Attachment III Subsection 4.3.16 (School-Based Services); 10. Laboratory services provided under the State serum alpha-feto-protein-testing program administered by the Genetic Disease Branch of California Department of Public Health (CDPH); 11. Pediatric Day Health Care, except for Contractors providing Whole Child Model (WCM) services; 12. State Supported Services; 13. Targeted Case Management (TCM) services as set forth in 42 USC section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR sections 51185 and 51351, and as described in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services). However, if Members less than twenty-one (21) years of age are not eligible for or accepted by a Regional Center (RC) or a local

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Term	Definition
	government health program for TCM services, CalOptima Health must ensure access to comparable services under the EPSDT benefit in accordance with DHCS APL 23-005; 14. Childhood lead poisoning case management provided by county health departments; 15. Non-medical services provided by Regional Centers (RC) to individuals with Developmental Disabilities, including but not limited to respite, out-of-home placement, and supportive living; 16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and DHCS APL 16-006; and 17. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with DHCS APL 22-012. OneCare: Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract~~.~~, or Care Coordination, or Coordination of Care as defined in the state Medicaid Agency Contract. PACE: Those items and services ~~set for the in~~ provided by CalOptima Health under the provisions of Welfare and Institutions Code, section 14132 and the California ~~Code of Regulations, title 22, chapter 3, article 4, beginning with section 51301, and title 17, division 1, chapter 4, subchapter 13, beginning with Section 6840, unless otherwise~~ State Plan, except those services specifically excluded under ~~the terms~~Exhibit E, Attachment 1 of the ~~DHCS PACE Contract with CalOptima Health, or other services as authorized by the~~ CalOptima Health ~~Board of Directors.~~ PACE contract, state law, or the California State Plan.
Downstream Entity	Medi-Cal: Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Health Program benefit, below the level of arrangement between CalOptima Health and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services. OneCare: Any party that enters into an acceptable written arrangement below the level of the arrangement between a Medicare Advantage (MA) organization (and contract applicant) and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.
Employee	For the purposes of this policy, any and all Employees of CalOptima Health, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary Employees (contractors) and volunteers.
First Tier, Downstream, and Related Entities (FDR)	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.

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Term	Definition
First Tier Entity	Medi-Cal: Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima Health to provide administrative services or health care services to a Member under a CalOptima Health Program. OneCare: Any party that enters into a written arrangement, acceptable to CMS, with an MAO or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare eligible individual under the MA program or Part D program.
Fraud	~~Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C Section 1347).~~An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with Title 42 Code of Federal Regulations section 455.2, Welfare and Institutions Code section 14043.1(i).
Governing Body	The Board of Directors of CalOptima Health.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information as amended.
Monitoring	Regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.
Protected Health Information (PHI)	Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. Individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima Health or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.

Term	Definition
Provider	~~Medi-Cal: A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, or other person or institution that furnishes Covered Services.~~ Medi-Cal: Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so. OneCare: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B.
Related Entity	Any entity that is related to ~~CalOptima Health~~the Medicare Advantage organization by common ownership or control and ~~that: performs~~: 1. Performs some of ~~CalOptima Health's~~the Medicare Advantage organization's management functions under contract or delegation; ~~furnishes~~ 2. Furnishes services to ~~Members~~Medicare enrollees under an oral or written agreement; or ~~leases~~ ~~1.~~3. Leases real property or sells materials to ~~CalOptima Health~~the Medicare Advantage organization at a cost of more than two thousand five hundred dollars ($2,500) during a contract period.
Waste	The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Health Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

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Policy:	HH.2023
Title:	**Compliance Training**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	*/s/*
Effective Date:	09/01/2015
Revised Date:	11/07/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ PACE ☐ Administrative

I. PURPOSE

This policy describes CalOptima Health's annual Compliance Training and education including, but not limited to, Anti-Fraud, Waste and Abuse (FWA), Code of Conduct, Compliance Plan, Health Insurance Portability and Accountability Act (HIPAA), and CalOptima Health Policies and Procedures for Employees, members of the Governing Body, and First Tier, Downstream, and Related Entities (FDRs).

II. POLICY

A. All CalOptima Health Employees, members of the Governing Body, and FDRs must successfully complete the required annual Compliance Training within ninety (90) calendar days of hire, or contracting, and annually thereafter.

B. All CalOptima Health Employees and members of the Governing Body shall complete the knowledge verification for the applicable annual Compliance Training with a score of eighty percent (80%) or greater.

C. When reviewing and establishing the content of the annual Compliance Training, the Chief Compliance Officer may consider applicable statutes, regulations, regulator contractual requirements, and regulatory guidance. The following are examples of topics the annual Compliance Training shall communicate:

1. A description of the Compliance Program, including a review of compliance policies and procedures, the Code of Conduct, and CalOptima Health's commitment to business ethics and compliance with all CalOptima Health program requirements;

2. An overview of how to ask compliance questions, request compliance clarification, or report suspected, or detected, non-compliance. Training should emphasize Confidentiality, anonymity, and non-Retaliation for reporting compliance related questions, or reports of suspected, or detected, non-compliance, or potential Fraud, Waste and Abuse (FWA);

3. The requirement to report to CalOptima Health actual or suspected program non-compliance, or potential FWA;

4. Scenarios of reportable non-compliance that an Employee might observe;

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5. A review of the disciplinary guidelines for non-compliant or fraudulent behavior. The guidelines will communicate how such behavior can result in mandatory retraining and may result in disciplinary action, including possible termination when such behavior is serious or repeated, or when knowledge of a possible violation is not reported;

6. Discussion of attendance and participation in the annual Compliance Training as a condition of continued employment and a criterion to be included in Employee evaluations;

7. A review of policies related to contracting with the government, such as the laws addressing gifts and gratuities for government Employees;

8. A review of potential conflicts of interest and CalOptima Health's system for disclosure of conflicts of interest;

9. An overview of HIPAA/Health Information Technology for Economic and Clinical Health Act (HITECH), the CMS Data Use Agreement (if applicable), and the importance of maintaining the Confidentiality of Protected Health Information (PHI);

10. An overview of the Monitoring and Auditing process; and

11. A review of the laws that govern Employee conduct in the CalOptima Health programs.

D. CalOptima Health Employees, members of the Governing Body, as well as FDR Employees who have involvement in the administration or delivery of Parts C and D benefits must, at a minimum, receive Compliance Training within ninety (90) calendar days of initial hiring (or contracting in the case of FDRs), and annually thereafter. Additionally, specialized or refresher training may be provided on issues posing FWA risks based on the individual's job function (e.g., pharmacist, statistician, customer service, etc.). Training may be provided:

1. Upon appointment to a new job function;

2. When requirements change;

3. When Employees are found to be non-compliant;

4. As a corrective action to address a non-compliance issue; and

5. When an Employee works in an area implicated in past FWA.

E. Topics that may be addressed in Compliance Training include, but are not limited to:

1. Laws and regulations related to Medicare Part C and Part D FWA (i.e., False Claims Act, Anti-Kickback statute, HIPAA/HITECH, etc.);

2. Obligations of FDRs to have appropriate policies and procedures to address FWA;

3. Processes for CalOptima Health Employees, members of the Governing Body, FDRs, and FDR Employees to report suspected FWA to CalOptima Health (or, for FDR Employees, either to CalOptima Health directly, or to their employers who then must report it to CalOptima Health);

4. Protections for CalOptima Health and FDR Employees who report suspected FWA; and

5. Types of FWA that can occur in the settings in which CalOptima Health and FDR Employees work. All CalOptima Health FDRs shall receive CalOptima Health Compliance Training upon contracting. Additionally, training modules are provided through the CalOptima Health vendor and Provider website with updates provided to FDRs and annually thereafter.

F. FDRs who have met the FWA (as per Chapter 21, Section 50.3 of the Medicare Managed Care Manual) training and education certification requirements through enrollment into Parts A or B of the Medicare program, or through accreditation as a supplier of Durable Medical Equipment, Prosthetics/Orthotics, and Supplies (DMEPOS), are NOT exempt from the annual Compliance Training requirement.

G. Compliance Training Documentation

1. CalOptima Health Employees, members of the Governing Body, FDRs, and FDR Employees, who are performing services on behalf of CalOptima Health shall successfully complete all required Compliance Training modules.

2. Failure to successfully complete all required Compliance Training may lead to disciplinary action (up to and including termination), Corrective Action Plan requirements, and/or Sanctions, in accordance with CalOptima Health Policies HH.2002: Sanctions and HH.2005: Corrective Action Plan. CalOptima Health Employees, members of the Governing Body, and FDRs are expected to inform CalOptima Health immediately in the event of any failure to comply with training requirements. For CalOptima Health Employees and members of the Governing Body, the Human Resources (HR) Training Unit has a systematic indicator that identifies those who fail to comply within the mandated timeframes; non-compliance will result in revoking CalOptima Health system access.

3. The Office of Compliance is responsible for Monitoring and Auditing the compliance of Employees, members of the Governing Body, and FDRs with annual Compliance Training requirements.

4. FDRs shall provide annual attestations confirming completion of all Compliance Training as stated in this policy. Failure to provide timely attestation may lead to corrective actions.

H. Training Document Retention.

1. CalOptima Health and FDRs shall maintain all evidence of Compliance-related training completion for at least ten (10) years. Such materials include, but are not limited to:

a. Attendance;

b. Topic;

c. Certificates of Completion;

d. FDR Attestations;

e. Test scores; and

f. Tests administered to Employees.

III. PROCEDURE

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A. Distributing Compliance Training for Existing Employees and Members of the Governing Body

1. On an annual basis, the HR Training Unit shall communicate to all Employees and members of the Governing Body that an updated Compliance Training is available and must be successfully completed within sixty (60) calendar days.

2. Upon completion, Employees and members of the Governing Body can access a learner transcript confirming successful completion. The transcript will include the training title and completion date. HR, via the HR Training Unit, is responsible for retaining evidence of an Employee's and members of the Governing Body's successful completion of all Compliance Training modules.

B. Distributing Compliance Training for New Employees and Members of the Governing Body

1. Upon hire, the HR Training Unit shall provide each new Employee and member(s) of the Governing Body with instructions to complete Compliance Training.

2. The HR Training Unit shall create a system generated report that identifies those who fail to comply within the mandated time frames. Non-compliance will result in revoking system access.

C. Distributing Compliance Training to FDRs

1. The Office of Compliance shall ensure the training is uploaded and available on the CalOptima Health vendor and Provider website.

2. Upon contracting, the Office of Compliance shall distribute an FDR Compliance Package composed of compliance documents, including the CalOptima Health Compliance Training, and an FDR Attestation that confirms the required Compliance Training is completed by FDRs and their Employees within ninety (90) calendar days of hire and at least annually thereafter.

3. Annually, the Office of Compliance shall distribute and Monitor receipt of updated attestation to all FDRs for execution.

4. When there are updates to Compliance Training materials and/or related policies and procedures, the Office of Compliance shall communicate updates to all FDRs with instructions to access the CalOptima Health vendor and Provider website to retrieve them.

IV. ATTACHMENT(S)

A. FDR Compliance Attestation

V. REFERENCE(S)

A. CalOptima Health Compliance Plan
B. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Health Contract with Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Health PACE Program Agreement
E. CalOptima Health Policy HH.2002: Sanctions
F. CalOptima Health Policy HH.2005: Corrective Action Plan

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G. CalOptima Health Policy HH.2028: Code of Conduct
H. Medicare Managed Care Manual, Chapter 21
I. Medicare Prescription Drug Benefit Manual, Chapter 9
J. Title 42, Code of Federal Regulations (C.F.R.), §§422.503(b)(4)(vi)(A) and (D)
K. Title 42, Code of Federal Regulations (C.F.R.), §§423.504(b)(4)(vi)(A) and (D)
L. Title 42, Code of Federal Regulations (C.F.R.), §438.608
M. Title 42, Code of Federal Regulations (C.F.R.), §455.2
N. "Update—Reducing the Burden of the Compliance Program Training Requirements," Health Plan Management System (HPMS) Memorandum, Issued 7/17/2015
O. "Additional Guidance -- Compliance Program Training Requirements and Audit Process Update," Health Management System (HPMS) Memorandum, Issued 2/10/2016.
P. Welfare and Institutions Code, §14043.1(a)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVIEW/REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	09/01/2015	HH.2023	Compliance Training	Medi-Cal
Revised	12/07/2017	HH.2023	Compliance Training	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.2023	Compliance Training	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.2023	Compliance Training	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.2023	Compliance Training	Medi-Cal OneCare OneCare Connect PACE

Action	Date	Policy	Policy Title	Program(s)
Revised	12/20/2021	HH.2023	Compliance Training	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	HH.2023	Compliance Training	Medi-Cal OneCare PACE
Revised	09/01/2023	HH.2023	Compliance Training	Medi-Cal OneCare PACE
Revised	11/07/2024	HH.2023	Compliance Training	Medi-Cal OneCare PACE

IX. GLOSSARY

Term	Definition
Abuse	Medi-Cal: Practices that are inconsistent with sound fiscal and business practices or medical standards, and result in an unnecessary cost to the Medi-Cal program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to the Medi-Cal program. OneCare: A Provider practice that is inconsistent with sound fiscal, business, or medical practice, and results in an unnecessary cost to CalOptima Health and the OneCare program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to CalOptima Health and the OneCare program.
Audit	A formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being audited and normally performed by individuals with one of several acknowledged certifications.
Code of Conduct	The statement setting forth the principles and standards governing CalOptima Health's activities to which CalOptima Health's Board of Directors, Employees, contractors, and agents are required to adhere.
Compliance Program	The program (including, without limitation, this Compliance Plan, Code of Conduct and Policies and Procedures and Procedures) developed and adopted by CalOptima Health to promote, monitor and ensure that CalOptima Health's operations and practices and the practices of its Board Member, Employees and FDRs comply with applicable law and ethical standards.
Compliance Training	Annually required, this includes, but is not limited to, training and education for the Anti-Fraud, Waste and Abuse (FWA) Plan, Code of Conduct, CalOptima Health's (or an approved FDR version) Compliance Plan, Health Insurance Portability and Accountability Act (HIPAA), and CalOptima Health Policies and Procedures.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima Health, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima Health departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima Health and its regulators.
Covered Services	Medi-Cal: Those health care services, set forth in W&I sections 14000 et seq. and 14131 et seq., 22 CCR section 51301 et seq., 17 CCR section 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, the contract with DHCS for Medi-Cal, and DHCS APLs that are made the responsibility of CalOptima Health pursuant to the California Section

Term	Definition
	1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS. Covered Services do not include: 1. Home and Community-Based Services (HCBS) program as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsections 4.3.15 (Services for Persons with Developmental Disabilities), 4.3.20 (Home and Community-Based Services Programs) regarding waiver programs, 4.3.21 (In-Home Supportive Services), and Department of Developmental Services (DDS) Administered Medicaid Home and Community-Based Services Waiver. HCBS programs do not include services that are available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service, as described in 22 CCR sections 51184, 51340 and 51340.1. EPSDT services are covered under the DHCS contract for Medi-Cal, as specified in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services), Subsection F4 regarding services for Members less than twenty-one (21) years of age. CalOptima Health is financially responsible for the payment of all EPSDT services; 2. California Children's Services (CCS) as specified in Exhibit A, Attachment III, Subsection 4.3.14 (California Children's Services), except for Contractors providing Whole Child Model (WCM) services; 3. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (Mental Health Services); 4. Alcohol and SUD treatment services, and outpatient heroin and other opioid detoxification, except for medications for addiction treatment as specified in Exhibit A, Attachment III, Subsection 4.3.13 (Alcohol and Substance Use Disorder Treatment Services); 5. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members); 6. Direct Observed Therapy for Treatment of Tuberculosis (TB) as specified in Exhibit A, Attachment III, Subsection 4.3.18 (Direct Observed Therapy for Treatment of Tuberculosis); 7. Dental services as specified in W&I sections 14131.10, 14132(h), 14132.22, 14132.23, and 14132.88, and EPSDT dental services as described in 22 CCR section 51340.1(b). However, CalOptima Health is responsible for all Covered Services as specified in Exhibit A, Attachment III, Subsection 4.3.17 (Dental) regarding dental services; 8. Prayer or spiritual healing as specified in 22 CCR section 51312; 9. Educationally Necessary Behavioral Health Services that are covered by a Local Education Agency (LEA) and provided pursuant to a Member's Individualized Education Plan (IEP) as set forth in Education Code section 56340 et seq., Individualized Family Service Plan (IFSP) as set forth in California Government Code (GC) section 95020, or Individualized Health and Support Plan (IHSP). However, CalOptima Health is responsible for all Medically Necessary Behavioral Health Services as specified in Exhibit A, Attachment III Subsection 4.3.16 (School-Based Services);

Term	Definition
	10. Laboratory services provided under the State serum alpha-feto-protein-testing program administered by the Genetic Disease Branch of California Department of Public Health (CDPH); 11. Pediatric Day Health Care, except for Contractors providing Whole Child Model (WCM) services; 12. State Supported Services; 13. Targeted Case Management (TCM) services as set forth in 42 USC section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR sections 51185 and 51351, and as described in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services). However, if Members less than twenty-one (21) years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, CalOptima Health must ensure access to comparable services under the EPSDT benefit in accordance with DHCS APL 23-005; 14. Childhood lead poisoning case management provided by county health departments; 15. Non-medical services provided by Regional Centers (RC) to individuals with Developmental Disabilities, including but not limited to respite, out-of-home placement, and supportive living; 16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and DHCS APL 16-006; and 17. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with DHCS APL 22-012. OneCare: Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract, or Care Coordination, or Coordination of Care as defined in the state Medicaid Agency Contract. PACE: Those items and services provided by CalOptima Health under the provisions of Welfare and Institutions Code, section 14132 and the California State Plan, except those services specifically excluded under Exhibit E, Attachment 1 of the CalOptima Health PACE contract, state law, or the California State Plan.
Downstream Entity	Medi-Cal: Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Health Program benefit, below the level of arrangement between CalOptima Health and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services. OneCare: Any party that enters into an acceptable written arrangement below the level of the arrangement between a Medicare Advantage (MA) organization (and contract applicant) and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.

Term	Definition
Employee	For the purposes of this policy, any and all Employees of CalOptima Health, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary Employees (contractors) and volunteers.
First Tier, Downstream, and Related Entities (FDR)	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
First Tier Entity	Medi-Cal: Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima Health to provide administrative services or health care services to a Member under a CalOptima Health Program. OneCare: Any party that enters into a written arrangement, acceptable to CMS, with an MAO or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare eligible individual under the MA program or Part D program.
Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with Title 42 Code of Federal Regulations section 455.2, Welfare and Institutions Code section 14043.1(i).
Governing Body	The Board of Directors of CalOptima Health.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information as amended.
Monitoring	Regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.
Protected Health Information (PHI)	Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations. Individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima Health or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.

Term	Definition
Provider	Medi-Cal: Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so. OneCare: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B.
Related Entity	Any entity that is related to the Medicare Advantage organization by common ownership or control and: 1. Performs some of the Medicare Advantage organization's management functions under contract or delegation; 2. Furnishes services to Medicare enrollees under an oral or written agreement; or 3. Leases real property or sells materials to the Medicare Advantage organization at a cost of more than two thousand five hundred dollars ($2,500) during a contract period.
Waste	The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Health Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

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FDR COMPLIANCE ATTESTATION

Please complete and execute this attestation and return it to CalOptima Health's Office of Compliance via email Compliance@caloptima.org, ~~or mail: CalOptima Health, Office of Compliance, Attn: Regulatory Affairs & Compliance Medicare Director, 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:	☐ Medi-Cal ☐PACE ☐OneCare

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 Health 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 as evidence of completed training)

☐ An internal training program that utilizes content available in CMS's Fraud, Waste, and Abuse training, General Compliance training, and HIPAA training module requirements, or training content that is materially the same. (The Organization shall maintain records as evidence of completed training)

Note: If selecting an internal training program that aligns with CMS's FWA, HIPAA, and General Compliance, please submit a copy of your organization's trainings to CalOptima Health's Office of Compliance for review to ensure they meet CMS's requirements.

II. Administer specialized compliance training to Organization and downstream entity board members, employees, temporary employees, and volunteers within the first ninety (90) calendar days of hire and at least annually thereafter as a condition of appointment, employment or contracting.

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) calendar 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 Health's Compliance Plan and Code of Conduct (https://www.caloptima.org/en/About/GeneralCompliance/GeneralComplianceResourceLinks.aspx)

☐ 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 Health's Office of Compliance for review 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 Medi-Cal 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), Restricted Provider Database(RPD) (as applicable), (hereafter "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 Health within five (5) calendar days, the relationship with the listed person/entity may be terminated as it relates to CalOptima Health, 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 Health 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 Health, confidentially and anonymously.

VII. **Disciplinary Action**. Understand that any violation of any laws, regulations, or CalOptima Health 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 Health 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)	

Attestation Concerning the Use of Offshore Subcontractors

If Organization offshores any protected health information (PHI) it must notify CalOptima Health prior to entering into or amending any agreement with an Offshore Subcontractor, and the Organization must complete the Offshore Subcontracting Attestation.

Which CalOptima Health program(s) does this form pertain to? Select all that apply.	☐ Medi-Cal ☐ PACE ☐ OneCare

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 Health.	☐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 beneficiary protected health information (PHI) and other personal information remains secure.	☐Yes ☐No*
B. Offshore subcontracting arrangement prohibits subcontractor's access to data not associated with CalOptima Health'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 Health 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 Health's policies and procedures, CMS training module instructions for FWA, General Compliance, General HIPAA, CalOptima Health's Code of Conduct, CalOptima Health's Compliance Plan can be accessed at https://www.caloptima.org/en/About/GeneralCompliance.aspx

FDR COMPLIANCE ATTESTATION

Please complete and execute this attestation and return it to CalOptima Health's Office of Compliance via email Compliance@caloptima.org, 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:	☐ Medi-Cal ☐PACE ☐OneCare

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 Health 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 as evidence of completed training)

☐ An internal training program that utilizes content available in CMS's Fraud, Waste, and Abuse training, General Compliance training, and HIPAA training module requirements, or training content that is materially the same. (The Organization shall maintain records as evidence of completed training)

Note: If selecting an internal training program that aligns with CMS's FWA, HIPAA, and General Compliance, please submit a copy of your organization's trainings to CalOptima Health's Office of Compliance for review to ensure they meet CMS's requirements.

II. Administer specialized compliance training to Organization and downstream entity board members, employees, temporary employees, and volunteers within the first ninety (90) calendar days of hire and at least annually thereafter as a condition of appointment, employment or contracting.

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) calendar 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 Health's Compliance Plan and Code of Conduct (https://www.caloptima.org/en/About/GeneralCompliance/GeneralComplianceResourceLinks.aspx)

☐ 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 Health's Office of Compliance for review 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 Medi-Cal 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), Restricted Provider Database(RPD) (as applicable), (hereafter "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 Health within five (5) calendar days, the relationship with the listed person/entity may be terminated as it relates to CalOptima Health, 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 Health 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 Health, confidentially and anonymously.

VII. **Disciplinary Action**. Understand that any violation of any laws, regulations, or CalOptima Health 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 Health 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)	

Attestation Concerning the Use of Offshore Subcontractors

If Organization offshores any protected health information (PHI) it must notify CalOptima Health prior to entering into or amending any agreement with an Offshore Subcontractor, and the Organization must complete the Offshore Subcontracting Attestation.

Which CalOptima Health program(s) does this form pertain to? Select all that apply.	☐ Medi-Cal ☐ PACE ☐ OneCare

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 Health.	☐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 beneficiary protected health information (PHI) and other personal information remains secure.	☐Yes ☐No*
B. Offshore subcontracting arrangement prohibits subcontractor's access to data not associated with CalOptima Health'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 Health 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 Health's policies and procedures, CMS training module instructions for FWA, General Compliance, General HIPAA, CalOptima Health's Code of Conduct, CalOptima Health's Compliance Plan can be accessed at https://www.caloptima.org/en/About/GeneralCompliance.aspx

Policy:	HH.2028
Title:	**Code of Conduct**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	*/s/*
Effective Date:	09/01/2015
Revised Date:	11/07/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ PACE ☐ Administrative

I. PURPOSE

This policy describes the process CalOptima Health utilizes to review, approve, and communicate its expectation that all Employees, members of its Governing Body, and First Tier, Downstream, and Related Entities (FDRs) conduct themselves in an ethical and legal manner and in compliance with the Code of Conduct.

II. POLICY

A. CalOptima Health requires that all members of the Governing Body, Employees, and FDRs to conduct themselves in an ethical and legal manner and in compliance with the Code of Conduct.

B. Failure to comply with the Code of Conduct or the guidelines for behavior that the Code of Conduct represents may lead to disciplinary action, up to and including termination. Employees and FDRs are expected to inform CalOptima Health's Office of Compliance immediately in the event of any violation(s) to the Code of Conduct, in accordance with CalOptima Health Policy HH.2019: Reporting Suspected or Actual Fraud, Waste, or Abuse (FWA), Violations of Applicable Laws and Regulations, and/or CalOptima Health Policies.

C. Employees, members of the Governing Body, and FDRs shall provide attestations they have received, read, understood and will comply with the Code of Conduct upon appointment, hire, or the commencement of the contract and annually thereafter. Completion and attestation of such review of the Code of Conduct is a condition of continued appointment, employment, or contract services.

III. PROCEDURE

A. Reviewing and Approving the Code of Conduct

1. The Office of Compliance is responsible for ensuring a review and approval of the current Code of Conduct by the Board of Directors, at least annually, or more frequently as needed. The following sources should be considered to determine if changes to the Code of Conduct are required:

   a. Changes in state and federal laws, or regulations;

   b. Changes in health care program requirements; and

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c. Other guidance, as applicable.

2. Once approved by the Board of Directors, the Office of Compliance is responsible for ensuring the Code of Conduct is made available on CalOptima Health's InfoNet, and ~~vendor and provider websites~~public website.

B. Distributing and Monitoring for CalOptima Health Employees

1. All CalOptima Health Employees shall receive CalOptima Health's Code of Conduct within ninety (90) calendar days of appointment, hire, or contracting, and at least annually thereafter, as well as when the Code of Conduct is modified.

2. If mid-year, or annual, revisions are made to the Code of Conduct, the Office of Compliance will inform the Human Resources Department, who will communicate to all Employees that an updated Code of Conduct is available and must be reviewed.

a. If the Code of Conduct is revised and distributed as part of the annual review, then the Human Resources Department shall distribute via web-based training, in accordance with CalOptima Health Policy HH.2023: Compliance Training.

b. If there are revisions to the Code of Conduct that occur mid-year, the Human Resources Department shall compose and distribute an email to all Employees announcing an updated Code of Conduct is available on CalOptima Health's InfoNet and to electronically confirm receipt, review, and understanding of the updated Code of Conduct.

3. The Code of Conduct shall be communicated to all Employees through CalOptima Health's web-based learning management system or other means of distribution, in accordance with CalOptima Health Policy HH.2023: Compliance Training.

C. Distributing and Monitoring for Members of the Governing Body

1. All members of CalOptima Health's Governing Body shall receive CalOptima Health's Code of Conduct within ninety (90) calendar days of appointment, at least annually thereafter, and when the Code of Conduct is modified.

2. If mid-year or annual revisions are made to the Code of Conduct, the Office of Compliance will inform the Clerk of the Board, who will communicate to all members of the Governing Body that an updated Code of Conduct is available and must be reviewed.

a. If the Code of Conduct is revised and distributed as part of the annual review, then the Human Resources Department shall distribute the Code of Conduct via web-based training, in accordance with CalOptima Health Policy HH.2023: Compliance Training. The Clerk of the Board shall also provide a copy of the current Code of Conduct to all members of the Governing Body through a written memorandum and request an updated attestation to be executed from all members of the Governing Body.

b. If there are revisions to the Code of Conduct that occur mid-year, the Clerk of the Board shall compose and distribute a written memorandum to all members of the Governing Body announcing an updated Code of Conduct is available and to electronically confirm receipt, review, and understanding of the updated Code of Conduct.

D. Distributing and Monitoring for FDRs

1. The Office of Compliance shall ensure the updated Code of Conduct is uploaded on to CalOptima Health vendor and Provider websites.

2. Upon contracting, the Office of Compliance distributes an FDR compliance attestation package composed of a cover letter containing a link to direct FDRs to CalOptima Health's policies and procedures, and Code of Conduct, as well as instructions on how to access CMS training modules on the topics for Fraud, Waste, and Abuse, General Compliance, and HIPAA. The packet also contains an FDR and Offshore attestation that are due within thirty (30) calendar days (for existing FDRs) or sixty (60) calendar days (new FDRs).

3. All CalOptima Health FDRs shall receive CalOptima Health's Code of Conduct within ninety (90) calendar days of appointment, hire, or contracting, and at least annually thereafter, as well as when the Code of Conduct is modified. Additionally, the Code of Conduct is provided through the CalOptima Health vendor and Provider websites with notification of updates provided via email.

    a. Upon contracting and annually thereafter, FDRs shall confirm receipt and understanding of CalOptima Health's Code of Conduct via the initial and annual FDR attestation.

4. FDRs are required to disseminate copies of the CalOptima Health's Code of Conduct and policies and procedures to their employees, agents, and Downstream Entities, or distribute a comparable Compliance Plan and Code of Conduct. If the latter option, the FDR must submit a copy of its Compliance Plan and Code of Conduct to CalOptima Health's Office of Compliance for review, to ensure they meet CMS requirements.

5. Annually, the Office of Compliance shall request an updated attestation to be executed from all FDRs. Failure to submit the requested documents may result in issuance of a notice of non-compliance, in accordance with CalOptima Health Policy HH.2005: Corrective Action Plan.

6. The Office of Compliance shall communicate any update(s) to compliance documents, with instructions to access the CalOptima Health vendor and provider websites, to all FDRs.

IV. ATTACHMENT(S)

~~Not Applicable~~
A. CalOptima Health Code of Conduct

V. REFERENCE(S)

A. CalOptima Health Compliance Plan
B. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Health PACE Program Agreement
E. CalOptima Health Policy HH.2005: Corrective Action Plan
F. CalOptima Health Policy HH.2019: Reporting Suspected or Actual Fraud, Waste, or Abuse (FWA), Violations of Applicable Laws and Regulations, and/or CalOptima Health Policies
G. CalOptima Health Policy HH.2023: Compliance Training
H. Medicare Managed Care Manual, Chapter 21
I. Medicare Prescription Drug Benefit Manual, Chapter 9
J. Title 42, Code of Federal Regulations (C.F.R.), §455.2
K. Title 42, Code of Federal Regulations (C.F.R.), §422.503(b)(4)(vi)(A)
L. Title 42, Code of Federal Regulations (C.F.R.), §423.504(b)(4)(vi)(A)

M. Title 42, Code of Federal Regulations (C.F.R.), §438.608
N. Welfare and Institutions Code, §14043.1(a)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	09/01/2015	HH.2028	Code of Conduct	Medi-Cal
Revised	12/01/2016	HH.2028	Code of Conduct	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.2028	Code of Conduct	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.2028	Code of Conduct	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.2028	Code of Conduct	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.2028	Code of Conduct	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.2028	Code of Conduct	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	HH.2028	Code of Conduct	Medi-Cal OneCare PACE

Action	Date	Policy	Policy Title	Program(s)
Revised	09/01/2023	HH.2028	Code of Conduct	Medi-Cal OneCare PACE
Revised	11/07/2024	HH.2028	Code of Conduct	Medi-Cal OneCare PACE

IX. GLOSSARY

Term	Definition
Code of Conduct	The statement setting forth the principles and standards governing CalOptima Health's activities to which Board Members, Employees, FDRs, and agents of CalOptima Health are expected to adhere.
Downstream Entity	Medi-Cal: Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Health Program benefit, below the level of arrangement between CalOptima Health and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services. OneCare: Any party that enters into an acceptable written arrangement below the level of the arrangement between a Medicare Advantage (MA) organization (and contract applicant) and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.
Employee	For purposes of this policy, any and all employees of CalOptima Health, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.
First Tier, Downstream, and Related Entities (FDR):	First Tier, Downstream or Related Entity, as separately defined herein. For the purposes of this policy, the term FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
First Tier Entity	Medi-Cal: Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima Health to provide administrative services or health care services to a Member under a CalOptima Health Program. OneCare: Any party that enters into a written arrangement, acceptable to CMS, with an MAO or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare eligible individual under the MA program or Part D program.
Governing Body	The Board of Directors of CalOptima Health.
Monitoring	~~Regular reviews~~An on-going process usually directed by management ~~and performed as part of normal operations to confirm ongoing compliance and~~ to ensure ~~that corrective actions~~processes are ~~undertaken and~~working as intended. Monitoring is an effective detective control within a process and is typically completed by department staff and communicated to department management.
Related Entity	Any entity that is related to CalOptima Health by common ownership or control and that: performs some of CalOptima Health's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima Health at a cost of more than two thousand five hundred dollars ($2,500) during a contract period.

Policy:	HH.2028
Title:	**Code of Conduct**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	*/s/*
Effective Date:	09/01/2015
Revised Date:	11/07/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ PACE ☐ Administrative

I. PURPOSE

This policy describes the process CalOptima Health utilizes to review, approve, and communicate its expectation that all Employees, members of its Governing Body, and First Tier, Downstream, and Related Entities (FDRs) conduct themselves in an ethical and legal manner and in compliance with the Code of Conduct.

II. POLICY

A. CalOptima Health requires that all members of the Governing Body, Employees, and FDRs to conduct themselves in an ethical and legal manner and in compliance with the Code of Conduct.

B. Failure to comply with the Code of Conduct or the guidelines for behavior that the Code of Conduct represents may lead to disciplinary action, up to and including termination. Employees and FDRs are expected to inform CalOptima Health's Office of Compliance immediately in the event of any violation(s) to the Code of Conduct, in accordance with CalOptima Health Policy HH.2019: Reporting Suspected or Actual Fraud, Waste, or Abuse (FWA), Violations of Applicable Laws and Regulations, and/or CalOptima Health Policies.

C. Employees, members of the Governing Body, and FDRs shall provide attestations they have received, read, understood and will comply with the Code of Conduct upon appointment, hire, or the commencement of the contract and annually thereafter. Completion and attestation of such review of the Code of Conduct is a condition of continued appointment, employment, or contract services.

III. PROCEDURE

A. Reviewing and Approving the Code of Conduct

1. The Office of Compliance is responsible for ensuring a review and approval of the current Code of Conduct by the Board of Directors, at least annually, or more frequently as needed. The following sources should be considered to determine if changes to the Code of Conduct are required:

   a. Changes in state and federal laws, or regulations;

   b. Changes in health care program requirements; and

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c. Other guidance, as applicable.

2. Once approved by the Board of Directors, the Office of Compliance is responsible for ensuring the Code of Conduct is made available on CalOptima Health's InfoNet, and public website.

B. Distributing and Monitoring for CalOptima Health Employees

1. All CalOptima Health Employees shall receive CalOptima Health's Code of Conduct within ninety (90) calendar days of appointment, hire, or contracting, and at least annually thereafter, as well as when the Code of Conduct is modified.

2. If mid-year, or annual, revisions are made to the Code of Conduct, the Office of Compliance will inform the Human Resources Department, who will communicate to all Employees that an updated Code of Conduct is available and must be reviewed.

a. If the Code of Conduct is revised and distributed as part of the annual review, then the Human Resources Department shall distribute via web-based training, in accordance with CalOptima Health Policy HH.2023: Compliance Training.

b. If there are revisions to the Code of Conduct that occur mid-year, the Human Resources Department shall compose and distribute an email to all Employees announcing an updated Code of Conduct is available on CalOptima Health's InfoNet and to electronically confirm receipt, review, and understanding of the updated Code of Conduct.

3. The Code of Conduct shall be communicated to all Employees through CalOptima Health's web-based learning management system or other means of distribution, in accordance with CalOptima Health Policy HH.2023: Compliance Training.

C. Distributing and Monitoring for Members of the Governing Body

1. All members of CalOptima Health's Governing Body shall receive CalOptima Health's Code of Conduct within ninety (90) calendar days of appointment, at least annually thereafter, and when the Code of Conduct is modified.

2. If mid-year or annual revisions are made to the Code of Conduct, the Office of Compliance will inform the Clerk of the Board, who will communicate to all members of the Governing Body that an updated Code of Conduct is available and must be reviewed.

a. If the Code of Conduct is revised and distributed as part of the annual review, then the Human Resources Department shall distribute the Code of Conduct via web-based training, in accordance with CalOptima Health Policy HH.2023: Compliance Training. The Clerk of the Board shall also provide a copy of the current Code of Conduct to all members of the Governing Body through a written memorandum and request an updated attestation to be executed from all members of the Governing Body.

b. If there are revisions to the Code of Conduct that occur mid-year, the Clerk of the Board shall compose and distribute a written memorandum to all members of the Governing Body announcing an updated Code of Conduct is available and to electronically confirm receipt, review, and understanding of the updated Code of Conduct.

D. Distributing and Monitoring for FDRs

1. The Office of Compliance shall ensure the updated Code of Conduct is uploaded on to CalOptima Health vendor and Provider websites.

2. Upon contracting, the Office of Compliance distributes an FDR compliance attestation package composed of a cover letter containing a link to direct FDRs to CalOptima Health's policies and procedures, and Code of Conduct, as well as instructions on how to access CMS training modules on the topics for Fraud, Waste, and Abuse, General Compliance, and HIPAA. The packet also contains an FDR and Offshore attestation that are due within thirty (30) calendar days (for existing FDRs) or sixty (60) calendar days (new FDRs).

3. All CalOptima Health FDRs shall receive CalOptima Health's Code of Conduct within ninety (90) calendar days of appointment, hire, or contracting, and at least annually thereafter, as well as when the Code of Conduct is modified. Additionally, the Code of Conduct is provided through the CalOptima Health vendor and Provider websites with notification of updates provided via email.

    a. Upon contracting and annually thereafter, FDRs shall confirm receipt and understanding of CalOptima Health's Code of Conduct via the initial and annual FDR attestation.

4. FDRs are required to disseminate copies of the CalOptima Health's Code of Conduct and policies and procedures to their employees, agents, and Downstream Entities, or distribute a comparable Compliance Plan and Code of Conduct. If the latter option, the FDR must submit a copy of its Compliance Plan and Code of Conduct to CalOptima Health's Office of Compliance for review, to ensure they meet CMS requirements.

5. Annually, the Office of Compliance shall request an updated attestation to be executed from all FDRs. Failure to submit the requested documents may result in issuance of a notice of non-compliance, in accordance with CalOptima Health Policy HH.2005: Corrective Action Plan.

6. The Office of Compliance shall communicate any update(s) to compliance documents, with instructions to access the CalOptima Health vendor and provider websites, to all FDRs.

IV. ATTACHMENT(S)

A. CalOptima Health Code of Conduct

V. REFERENCE(S)

A. CalOptima Health Compliance Plan
B. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Health PACE Program Agreement
E. CalOptima Health Policy HH.2005: Corrective Action Plan
F. CalOptima Health Policy HH.2019: Reporting Suspected or Actual Fraud, Waste, or Abuse (FWA), Violations of Applicable Laws and Regulations, and/or CalOptima Health Policies
G. CalOptima Health Policy HH.2023: Compliance Training
H. Medicare Managed Care Manual, Chapter 21
I. Medicare Prescription Drug Benefit Manual, Chapter 9
J. Title 42, Code of Federal Regulations (C.F.R.), §455.2
K. Title 42, Code of Federal Regulations (C.F.R.), §422.503(b)(4)(vi)(A)
L. Title 42, Code of Federal Regulations (C.F.R.), §423.504(b)(4)(vi)(A)
M. Title 42, Code of Federal Regulations (C.F.R.), §438.608

N. Welfare and Institutions Code, §14043.1(a)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	09/01/2015	HH.2028	Code of Conduct	Medi-Cal
Revised	12/01/2016	HH.2028	Code of Conduct	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.2028	Code of Conduct	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.2028	Code of Conduct	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.2028	Code of Conduct	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.2028	Code of Conduct	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.2028	Code of Conduct	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	HH.2028	Code of Conduct	Medi-Cal OneCare PACE

Action	Date	Policy	Policy Title	Program(s)
Revised	09/01/2023	HH.2028	Code of Conduct	Medi-Cal OneCare PACE
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IX. GLOSSARY

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Governing Body	The Board of Directors of CalOptima Health.
Monitoring	An on-going process usually directed by management to ensure processes are working as intended. Monitoring is an effective detective control within a process and is typically completed by department staff and communicated to department management.
Related Entity	Any entity that is related to CalOptima Health by common ownership or control and that: performs some of CalOptima Health's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima Health at a cost of more than two thousand five hundred dollars ($2,500) during a contract period.

~~2024~~ 2025 Code of Conduct

(Revised September 2024~~3~~)

Document maintained by: John Tanner
CalOptima Health Chief Compliance Officer

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Message from Chief Compliance Officer (CCO)

CalOptima Health is committed to its mission "to serve member health with excellence and dignity, respecting the value and needs of each person." Foundational to fulfilling this commitment is conducting ourselves in an ethical and compliant manner in the course of our daily activities and interactions. CalOptima Health expects all employees, contractors, officers, board members, network providers, subcontractors and downstream contractors act ethically and have a responsibility in ensuring compliance.

This document is a guide with 112 principles and related standards to provide a framework for CalOptima Health's Code of Conduct and how we are to conduct ourselves in serving our members. Please review this Code of Conduct and reach out to the Chief Compliance Officer or a representative from the Office of Compliance if you have any questions regarding this information.

It is incumbent upon all Board members, employees, providers and contractors to report any potential issues of non-compliance or misconduct. Reporting can be done online via the InfoNet or the CalOptima Health website, email, or phone.

You also have the option to anonymously report issues to the:

Compliance and Ethics Hotline at 1-855-507-1805

If you are unsure of a particular matter or situation, talk to your supervisor or a representative from the Office of Compliance to discuss your concerns and get guidance. Conducting our business compliantly and ethically is key to sustaining our business and maintaining our focus in serving our members.

Thank you for your dedication to serving our members and to following this Code of Conduct.

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Code of Conduct 11~~2~~ Principles

1. Mission, Vision, and Values:
CalOptima Health is committed to its Mission, Vision, and Values

2. Member Rights:
CalOptima Health is committed to meeting the health care needs of its members by providing access to quality health care services.

3. Compliance with the Law and Applicable Program Requirements:
CalOptima Health is committed to conducting all activities and operations in compliance with all applicable requirements and standards under its contract with DHCS and all ~~law~~ and federal and state ~~applicable program~~ requirements including CMS requirements.

4. Business Ethics:
In furtherance of CalOptima Health's commitment to the highest standards of business ethics, employees and contractors shall accurately and honestly represent CalOptima Health and shall not engage in any activity or scheme intended to defraud anyone of money, property, or honest services.

5. Conflicts of Interests:
Board members, ~~and~~ employees, and contractors owe a duty of undivided and unqualified loyalty to CalOptima Health.

~~**Business Relationships:**~~

~~**6.** Business transactions with vendors, contractors, and other third parties shall be conducted at arm's length in fact and in appearance, transacted free from improper inducements and in accordance with applicable law and ethical standards.~~**Public Integrity:**
CalOptima Health and its Board members, employees, and contractors shall comply with laws and regulations governing public agencies.

7. Confidentiality:
Board members, employees, and contractors shall maintain the confidentiality of all confidential information in accordance with applicable law and shall not disclose such confidential information except as specifically authorized by CalOptima Health policies, procedures, and applicable laws.

~~6.~~8. Compliance Program Reporting:
Board members, employees, and contractors have a duty to comply with CalOptima Health's Compliance Program and such duty shall be a condition of their respective appointment, employment, or engagement.

~~**7.1. Confidentiality:**~~
~~Board members, employees, and contractors shall maintain the confidentiality of all confidential information in accordance with applicable law and shall not disclose such confidential information except as specifically authorized by CalOptima Health policies, procedures, and applicable laws.~~

~~**8. Public Integrity:**~~
~~CalOptima Health and its Board members and employees shall comply with laws and regulations governing public agencies.~~

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~~9.1. Business Relationships:~~

~~Business transactions with vendors, contractors, and other third parties shall be conducted at arm's length in fact and in appearance, transacted free from improper inducements and in accordance with applicable law and ethical standards.~~

~~10.~~9. **Discrimination:**

CalOptima Health acknowledges that fair and equitable treatment of employees, contractors, members, providers, and other persons is fundamental to fulfilling its mission and goals.

~~11.~~10. **Participation Status:**

CalOptima Health requires that employees, contractors, providers, and suppliers meet Government requirements for participation in CalOptima Health's programs.

~~12.~~11. **Government Inquiries/Legal Disputes:**

Employees and contractors shall notify CalOptima Health upon receipt of Government inquiries and shall not destroy or alter documents in response to a government request for documents or information.

Code of Conduct Principles and Standards

Principle	Standard
1. **Mission, Vision, and Values** CalOptima Health is committed to its Mission, Vision, and Values	**Mission** To serve member health with excellence and dignity, respecting the value and needs of each person. **Vision by 2027** • CalOptima Health Same-Day Treatment Authorizations • Real-Time Claims Payments • Annual Assessments of Member's Social Determinants of Health. **Values = CalOptima Health CARES** **C**ollaboration; **A**ccountability; **R**espect; **E**xcellence; **S**tewardship
2. **Member Rights** CalOptima Health is committed to meeting the health care needs of its members by providing access to quality health care services.	**Member Choice, Access to Health Care Services, Continuity of Care** Employees and contractors shall comply with CalOptima Health policies and procedures and applicable law governing member choice, access to health care services, and continuity of member care. Employees and contractors shall comply with all requirements for coordination of medical and support services for persons with special needs. Health Equity Employees and contractors shall endeavor to address and prioritize health equity in the design and implementation of CalOptima Health strategies and programs.

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Principle	Standard
	Cultural and Linguistic Services CalOptima Health and contractors shall provide culturally, linguistically, and sensory appropriate services to CalOptima Health members to ensure effective communication regarding diagnosis, medical history, and treatment, and health education. **Disabled Member Access** CalOptima Health's facilities shall adhere to the requirements of Title III of the Americans with Disabilities Act of 1990 by providing access for disabled members. **Emergency Treatment** Employees and contractors shall comply with all applicable guidelines, policies and procedures, and laws governing CalOptima Health member access and payment of emergency services including, without limitation, the Emergency Medical Treatment and Active Labor Act ("EMTALA") and state patient "anti-dumping" laws, prior authorization limitations, and payment standards. **Grievance and Appeals Processes** CalOptima Health, its physician groups, its Health Networks, and third-party administrators (TPA) shall ensure that CalOptima Health members are informed of their grievance and appeal rights including, the state hearing process, through member handbooks and other communications in accordance with CalOptima Health policies and procedures and applicable laws. Employees and contractors shall address, investigate, and resolve CalOptima Health member complaints and grievances in a prompt and nondiscriminatory manner in accordance with CalOptima Health policies and applicable laws.
3. Compliance with the Law and Applicable Program Requirements CalOptima Health is committed to conducting all activities and operations in compliance with applicable law and program requirements.	**Transparent, Legal, and Ethical Business Conduct** CalOptima Health is committed to conducting its business with integrity, honesty, and fairness and in compliance with all federal and state laws and~~laws and~~ regulations,~~.~~ and applicable requirements and standards under its Contract with DHCS. CalOptima Health expects all employees, contractors, officers, board of directors members, network providers, subcontractors, and downstream contractors to act ethically and are responsible for ensuring CalOptima Health compliance.~~that apply to its operations. CalOptima Health depends on its Board members, employees, and those who do business with it to help fulfill this commitment.~~ **Obeying the Law**

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Principle	Standard
	Board members, employees, and contractors (including First Tier and Downstream Entities included in the term "FDRs") shall not lie, steal, cheat, or violate any law in connection with their employment and/or engagement with CalOptima Health. **Fraud, Waste, & Abuse (FWA)** CalOptima Health shall refrain from conduct which would violate the Fraud, Waste, and Abuse laws. CalOptima Health is committed to the detection, prevention, and reporting of Fraud, Waste, and Abuse. CalOptima Health is also responsible for ensuring that Board members, employees, contractors, and FDRs receive appropriate FWA training as described in regulatory guidance. CalOptima Health's Compliance Plan, Anti-Fraud, Waste, and Abuse Plan and policies describe examples of Potential Fraud, Waste, and Abuse and discuss employee and contractor FWA obligations and potential Sanctions arising from relevant federal and state FWA laws. CalOptima Health expects and requires that its Board members, employees, and contractors do not participate in any conduct that may violate the FWA laws including federal and state anti-kickback laws, false claims acts, and civil monetary penalty laws. **Political Activities** CalOptima Health's political participation is limited by law. CalOptima Health funds, property, and resources are not to be used to contribute to political campaigns, political parties, and/or organizations. Board members, employees and contractors may participate in the political process on their own time and at their own expense but shall not give the impression that they are speaking on behalf of or representing CalOptima Health in these activities. **Anti-Trust** All Board members, employees, and contractors must comply with applicable antitrust, unfair competition, and similar laws which regulate competition. Such persons shall seek advice from legal counsel if they encounter any business decisions involving a risk of violation of antitrust laws. The types of activities that potentially implicate antitrust laws include, without limitation, agreements to fix prices, bid rigging, and related activities; boycotts, certain exclusive dealings, and price discrimination agreements; unfair trade practices; sales or purchases conditioned on reciprocal purchases or sales; and discussion of factors determinative of prices at trade association meetings.
4. Business Ethics	**Candor & Honesty**

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Principle	Standard
In furtherance of CalOptima Health's commitment to the highest standards of business ethics, employees and contractors shall accurately and honestly represent CalOptima Health and shall not engage in any activity or scheme intended to defraud anyone of money, property, or honest services.	CalOptima Health requires candor and honesty from individuals in the performance of their responsibilities and in communications including, communications with CalOptima Health's Board of Directors, supervisory employees, attorneys, and auditors. No Board member, employee, or contractor shall make false or misleading statements to any members and/or persons, or entities, doing business with CalOptima Health about products or services of CalOptima Health. **Financial and Data Reporting** All financial reports, accounting records, research reports, expense accounts, data submissions, attestations, timesheets, and other documents must accurately and clearly represent the relevant facts and the true nature of a transaction. CalOptima Health maintains a system of internal controls to ensure that all transactions are executed in accordance with Management's authorization and recorded in a proper manner to maintain accountability of the agency's assets. Improper or fraudulent accounting documentation or financial reporting or false or misleading encounter, claims, cost, or other required regulatory data submissions is contrary to the policy of CalOptima Health and may be in violation of applicable laws and regulatory obligations. **Regulatory Agencies and Accrediting Bodies** CalOptima Health will deal with all Regulatory Agencies and accrediting bodies in a direct, open, and honest manner. Employees and contractors shall not take action with Regulatory Agencies and accrediting bodies that is false or misleading.

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Principle	Standard
5. Conflicts of Interests Board members, ~~and~~ employees, and contractors owe a duty of undivided and unqualified loyalty to CalOptima Health.	**Conflicts of Interest ~~Code~~** Designated employees and contractors~~, including Board members,~~ shall comply with the requirements of GA.8012: Conflicts of Interest (policy), ~~the CalOptima Health Conflict of Interest Code~~ and applicable laws. Board members~~, and~~ employees, and contractors are expected to conduct their activities to avoid impropriety and/or the appearance of impropriety, which might arise from the influence of those activities on business decisions of CalOptima Health, or from disclosure of CalOptima Health's business operations. In addition to these provisions, designated employees are also subject to the provisions of the Conflict of Interest Code adopted by the CalOptima Health Board of Directors in compliance with the California Government Code. Designated employees must complete a Form 700 Statement of Economic Interests and a CalOptima Health Supplement to Form 700 upon hire, annually, and upon separation of employment. The HR department coordinates this activity with the CalOptima Health Clerk of the Board. See CalOptima Health Policies GA.8012: Conflicts of Interest, AA.1204: Gifts, Honoraria, and Travel Payments, and AA.1216: Solicitation and Receipts of Gifts to CalOptima Health. ~~**Outside Services and Interests**~~ ~~Without the prior written approval of the Chief Executive Officer (or in the case of the Chief Executive Officer, the Chair of the CalOptima Health Board of Directors), no employee shall (1) perform work or render services for any contractor, association of contractors or other organizations with which CalOptima Health does business or which seek to do business with CalOptima Health; (2) be a director, officer, or consultant of any such contractor or association of contractors; or (3) permit his or her name to be used in any fashion that would tend to indicate a business connection with any such contractor or association of contractors.~~
6. Public Integrity CalOptima Health and its Board members, employees, and contractors shall comply with laws and regulations governing public agencies.	**Public Records** CalOptima Health shall provide access to CalOptima Health Public Records to any person, corporation, partnership, firm, or association requesting to inspect and copy them in accordance with the California Public Records Act, California Government Code Sections 6250 et seq. and CalOptima Health policies. **Public Funds** CalOptima Health, its Board members, employees, and contractors shall not make gifts of public funds or assets or lend credit to private persons without

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Principle	Standard
	adequate consideration unless such actions clearly serve a public purpose within the authority of the agency and are otherwise approved by legal counsel. CalOptima Health, its Board members, employees, and contractors shall comply with applicable law and CalOptima Health policies governing the investment of public funds and expenditure limitations. **Public Meetings** CalOptima Health, its Board members, employees, and contractors shall comply with requirements relating to the notice and operation of public meetings in accordance with the Ralph M. Brown Act, California Government Code Sections 54950 et seq.
7. Confidentiality Board members, employees, and contractors shall maintain the confidentiality of all confidential information in accordance with applicable law and shall not disclose such confidential information except as specifically authorized by CalOptima Health policies, procedures, and applicable laws.	**No Personal Benefit** Board members, employees and contractors shall not use confidential or proprietary CalOptima Health information for their own personal benefit or for the benefit of any other person or entity, while employed at, or engaged by, CalOptima Health, or at any time thereafter. **Duty to Safeguard Member Confidential Information** CalOptima Health recognizes the importance of its members' right to confidentiality and implements policies and procedures to ensure its members' confidentiality rights and the protection of medical and other confidential information. Board members, employees and contractors shall safeguard CalOptima Health member identity, eligibility, social security, medical information and other confidential information in accordance with applicable laws including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH Act) and implementing regulations, the California Security Breach Notification Law, the California Confidentiality of Medical Information Act, other applicable federal and state privacy laws, and CalOptima Health's policies and procedures. **Personnel Files** Personal information contained in employee personnel files shall be maintained in a manner designed to ensure confidentiality in accordance with applicable laws. **Proprietary Information** Subject to its obligations under the Public Records Act, CalOptima Health shall safeguard confidential proprietary information including, without limitation, contractor information and proprietary computer software, in accordance with and, to the extent required by contract or law. CalOptima

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Principle	Standard
	Health shall safeguard provider identification numbers including, without limitation, Medi-Cal license, Medicare numbers, social security numbers, and other identifying numbers.
~~6.~~8.**Compliance Program Reporting** Board members, employees, and contractors have a duty to comply with CalOptima Health's Compliance Program and such duty shall be a condition of their respective appointment, employment, or engagement.	**Reporting Requirements** In alignment with CalOptima Health's reporting policies, all Board members, employees and contractors are expected and required to promptly report suspected violations of any statute, regulation, or guideline applicable to Federal and/or State health care programs or of CalOptima Health's policies and Compliance Plan.~~All Board members, employees and contractors are expected and required to promptly report suspected violations of any statute, regulation, or guideline applicable to Federal and/or State health care programs or of CalOptima Health's own policies in accordance with CalOptima Health's reporting policies and its Compliance Plan~~. Such reports may be made to a Supervisor ~~or,~~ the Chief Compliance Officer~~. Reports can~~ or may also be made to CalOptima Health's Compliance and Ethics H~~h~~otline number below. Persons making reports to the hotline can do so on an anonymous basis. **Compliance and Ethics Hotline: 1-855-507-1805** **Disciplinary Action** Failure to comply with the Compliance Program, including the Code of Conduct, policies, and/or applicable statutes, regulations and guidelines may lead to disciplinary action. Discipline for failure to abide by the Code of Conduct may, in CalOptima Health's discretion, range from oral correction to termination in accordance with CalOptima Health's policies. In addition, failure to comply may result in the imposition of civil, criminal, or administrative fines on the individual, or entity, and CalOptima Health or Exclusion or Preclusion from participation in Federal and/or State health care programs. **Training and Education** CalOptima Health provides training and education to Board members, employees, contractors, and FDRs. Timely completion of compliance and HIPAA training is mandatory for all CalOptima Health employees and contractors. **Non-Retaliation Policy** CalOptima Health prohibits retaliation against any individual who reports discrimination, harassment, or compliance concerns, or participates in an investigation of such reports, in good faith. Employees and contractors

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Principle	Standard
	involved in any retaliatory acts may be subject to discipline, up to and including termination of employment. **Referrals of FWA to Government Agencies** CalOptima Health is obligated to coordinate compliance activities with federal and state regulators. Employees and contractors shall comply with CalOptima Health policies related to FWA referral requirements to federal and state regulators, delegated program integrity contractors, and law enforcement agencies. **Certification** All Board members, employees, and contractors are required to certify, in writing, that they have received, read, understand, and will abide by the Code of Conduct and applicable policies.
~~**7. Confidentiality**~~ ~~Board members, employees, and contractors shall maintain the confidentiality of all confidential information in accordance with applicable law and shall not disclose such confidential information except as specifically authorized by CalOptima Health policies, procedures, and applicable laws.~~	~~**No Personal Benefit**~~ ~~Board members, employees and contractors shall not use confidential or proprietary CalOptima Health information for their own personal benefit or for the benefit of any other person or entity, while employed at, or engaged by, CalOptima Health, or at any time thereafter.~~ ~~**Duty to Safeguard Member Confidential Information**~~ ~~CalOptima Health recognizes the importance of its members' right to confidentiality and implements policies and procedures to ensure its members' confidentiality rights and the protection of medical and other confidential information. Board members, employees and contractors shall safeguard CalOptima Health member identity, eligibility, social security, medical information and other confidential information in accordance with applicable laws including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH Act) and implementing regulations, the California Security Breach Notification Law, the California Confidentiality of Medical Information Act, other applicable federal and state privacy laws, and CalOptima Health's policies and procedures.~~ ~~**Personnel Files**~~ ~~Personal information contained in Employee employee personnel files shall be maintained in a manner designed to ensure confidentiality in accordance with applicable laws.~~ ~~**Proprietary Information**~~

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Principle	Standard
	Subject to its obligations under the Public Records Act, CalOptima Health shall safeguard confidential proprietary information including, without limitation, contractor information and proprietary computer software, in accordance with and, to the extent required by contract or law. CalOptima Health shall safeguard provider identification numbers including, without limitation, Medi-Cal license, Medicare numbers, social security numbers, and other identifying numbers.
8. Public Integrity CalOptima Health and its Board members and employees shall comply with laws and regulations governing public agencies.	**Public Records** CalOptima Health shall provide access to CalOptima Health Public Records to any person, corporation, partnership, firm, or association requesting to inspect and copy them in accordance with the California Public Records Act, California Government Code Sections 6250 et seq. and CalOptima Health policies. **Public Funds** CalOptima Health, its Board members, and employees shall not make gifts of public funds or assets or lend credit to private persons without adequate consideration unless such actions clearly serve a public purpose within the authority of the agency and are otherwise approved by legal counsel. CalOptima Health, its Board members, and employees shall comply with applicable law and CalOptima Health policies governing the investment of public funds and expenditure limitations. **Public Meetings** CalOptima Health, and its Board members, and employees shall comply with requirements relating to the notice and operation of public meetings in accordance with the Ralph M. Brown Act, California Government Code Sections 54950 et seq.
9. Business Relationships Business transactions with vendors, contractors, and other third parties shall be conducted at arm's length in fact and in appearance, transacted free from improper inducements and in accordance with	**Business Inducements** Board members, employees, and contractors shall not seek to gain advantage through improper use of payments, business courtesies, or other inducements. The offering, giving, soliciting, or receiving of any form of bribe or other improper payment is prohibited. Board members, employees, contractors, and providers shall not use their positions to personally profit or assist others in profiting in any way at the expense of Federal and/or State health care programs, CalOptima Health, or CalOptima Health members. **Gifts to CalOptima Health** Board members and employees are specifically prohibited from soliciting and accepting personal gratuities, gifts, favors, services, entertainment, or

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Principle	Standard
applicable law and ethical standards.	any other things of value from any person or entity that furnishes items or services used, or that may be used, in CalOptima Health and its programs unless specifically permitted under CalOptima Health policies. Employees may not accept cash or cash equivalents. Perishable or consumable gifts given to a department or group are not subject to any specific limitation and business meetings at which a meal is served is not considered a prohibited business courtesy. **Provision of Gifts by CalOptima Health** Employees may provide gifts, entertainment, or meals of nominal value to CalOptima Health's current and prospective business partners and other persons when such activities have a legitimate business purpose, are reasonable, and are otherwise consistent with applicable law and CalOptima Health policies on this subject. In addition to complying with statutory and regulatory requirements, it is critical to even avoid the appearance of impropriety when giving gifts to persons and entities that do business or are seeking to do business with CalOptima Health. **Third-Party Sponsored Events** CalOptima Health's joint participation in contractor, vendor, or other third-party sponsored events, educational programs and workshops is subject to compliance with applicable law, including gift of public fund requirements and fraud and abuse prohibitions, and must be approved in accordance with CalOptima Health policies on this subject. In no event, shall CalOptima Health participate in any joint contractor, vendor, or third party sponsored event where the intent of the other participant is to improperly influence, or gain unfair advantage from, CalOptima Health or its operations. Employees' attendance at contractor, vendor, or other third-party sponsored events, educational programs and workshops is generally permitted where there is a legitimate business purpose but is subject to prior approval in accordance with CalOptima Health policies. **Provision of Gifts to Government Agencies** Board members, employees, and contractors shall not offer or provide any money, gifts, or other things of value to any government entity or its representatives, except campaign contributions to elected officials in accordance with applicable campaign contribution laws. **Broad Application of Standards** CalOptima Health intends that these standards be construed broadly to avoid even the appearance of improper activity.

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~~10.~~9. **Discrimination** CalOptima Health acknowledges that fair and equitable treatment of employees, contractors, members, providers, and other persons is fundamental to fulfilling its mission and goals.	**No Discrimination** CalOptima Health is committed to compliance with applicable anti-discrimination laws including Title VI of the Civil Right Act of 1964. Board members, employees and contractors shall not unlawfully discriminate on the basis of race, color, national origin, creed, ancestry, religion, language, age, marital status, gender (which includes sex, gender identity, gender transition status and gender expression), sexual orientation, health status, pregnancy, physical or mental disability, military status or any other classification protected by law. CalOptima Health is committed to providing a work environment free from discrimination and harassment based on any classification noted above. **Reassignment** CalOptima Health, physician groups, and Health Networks shall not reassign members in a discriminatory manner, including based on the enrollee's health status.
~~11.~~10. **Participation Status** CalOptima Health requires that employees, contractors, providers, and suppliers meet Government requirements for participation in CalOptima Health's programs.	**Federal and State Health Care Program Participation Status** Board members, employees, and contractors shall not be currently suspended, terminated, debarred, or otherwise ineligible to participate in any Federal or State health care program, including the Medi-Cal program and Medicare programs. **CalOptima Health Screening** CalOptima Health will Monitor the participation status of employees, individuals and entities doing business with CalOptima Health by conducting regular Exclusion and Preclusion screening reviews in accordance with CalOptima Health policies. **Disclosure of Participation Status** Board members, employees and contractors shall disclose to CalOptima Health whether they are currently suspended, terminated, debarred, or otherwise ineligible to participate in any Federal and/or State health care program. Employees, individuals, and entities that do business with CalOptima Health shall disclose to CalOptima Health any pending investigation, disciplinary action, or other matter that could potentially result in their ~~Exclusion~~ exclusion or ~~Preclusion~~ preclusion from participation in any Federal or State health care program. **Delegated Third Party Administrator Review** CalOptima Health requires that its Health Networks, physician groups, and third-party administrators review participating providers and suppliers for

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	licensure and participation status as part of the delegated credentialing and recredentialing processes when such obligations have been delegated to them. **Licensure** CalOptima Health requires that all employees, contractors, Health Networks, participating providers, and suppliers who are required to be licensed, credentialed, certified, and/or registered in order to furnish items or services to CalOptima Health and its members have valid and current licensure, credentials, certification and/or registration, as applicable.
~~12.~~11. **Government Inquiries/Legal Disputes** Employees and contractors shall notify CalOptima Health upon receipt of ~~Government~~ government inquiries and shall not destroy or alter documents in response to a government request for documents or information.	**Notification of Government Inquiry** Employees and contractors shall notify the Chief Compliance Officer and/or their supervisor immediately upon the receipt (at work or at home) of an inquiry, subpoena, or other agency or government requests for information regarding CalOptima Health. **No Destruction of Documents** Employees and contractors shall not destroy or alter CalOptima Health information or documents in anticipation of, or in response to, a request for documents by any governmental agency or from a court of competent jurisdiction. **Preservation of Documents Including Electronically Stored Information** Board members~~, and~~ employees, and contractors shall comply with all obligations to preserve documents, data, and records including, electronically stored information in accordance with CalOptima Health policies and shall comply with instructions on preservation of information and prohibitions and destruction of information issued by legal counsel.

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2025 Code of Conduct

(Revised September 2024)

Document maintained by: John Tanner
CalOptima Health Chief Compliance Officer

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Message from Chief Compliance Officer (CCO)

CalOptima Health is committed to its mission "to serve member health with excellence and dignity, respecting the value and needs of each person." Foundational to fulfilling this commitment is conducting ourselves in an ethical and compliant manner in the course of our daily activities and interactions. CalOptima Health expects all employees, contractors, officers, board members, network providers, subcontractors and downstream contractors act ethically and have a responsibility in ensuring compliance.

This document is a guide with 11 principles and related standards to provide a framework for CalOptima Health's Code of Conduct and how we are to conduct ourselves in serving our members. Please review this Code of Conduct and reach out to the Chief Compliance Officer or a representative from the Office of Compliance if you have any questions regarding this information.

It is incumbent upon all Board members, employees, providers and contractors to report any potential issues of non-compliance or misconduct. Reporting can be done online via the InfoNet or the CalOptima Health website, email, or phone.

You also have the option to anonymously report issues to the:

Compliance and Ethics Hotline at 1-855-507-1805

If you are unsure of a particular matter or situation, talk to your supervisor or a representative from the Office of Compliance to discuss your concerns and get guidance. Conducting our business compliantly and ethically is key to sustaining our business and maintaining our focus in serving our members.

Thank you for your dedication to serving our members and to following this Code of Conduct.

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Code of Conduct 11 Principles

1. **Mission, Vision, and Values:**
   CalOptima Health is committed to its Mission, Vision, and Values

2. **Member Rights:**
   CalOptima Health is committed to meeting the health care needs of its members by providing access to quality health care services.

3. **Compliance with the Law and Applicable Program Requirements:**
   CalOptima Health is committed to conducting all activities and operations in compliance with all applicable requirements and standards under its contract with DHCS and all and federal and state requirements including CMS requirements.

4. **Business Ethics:**
   In furtherance of CalOptima Health's commitment to the highest standards of business ethics, employees and contractors shall accurately and honestly represent CalOptima Health and shall not engage in any activity or scheme intended to defraud anyone of money, property, or honest services.

5. **Conflicts of Interests:**
   Board members, employees, and contractors owe a duty of undivided and unqualified loyalty to CalOptima Health.

6. **Public Integrity:**
   CalOptima Health and its Board members, employees, and contractors shall comply with laws and regulations governing public agencies.

7. **Confidentiality:**
   Board members, employees, and contractors shall maintain the confidentiality of all confidential information in accordance with applicable law and shall not disclose such confidential information except as specifically authorized by CalOptima Health policies, procedures, and applicable laws.

8. **Compliance Program Reporting:**
   Board members, employees, and contractors have a duty to comply with CalOptima Health's Compliance Program and such duty shall be a condition of their respective appointment, employment, or engagement.

9. **Discrimination:**
   CalOptima Health acknowledges that fair and equitable treatment of employees, contractors, members, providers, and other persons is fundamental to fulfilling its mission and goals.

10. **Participation Status:**
    CalOptima Health requires that employees, contractors, providers, and suppliers meet Government requirements for participation in CalOptima Health's programs.

11. **Government Inquiries/Legal Disputes:**
    Employees and contractors shall notify CalOptima Health upon receipt of Government inquiries and shall not destroy or alter documents in response to a government request for documents or information.

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Code of Conduct Principles and Standards

Principle	Standard
1. Mission, Vision, and Values CalOptima Health is committed to its Mission, Vision, and Values	**Mission** To serve member health with excellence and dignity, respecting the value and needs of each person. **Vision by 2027** • CalOptima Health Same-Day Treatment Authorizations • Real-Time Claims Payments • Annual Assessments of Member's Social Determinants of Health. **Values = CalOptima Health CARES** **C**ollaboration; **A**ccountability; **R**espect; **E**xcellence; **S**tewardship
2. Member Rights CalOptima Health is committed to meeting the health care needs of its members by providing access to quality health care services.	**Member Choice, Access to Health Care Services, Continuity of Care** Employees and contractors shall comply with CalOptima Health policies and procedures and applicable law governing member choice, access to health care services, and continuity of member care. Employees and contractors shall comply with all requirements for coordination of medical and support services for persons with special needs. Health Equity Employees and contractors shall endeavor to address and prioritize health equity in the design and implementation of CalOptima Health strategies and programs. **Cultural and Linguistic Services** CalOptima Health and contractors shall provide culturally, linguistically, and sensory appropriate services to CalOptima Health members to ensure effective communication regarding diagnosis, medical history, and treatment, and health education. **Disabled Member Access** CalOptima Health's facilities shall adhere to the requirements of Title III of the Americans with Disabilities Act of 1990 by providing access for disabled members. **Emergency Treatment** Employees and contractors shall comply with all applicable guidelines, policies and procedures, and laws governing CalOptima Health member access and payment of emergency services including, without limitation, the Emergency Medical Treatment and Active Labor Act ("EMTALA") and

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	state patient "anti-dumping" laws, prior authorization limitations, and payment standards. **Grievance and Appeals Processes** CalOptima Health, its physician groups, its Health Networks, and third-party administrators (TPA) shall ensure that CalOptima Health members are informed of their grievance and appeal rights including, the state hearing process, through member handbooks and other communications in accordance with CalOptima Health policies and procedures and applicable laws. Employees and contractors shall address, investigate, and resolve CalOptima Health member complaints and grievances in a prompt and nondiscriminatory manner in accordance with CalOptima Health policies and applicable laws.
3. Compliance with the Law and Applicable Program Requirements CalOptima Health is committed to conducting all activities and operations in compliance with applicable law and program requirements.	**Transparent, Legal, and Ethical Business Conduct** CalOptima Health is committed to conducting its business with integrity, honesty, and fairness and in compliance with all federal and state laws and regulations**,** and applicable requirements and standards under its Contract with DHCS. CalOptima Health expects all employees, contractors, officers, board of directors members, network providers, subcontractors, and downstream contractors to act ethically and are responsible for ensuring CalOptima Health compliance. **Obeying the Law** Board members, employees, and contractors (including First Tier and Downstream Entities included in the term "FDRs") shall not lie, steal, cheat, or violate any law in connection with their employment and/or engagement with CalOptima Health. **Fraud, Waste, & Abuse (FWA)** CalOptima Health shall refrain from conduct which would violate the Fraud, Waste, and Abuse laws. CalOptima Health is committed to the detection, prevention, and reporting of Fraud, Waste, and Abuse. CalOptima Health is also responsible for ensuring that Board members, employees, contractors, and FDRs receive appropriate FWA training as described in regulatory guidance. CalOptima Health's Compliance Plan, Anti-Fraud, Waste, and Abuse Plan and policies describe examples of Potential Fraud, Waste, and Abuse and discuss employee and contractor FWA obligations and potential Sanctions arising from relevant federal and state FWA laws. CalOptima Health expects and requires that its Board members, employees, and contractors do not participate in any conduct that may violate the FWA laws including federal and state anti-kickback laws, false claims acts, and civil monetary penalty laws.

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	Political Activities CalOptima Health's political participation is limited by law. CalOptima Health funds, property, and resources are not to be used to contribute to political campaigns, political parties, and/or organizations. Board members, employees and contractors may participate in the political process on their own time and at their own expense but shall not give the impression that they are speaking on behalf of or representing CalOptima Health in these activities. **Anti-Trust** All Board members, employees, and contractors must comply with applicable antitrust, unfair competition, and similar laws which regulate competition. Such persons shall seek advice from legal counsel if they encounter any business decisions involving a risk of violation of antitrust laws. The types of activities that potentially implicate antitrust laws include, without limitation, agreements to fix prices, bid rigging, and related activities; boycotts, certain exclusive dealings, and price discrimination agreements; unfair trade practices; sales or purchases conditioned on reciprocal purchases or sales; and discussion of factors determinative of prices at trade association meetings.
4. Business Ethics In furtherance of CalOptima Health's commitment to the highest standards of business ethics, employees and contractors shall accurately and honestly represent CalOptima Health and shall not engage in any activity or scheme intended to defraud anyone of money, property, or honest services.	**Candor & Honesty** CalOptima Health requires candor and honesty from individuals in the performance of their responsibilities and in communications including, communications with CalOptima Health's Board of Directors, supervisory employees, attorneys, and auditors. No Board member, employee, or contractor shall make false or misleading statements to any members and/or persons, or entities, doing business with CalOptima Health about products or services of CalOptima Health. **Financial and Data Reporting** All financial reports, accounting records, research reports, expense accounts, data submissions, attestations, timesheets, and other documents must accurately and clearly represent the relevant facts and the true nature of a transaction. CalOptima Health maintains a system of internal controls to ensure that all transactions are executed in accordance with Management's authorization and recorded in a proper manner to maintain accountability of the agency's assets. Improper or fraudulent accounting documentation or financial reporting or false or misleading encounter, claims, cost, or other required regulatory data submissions is contrary to the

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	policy of CalOptima Health and may be in violation of applicable laws and regulatory obligations. **Regulatory Agencies and Accrediting Bodies** CalOptima Health will deal with all Regulatory Agencies and accrediting bodies in a direct, open, and honest manner. Employees and contractors shall not take action with Regulatory Agencies and accrediting bodies that is false or misleading.
5. Conflicts of Interests Board members, employees, and contractors owe a duty of undivided and unqualified loyalty to CalOptima Health.	**Conflicts of Interest** Designated employees and contractors shall comply with the requirements of GA.8012: Conflicts of Interest (policy), and applicable laws. Board members, employees, and contractors are expected to conduct their activities to avoid impropriety and/or the appearance of impropriety, which might arise from the influence of those activities on business decisions of CalOptima Health, or from disclosure of CalOptima Health's business operations. In addition to these provisions, designated employees are also subject to the provisions of the Conflict of Interest Code adopted by the CalOptima Health Board of Directors in compliance with the California Government Code. Designated employees must complete a Form 700 Statement of Economic Interests and a CalOptima Health Supplement to Form 700 upon hire, annually, and upon separation of employment. The HR department coordinates this activity with the CalOptima Health Clerk of the Board. See CalOptima Health Policies GA.8012: Conflicts of Interest, AA.1204: Gifts, Honoraria, and Travel Payments, and AA.1216: Solicitation and Receipts of Gifts to CalOptima Health.
6. Public Integrity CalOptima Health and its Board members, employees, and contractors shall comply with laws and regulations governing public agencies.	**Public Records** CalOptima Health shall provide access to CalOptima Health Public Records to any person, corporation, partnership, firm, or association requesting to inspect and copy them in accordance with the California Public Records Act, California Government Code Sections 6250 et seq. and CalOptima Health policies. **Public Funds** CalOptima Health, its Board members, employees, and contractors shall not make gifts of public funds or assets or lend credit to private persons without adequate consideration unless such actions clearly serve a public purpose within the authority of the agency and are otherwise approved by legal

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	counsel. CalOptima Health, its Board members, employees, and contractors shall comply with applicable law and CalOptima Health policies governing the investment of public funds and expenditure limitations. **Public Meetings** CalOptima Health, its Board members, employees, and contractors shall comply with requirements relating to the notice and operation of public meetings in accordance with the Ralph M. Brown Act, California Government Code Sections 54950 et seq.
7. Confidentiality Board members, employees, and contractors shall maintain the confidentiality of all confidential information in accordance with applicable law and shall not disclose such confidential information except as specifically authorized by CalOptima Health policies, procedures, and applicable laws.	**No Personal Benefit** Board members, employees and contractors shall not use confidential or proprietary CalOptima Health information for their own personal benefit or for the benefit of any other person or entity, while employed at, or engaged by, CalOptima Health, or at any time thereafter. **Duty to Safeguard Member Confidential Information** CalOptima Health recognizes the importance of its members' right to confidentiality and implements policies and procedures to ensure its members' confidentiality rights and the protection of medical and other confidential information. Board members, employees and contractors shall safeguard CalOptima Health member identity, eligibility, social security, medical information and other confidential information in accordance with applicable laws including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH Act) and implementing regulations, the California Security Breach Notification Law, the California Confidentiality of Medical Information Act, other applicable federal and state privacy laws, and CalOptima Health's policies and procedures. **Personnel Files** Personal information contained in employee personnel files shall be maintained in a manner designed to ensure confidentiality in accordance with applicable laws. **Proprietary Information** Subject to its obligations under the Public Records Act, CalOptima Health shall safeguard confidential proprietary information including, without limitation, contractor information and proprietary computer software, in accordance with and, to the extent required by contract or law. CalOptima Health shall safeguard provider identification numbers including, without

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	limitation, Medi-Cal license, Medicare numbers, social security numbers, and other identifying numbers.
8. Compliance Program Reporting Board members, employees, and contractors have a duty to comply with CalOptima Health's Compliance Program and such duty shall be a condition of their respective appointment, employment, or engagement.	**Reporting Requirements** In alignment with CalOptima Health's reporting policies, all Board members, employees and contractors are expected and required to promptly report suspected violations of any statute, regulation, or guideline applicable to Federal and/or State health care programs or of CalOptima Health's policies and Compliance Plan.. Such reports may be made to a Supervisor, the Chief Compliance Officer or may also be made to CalOptima Health's Compliance and Ethics Hotline number below. Persons making reports to the hotline can do so on an anonymous basis. **Compliance and Ethics Hotline: 1-855-507-1805** **Disciplinary Action** Failure to comply with the Compliance Program, including the Code of Conduct, policies, and/or applicable statutes, regulations and guidelines may lead to disciplinary action. Discipline for failure to abide by the Code of Conduct may, in CalOptima Health's discretion, range from oral correction to termination in accordance with CalOptima Health's policies. In addition, failure to comply may result in the imposition of civil, criminal, or administrative fines on the individual, or entity, and CalOptima Health or Exclusion or Preclusion from participation in Federal and/or State health care programs. **Training and Education** CalOptima Health provides training and education to Board members, employees, contractors, and FDRs. Timely completion of compliance and HIPAA training is mandatory for all CalOptima Health employees and contractors. **Non-Retaliation Policy** CalOptima Health prohibits retaliation against any individual who reports discrimination, harassment, or compliance concerns, or participates in an investigation of such reports, in good faith. Employees and contractors involved in any retaliatory acts may be subject to discipline, up to and including termination of employment. **Referrals of FWA to Government Agencies** CalOptima Health is obligated to coordinate compliance activities with federal and state regulators. Employees and contractors shall comply with

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Principle	Standard
	CalOptima Health policies related to FWA referral requirements to federal and state regulators, delegated program integrity contractors, and law enforcement agencies. **Certification** All Board members, employees, and contractors are required to certify, in writing, that they have received, read, understand, and will abide by the Code of Conduct and applicable policies.
9. Discrimination CalOptima Health acknowledges that fair and equitable treatment of employees, contractors, members, providers, and other persons is fundamental to fulfilling its mission and goals.	**No Discrimination** CalOptima Health is committed to compliance with applicable anti-discrimination laws including Title VI of the Civil Right Act of 1964. Board members, employees and contractors shall not unlawfully discriminate on the basis of race, color, national origin, creed, ancestry, religion, language, age, marital status, gender (which includes sex, gender identity, gender transition status and gender expression), sexual orientation, health status, pregnancy, physical or mental disability, military status or any other classification protected by law. CalOptima Health is committed to providing a work environment free from discrimination and harassment based on any classification noted above. **Reassignment** CalOptima Health, physician groups, and Health Networks shall not reassign members in a discriminatory manner, including based on the enrollee's health status.
10. Participation Status CalOptima Health requires that employees, contractors, providers, and suppliers meet Government requirements for participation in CalOptima Health's programs.	**Federal and State Health Care Program Participation Status** Board members, employees, and contractors shall not be currently suspended, terminated, debarred, or otherwise ineligible to participate in any Federal or State health care program, including the Medi-Cal program and Medicare programs. **CalOptima Health Screening** CalOptima Health will Monitor the participation status of employees, individuals and entities doing business with CalOptima Health by conducting regular Exclusion and Preclusion screening reviews in accordance with CalOptima Health policies. **Disclosure of Participation Status** Board members, employees and contractors shall disclose to CalOptima Health whether they are currently suspended, terminated, debarred, or otherwise ineligible to participate in any Federal and/or State health care

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	program. Employees, individuals, and entities that do business with CalOptima Health shall disclose to CalOptima Health any pending investigation, disciplinary action, or other matter that could potentially result in their exclusion or preclusion from participation in any Federal or State health care program. **Delegated Third Party Administrator Review** CalOptima Health requires that its Health Networks, physician groups, and third-party administrators review participating providers and suppliers for licensure and participation status as part of the delegated credentialing and recredentialing processes when such obligations have been delegated to them. **Licensure** CalOptima Health requires that all employees, contractors, Health Networks, participating providers, and suppliers who are required to be licensed, credentialed, certified, and/or registered in order to furnish items or services to CalOptima Health and its members have valid and current licensure, credentials, certification and/or registration, as applicable.
11. Government Inquiries/Legal Disputes Employees and contractors shall notify CalOptima Health upon receipt of government inquiries and shall not destroy or alter documents in response to a government request for documents or information.	**Notification of Government Inquiry** Employees and contractors shall notify the Chief Compliance Officer and/or their supervisor immediately upon the receipt (at work or at home) of an inquiry, subpoena, or other agency or government requests for information regarding CalOptima Health. **No Destruction of Documents** Employees and contractors shall not destroy or alter CalOptima Health information or documents in anticipation of, or in response to, a request for documents by any governmental agency or from a court of competent jurisdiction. **Preservation of Documents Including Electronically Stored Information** Board members, employees, and contractors shall comply with all obligations to preserve documents, data, and records including, electronically stored information in accordance with CalOptima Health policies and shall comply with instructions on preservation of information and prohibitions and destruction of information issued by legal counsel.

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Policy:	HH.3000
Title:	**Notice of Privacy Practices**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	*/s/*
Effective Date:	04/01/2003
Revised Date:	11/07/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ PACE ☐ Administrative

I. PURPOSE

This policy identifies the required content of CalOptima Health's Notice of Privacy Practices (NPP) and the process by which the NPP is distributed to CalOptima Health Members. -It outlines the controls for physical and electronic access to Member data which includes Protected Health Information (PHI) and Personally Identifiable Information (PII). -The NPP also outlines the impermissible and permissible uses of Member data, including PHI/PII.

II. POLICY

A. CalOptima Health Members have the right to adequate notice of the Uses and Disclosures of Protected Health Information (PHI) and Personally Identifiable Information (PII) data, that may be made by CalOptima Health and of the Members' rights and CalOptima Health's legal duties with respect to PHI/PII data.

B. CalOptima Health shall provide information that directs Members on the process to file complaints with CalOptima Health and its regulators and will not retaliate against Members who file complaints when ~~they believe~~the Member believes their privacy rights have been violated, in accordance with CalOptima Health Policy HH.3012: Non-Retaliation for Reporting Violations.

C. CalOptima Health shall provide the NPP to Members and former Members as ~~Required by Law~~required by law and accreditation standards~~.~~, including providing the NPP upon enrollment and providing notice upon material revisions of the NPP in an easily accessible location on CalOptima Health's public website.

D. The CalOptima Health NPP shall describe steps ~~the Member~~Members may consider taking to help protect the privacy and security of their PHI/PII.

III. PROCEDURE

A. The content of the NPP shall be written in plain language and contain the following elements:

1. Mandated header;

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2. Description and one (1) example each, of the types of Use and Disclosures that CalOptima Health is permitted under state and federal regulations for the purposes of Treatment, Payment, and Health Care Operations. If a Use or Disclosure for any purpose described ~~in paragraphs~~ at 45 CFR Section 164.520(b)(1)(ii)(A) or (B) ~~of Title 45, Code of Federal Regulations, Section 164.520~~ is prohibited or materially limited by other applicable law, for example 42 CFR Part 2, the description of such Use or Disclosure must reflect the more stringent law as defined in ~~Title 45, Code of Federal Regulations,~~45 CFR Section 160.202;

3. A description of each of the types of Uses ~~and~~or Disclosures, other than for purposes of Treatment, Payment, and Health Care Operations, that ~~requires~~CalOptima Health is permitted or required by 45 CFR Part 164, Subpart E, to make without the Member's written consent.

~~3.~~4. A description of the types of Uses and Disclosures that require an authorization under 45 CFR Section 164.~~504~~508(a)(2)-(a)(4), and Title 42 Code of Federal Regulations Part 2, a statement that other ~~Use~~Uses and Disclosures not described in ~~this notice~~the NPP will be made only with the Member's written authorization, and a statement that the Member may revoke such authorization as provided by 45 CFR Section 164.508(b)(5);

5. A description and one (1) example each of the types of Uses and Disclosures of PHI related to lawful Reproductive Health Care for the following prohibited purposes under 45 CFR Section 164.502(a)(5)(iii): (i) conducting a criminal, civil, or administrative investigation into any person for the mere act of seeking, obtaining, providing, or facilitating Reproductive Health Care; (ii) imposing criminal, civil, or administrative liability on any person for the mere act of seeking, obtaining, providing, or facilitating Reproductive Health Care; (iii) or to identify any person for any purpose previously described

6. A description and one (1) example each of the following the Uses and Disclosures for which an attestation is required under 45 CFR Section 164.509: (i) health oversight activities under 45 CFR Section 164.512(d); (ii) judicial or administrative proceedings under 45 CFR Section 164.512(e); (iii) disclosures for law enforcement purposes under 45 CFR Section 164.512(f); and (iv) disclosures about decedents to coroners and medical examiners under 45 CFR Section 164.512(g)(1);

7. A statement adequate to put the Member on notice of the potential for information disclosed by CalOptima Health pursuant to the NPP to be subject to redisclosure by the recipient and no longer protected by applicable privacy laws;

~~4.~~8. Statement to describe the Member's rights concerning his or her PHI/PII, how to exercise these rights, and restrictions on such rights, which shall include information on:

a. ~~Restrictions concerning~~Right to request restrictions on certain ~~Use~~Uses and Disclosures of PHI/PII, and provision that CalOptima Health is not required to agree to those restrictions, except in case of a Disclosure restricted under 45 CFR Section 164.522(a)(1)(iv) and in accordance with CalOptima Health Policy HH.3007: Member ~~Right~~Rights to Request Restrictions on Use and Disclosure of Protected Health Information;

b. Right to receive confidential communications of PHI/PII, in accordance with CalOptima Health Policy HH.3008: Member Right to Request Confidential Communications;

c. Right to inspect and copy PHI/PII , in accordance with CalOptima Health Policy HH.3001: Member Access to Designated Record Set;

d. Right to request amendment to PHI/PII, in accordance with CalOptima Health Policy HH.3004: Member Request to Amend ~~Record~~Records;

e. Right to receive accounting of Disclosures, with certain exceptions, in accordance with CalOptima Health Policy HH.3005: Member Request for ~~an~~ Accounting of Disclosures; and

f. Right to receive a paper copy of the NPP, in accordance with this Policy.

~~5.~~9. Statement specifically describing CalOptima Health's duties and rights under the privacy rule, including:

a. A statement that CalOptima Health is ~~Required~~required by ~~Law~~law to maintain the privacy of the Member's PHI, to provide individuals with notice of its legal duties and privacy practices with respect to PHI/PII, and to notify affected Members following a breach of unsecured PHI/PII, and in accordance with CalOptima Health policies, which shall include processes to ensure internal protection of verbal (i.e., when talking to individuals on the telephone or in person about a Member), and written information, in accordance with CalOptima Health Policies HH.3003: Verification of Identity for Disclosures of Protected Health Information (PHI), HH.3009: Access by Member's Personal Representative, HH.3016: Guidelines for Handling Protected Health Information (PHI) Off-site, and HH.3019: De-identification of Protected Health Information (PHI).

b. The responsibility to abide by the terms of the NPP currently in effect;

c. ~~Reserve our~~CalOptima Health's right to make changes to the terms of the NPP when ~~we make~~it makes changes to ~~our~~its privacy practices; and

d. A description of how CalOptima Health provides Members with a revised NPP.

~~6.~~10. Statement that the Member may file a complaint as part of their privacy rights, and without retaliation, to CalOptima Health's Customer Service Department or Privacy Officer, the California Department of Health Care Services (DHCS), and/or the United States Department of Health and Human Services (HHS), if the Member believes his or her privacy rights have been violated, and include contact title and telephone number for filing the complaint with CalOptima Health, or to get further information concerning the notice. The contact information should include:

a. ~~Attn:~~ CalOptima Health
Privacy Officer
~~**CalOptima Health**~~
505 City Parkway West
Orange CA 92868
Telephone: 1-888-587-8088 (TTY: 711)

Or call:

CalOptima Health Customer Service Department
Telephone: 1-714-246-8500
Toll-free: 1-888-587-8088
TTY: 711

b. Department of Health Care Services

Back to Agenda Back to Item

Privacy Officer
c/o: Office of HIPAA Compliance
~~a. Department of Health Care Services~~
P.O. Box 997413 MS 4722
Sacramento CA 95899-7413
Email: privacyofficer@dhcs.ca.gov
Telephone: 1-916-445-4646
Fax: 1-916-440-7680

~~Regional Manager~~
~~Office for Civil Rights~~
~~a.~~c. **U.S. Department of Health and Human Services**
Office for Civil Rights
Regional Manager
90 7th Street Suite 4-100
San Francisco CA 94103
Phone: 1-800-368-1019
Fax: 1-415-437-8329
TDD: 1-800-537-7697
Email: OCRComplaint@hhs.gov

~~7.~~11. Effective date of the notice.

B. The NPP shall be made available to anyone, upon request, by calling or writing to the CalOptima Health Customer Service Department. CalOptima Health's Customer Service Department shall make the NPP available in Threshold Languages to anyone by mail, in person, or through the CalOptima Health website. CalOptima Health shall distribute the NPP by:

~~1. Ensuring initial distribution by mail to all Members, prior to April 2003;~~

~~2.~~1. Including copies in all new enrollment packets~~, effective April 2003;~~.

~~3.~~2. Posting a copy in the Customer Service Department lobby in Threshold Languages~~;~~.

~~4.~~3. Posting the NPP on the CalOptima Health website~~;~~.

a. Upon a material change to the NPP, CalOptima Health shall prominently post the change, or the revised NPP, on the CalOptima Health website by the effective date of the material change to the notice.

~~5.~~4. Providing a revised NPP, or information about the material change and how to obtain the revised NPP, in the next annual mailing to Members~~; and~~.

~~6.~~5. Notifying all Members at least once every three (3) years that a copy of the NPP is available upon request or may be obtained on the CalOptima Health website at www.CalOptima Health.org.

~~7.~~6. Ensuring all mailings of the NPP comply with CalOptima Health's Cultural and Linguistic Services guidelines, in accordance with CalOptima Health Policies DD.2002: Cultural and Linguistic Services~~, and MA.4002: Cultural and Linguistic Services~~.

~~8.~~7. PACE Member materials shall include a statement of non-discrimination acknowledging that CalOptima Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex and taglines informing members of the availability of language assistance services.

C. Documentation and Retention:

1. CalOptima Health shall document compliance with this Policy and retain copies of the notices issued for a period of ten (10) years from the effective date of the notice.

IV. ATTACHMENT(S)

A. Notice of Privacy Practices (NPP)

V. REFERENCE(S)

A. CalOptima Health Compliance Plan
B. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Health PACE Program Agreement
E. CalOptima Health Policy DD.2002: Cultural and Linguistic Services
~~F. CalOptima Health Policy GA.5005a: Use of Technology Resources~~
~~G. CalOptima Health Policy GA.5005b: Email and Internet Use~~
~~H. CalOptima Health Policy GA.5005c: Loaner Laptop~~
~~I.~~F. CalOptima Health Policy HH.3001: Member Access to Designated Record Set
~~J.~~G. CalOptima Health Policy HH.3003: Verification of Identity for Disclosures of Protected Health Information (PHI)
~~K.~~H. CalOptima Health Policy HH.3004: Member Request to Amend ~~Record~~Records
~~L.~~I. CalOptima Health Policy HH.3005: Member Request for ~~an~~ Accounting of Disclosures
~~M.~~J. CalOptima Health Policy HH.3007: Member ~~Right~~Rights to Request Restrictions on Use and Disclosure of Protected Health Information (PHI)
~~N.~~K. CalOptima Health Policy HH.3008: Member Right to Request Confidential Communications
~~O.~~L. CalOptima Health Policy HH.3009: Access by Member's ~~Authorized~~Personal Representative
~~P.~~M. CalOptima Health Policy HH.3012: Non-Retaliation ~~on~~for Reporting Violations
~~Q.~~N. CalOptima Health Policy HH.3014: Use of Electronic Mail with Protected Health Information
~~R.~~O. CalOptima Health Policy HH.3016: Guidelines for Handling Protected Health Information (PHI) ~~Offsite~~Off-site
~~S.~~P. CalOptima Health Policy HH.3019: De-identification of Protected Health Information (PHI)
~~T. CalOptima Health Policy MA.4002: Cultural and Linguistic Services~~
~~U.~~Q. Department of Health Care Services (DHCS) All Plan Letter (APL) 06-001: Notice of Privacy Practices and Notification of Breaches
~~V.~~R. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-026: Inoperability and Patient Access Final Rule
~~W.~~S. NCQA Standard MED5 Privacy and Confidentiality: Element A: Adopting Written Policies, Factor 1-2017
~~X. Title 45, Code of Federal Regulations (C.F.R.), §160.202~~
~~Y. Title 45, Code of Federal Regulations (C.F.R.), §164.105(c)(2)~~
~~Z. Title 45, Code of Federal Regulations (C.F.R.), §164.504(a)(2) (a)(4)~~
~~AA. Title 45, Code of Federal Regulations (C.F.R.), §164.508(b)(5)~~
~~BB. Title 45, Code of Federal Regulations (C.F.R.), §164.520(b)(1)(ii)(A) or (B)~~
~~CC. Title 45, Code of Federal Regulations (C.F.R.), §164.530(g)~~

~~DD.~~T. Patient Protection and Affordable Care Act §1557
U. 45 CFR Part 2
V. 45CFR §160.202
W. 45 CFR §164.105(c)(2)
X. 45 CFR §164.504(a)(2)-(a)(4)
Y. 45 CFR §164.508(b)(5)
Z. 45 CFR §164.520(b)(1)(ii)(A) or (B)
AA. 45 CFR §164.530(g)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
01/19/2022	Department of Health Care Services (DHCS)	Approved as Submitted
05/02/2023	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/01/2003	HH.3000	Notice of Privacy Practices	Medi-Cal
Revised	07/01/2007	HH.3000	Notice of Privacy Practices	Medi-Cal
Revised	04/01/2009	HH.3000	Notice of Privacy Practices	Medi-Cal
Revised	01/01/2011	HH.3000	Notice of Privacy Practices	Medi-Cal
Revised	01/01/2013	HH.3000	Notice of Privacy Practices	Medi-Cal OneCare
Revised	01/01/2014	HH.3000	Notice of Privacy Practices	Medi-Cal
Revised	09/01/2015	HH.3000	Notice of Privacy Practices	Medi-Cal
Revised	12/01/2016	HH.3000	Notice of Privacy Practices	Medi-Cal OneCare OneCare Connect PACE
Reviewed	03/01/2017	HH.3000	Notice of Privacy Practices	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.3000	Notice of Privacy Practices	Medi-Cal OneCare OneCare Connect PACE

Action	Date	Policy	Policy Title	Program(s)
Revised	12/06/2018	HH.3000	Notice of Privacy Practices	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.3000	Notice of Privacy Practices	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.3000	Notice of Privacy Practices	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.3000	Notice of Privacy Practices	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	HH.3000	Notice of Privacy Practices	Medi-Cal OneCare PACE
Revised	03/01/2023	HH.3000	Notice of Privacy Practices	Medi-Cal OneCare PACE
Revised	11/07/2024	HH.3000	Notice of Privacy Practices	Medi-Cal OneCare PACE

IX. GLOSSARY

Term	Definition
CFR~~Disclosure~~	~~Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.~~ Means the Code of Federal Regulations.
Disclosure~~Health Care Operations~~	~~Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities, customer services, resolution of internal grievances, business planning, and development and activities related to compliance with the privacy rule.~~Has the meaning in 45 CFR Section 160.103, including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
Health ~~Maintenance Organization~~Care Operations	~~A health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975, as amended, commencing with Section 1340 of the California Health and Safety Code.~~Has the meaning given such term in 45 CFR Section 164.501, including activities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities, customer services, resolution of internal grievances, business planning, and development and activities related to compliance with the privacy rule.
Member	A beneficiary enrolled in a CalOptima Health program.
Notice of Privacy Practices (NPP)	Notice provided to a Member that describes Cal Optima's practices in the Use and Disclosure of Protected Health Information, Member rights, and CalOptima Health legal duties with respect to Protected Health Information.
Payment	Has the meaning in ~~42 Code of Federal Regulations~~45 CFR Section 164.501, including: activities carried out by CalOptima Health including: 1. Determination of eligibility, risk adjustments based on Member health status and demographics, billing claims management, and collection activities; 2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and, 3. Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.
Personally Identifiable Information (PII)	PII is —any information about an individual maintained by an agency, including (1) any information that can be Used to distinguish or trace an individual's identity, such as name, social security number, date and place of birth, mother's maiden name, biometric records, race, ethnicity, language (REL), sexual orientation and gender identity (SOGI); and (2) any other information that is linked or linkable to an individual, such as medical, educational, financial, and employment information.

Term	Definition
Protected Health Information (PHI)	Has the meaning in 45~~, Code of Federal Regulations~~ CFR Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be Used to identify the individual. The information was created or received by CalOptima Health or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
~~Required by Law~~Reproductive Health Care	~~Has the meaning in 45 Code of Federal Regulations (CFR) Section 164.103 which specifies a mandate contained in law that compels an entity to make a Use or Disclosure of PHI and that is enforceable in a court of law and which are permissible grounds for a covered entity to Use of Disclose PHI under 45 CFR Section 164.512(a) when relevant requirements are met.~~ Means health care, as defined at 45 CFR § 160.103, that affects the health of a Member in all matters relating to the reproductive system and to its functions and processes.
Threshold Languages	~~Medi-Cal: Those languages identified based upon State requirements and/or findings of the Population Needs Assessment (PNA).~~ Medi-Cal: The non-English threshold and concentration standard languages in which Contractor is required to provide written translations of Member Information, as determined by DHCS. OneCare: A threshold language is defined by CMS as the native language of a group who compromises five percent (5%) or more of the people served by the CMS Program.
Treatment	Has the meaning in ~~42 Code of Federal Regulations~~45 CFR Section 164.501, including: activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the Member's health care benefits.
Use	Has the meaning in 45~~, Code of Federal Regulations~~ CFR Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

1

Policy:	HH.3000
Title:	**Notice of Privacy Practices**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	*/s/*
Effective Date:	04/01/2003
Revised Date:	11/07/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ PACE ☐ Administrative

I. PURPOSE

This policy identifies the required content of CalOptima Health's Notice of Privacy Practices (NPP) and the process by which the NPP is distributed to CalOptima Health Members. It outlines the controls for physical and electronic access to Member data which includes Protected Health Information (PHI) and Personally Identifiable Information (PII). The NPP also outlines the impermissible and permissible uses of Member data, including PHI/PII.

II. POLICY

A. CalOptima Health Members have the right to adequate notice of the Uses and Disclosures of Protected Health Information (PHI) and Personally Identifiable Information (PII) data, that may be made by CalOptima Health and of the Members' rights and CalOptima Health's legal duties with respect to PHI/PII data.

B. CalOptima Health shall provide information that directs Members on the process to file complaints with CalOptima Health and its regulators and will not retaliate against Members who file complaints when the Member believes their privacy rights have been violated, in accordance with CalOptima Health Policy HH.3012: Non-Retaliation for Reporting Violations.

C. CalOptima Health shall provide the NPP to Members and former Members as required by law and accreditation standards, including providing the NPP upon enrollment and providing notice upon material revisions of the NPP in an easily accessible location on CalOptima Health's public website.

D. The CalOptima Health NPP shall describe steps Members may consider taking to help protect the privacy and security of their PHI/PII.

III. PROCEDURE

A. The content of the NPP shall be written in plain language and contain the following elements:

1. Mandated header;

2. Description and one (1) example each, of the types of Use and Disclosures that CalOptima Health is permitted under state and federal regulations for the purposes of Treatment, Payment,

and Health Care Operations. If a Use or Disclosure for any purpose described at 45 CFR Section 164.520(b)(1)(ii)(A) or (B) is prohibited or materially limited by other applicable law, for example 42 CFR Part 2, the description of such Use or Disclosure must reflect the more stringent law as defined in 45 CFR Section 160.202;

3. A description of each of the types of Uses or Disclosures, other than for purposes of Treatment, Payment, and Health Care Operations, that CalOptima Health is permitted or required by 45 CFR Part 164, Subpart E, to make without the Member's written consent.

4. A description of the types of Uses and Disclosures that require an authorization under 45 CFR Section 164.508(a)(2)-(a)(4), and Title 42 Code of Federal Regulations Part 2, a statement that other Uses and Disclosures not described in the NPP will be made only with the Member's written authorization, and a statement that the Member may revoke such authorization as provided by 45 CFR Section 164.508(b)(5);

5. A description and one (1) example each of the types of Uses and Disclosures of PHI related to lawful Reproductive Health Care for the following prohibited purposes under 45 CFR Section 164.502(a)(5)(iii): (i) conducting a criminal, civil, or administrative investigation into any person for the mere act of seeking, obtaining, providing, or facilitating Reproductive Health Care; (ii) imposing criminal, civil, or administrative liability on any person for the mere act of seeking, obtaining, providing, or facilitating Reproductive Health Care; (iii) or to identify any person for any purpose previously described

6. A description and one (1) example each of the following the Uses and Disclosures for which an attestation is required under 45 CFR Section 164.509: (i) health oversight activities under 45 CFR Section 164.512(d); (ii) judicial or administrative proceedings under 45 CFR Section 164.512(e); (iii) disclosures for law enforcement purposes under 45 CFR Section 164.512(f); and (iv) disclosures about decedents to coroners and medical examiners under 45 CFR Section 164.512(g)(1);

7. A statement adequate to put the Member on notice of the potential for information disclosed by CalOptima Health pursuant to the NPP to be subject to redisclosure by the recipient and no longer protected by applicable privacy laws;

8. Statement to describe the Member's rights concerning his or her PHI/PII, how to exercise these rights, and restrictions on such rights, which shall include information on:

   a. Right to request restrictions on certain Uses and Disclosures of PHI/PII, and provision that CalOptima Health is not required to agree to those restrictions, except in case of a Disclosure restricted under 45 CFR Section 164.522(a)(1)(iv) and in accordance with CalOptima Health Policy HH.3007: Member Rights to Request Restrictions on Use and Disclosure of Protected Health Information;

   b. Right to receive confidential communications of PHI/PII, in accordance with CalOptima Health Policy HH.3008: Member Right to Request Confidential Communications;

   c. Right to inspect and copy PHI/PII , in accordance with CalOptima Health Policy HH.3001: Member Access to Designated Record Set;

   d. Right to request amendment to PHI/PII, in accordance with CalOptima Health Policy HH.3004: Member Request to Amend Records;

e. Right to receive accounting of Disclosures, with certain exceptions, in accordance with CalOptima Health Policy HH.3005: Member Request for Accounting of Disclosures; and

f. Right to receive a paper copy of the NPP, in accordance with this Policy.

9. Statement specifically describing CalOptima Health's duties and rights under the privacy rule, including:

   a. A statement that CalOptima Health is required by law to maintain the privacy of the Member's PHI, to provide individuals with notice of its legal duties and privacy practices with respect to PHI/PII, and to notify affected Members following a breach of unsecured PHI/PII, and in accordance with CalOptima Health policies, which shall include processes to ensure internal protection of verbal (i.e., when talking to individuals on the telephone or in person about a Member), and written information, in accordance with CalOptima Health Policies HH.3003: Verification of Identity for Disclosures of Protected Health Information (PHI), HH.3009: Access by Member's Personal Representative, HH.3016: Guidelines for Handling Protected Health Information (PHI) Off-site, and HH.3019: De-identification of Protected Health Information (PHI).

   b. The responsibility to abide by the terms of the NPP currently in effect;

   c. CalOptima Health's right to make changes to the terms of the NPP when it makes changes to its privacy practices; and

   d. A description of how CalOptima Health provides Members with a revised NPP.

10. Statement that the Member may file a complaint as part of their privacy rights, and without retaliation, to CalOptima Health's Customer Service Department or Privacy Officer, the California Department of Health Care Services (DHCS), and/or the United States Department of Health and Human Services (HHS), if the Member believes his or her privacy rights have been violated, and include contact title and telephone number for filing the complaint with CalOptima Health, or to get further information concerning the notice. The contact information should include:

    a. CalOptima Health
    Privacy Officer
    505 City Parkway West
    Orange CA 92868
    Telephone: 1-888-587-8088 (TTY: 711)

    Or call:

    CalOptima Health Customer Service Department
    Telephone: 1-714-246-8500
    Toll-free: 1-888-587-8088
    TTY: 711

    b. Department of Health Care Services
    Privacy Officer
    c/o: Office of HIPAA Compliance
    P.O. Box 997413 MS 4722
    Sacramento CA 95899-7413

Email: privacyofficer@dhcs.ca.gov
Telephone: 1-916-445-4646
Fax: 1-916-440-7680

c. **U.S. Department of Health and Human Services**
Office for Civil Rights
Regional Manager
90 7th Street Suite 4-100
San Francisco CA 94103
Phone: 1-800-368-1019
Fax: 1-415-437-8329
TDD: 1-800-537-7697
Email: OCRComplaint@hhs.gov

11. Effective date of the notice.

B. The NPP shall be made available to anyone, upon request, by calling or writing to the CalOptima Health Customer Service Department. CalOptima Health's Customer Service Department shall make the NPP available in Threshold Languages to anyone by mail, in person, or through the CalOptima Health website. CalOptima Health shall distribute the NPP by:

1. Including copies in all new enrollment packets.

2. Posting a copy in the Customer Service Department lobby in Threshold Languages.

3. Posting the NPP on the CalOptima Health website.

   a. Upon a material change to the NPP, CalOptima Health shall prominently post the change, or the revised NPP, on the CalOptima Health website by the effective date of the material change to the notice.

4. Providing a revised NPP, or information about the material change and how to obtain the revised NPP, in the next annual mailing to Members.

5. Notifying all Members at least once every three (3) years that a copy of the NPP is available upon request or may be obtained on the CalOptima Health website at www.CalOptima Health.org.

6. Ensuring all mailings of the NPP comply with CalOptima Health's Cultural and Linguistic Services guidelines, in accordance with CalOptima Health Policies DD.2002: Cultural and Linguistic Services.

7. PACE Member materials shall include a statement of non-discrimination acknowledging that CalOptima Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex and taglines informing members of the availability of language assistance services.

C. Documentation and Retention:

1. CalOptima Health shall document compliance with this Policy and retain copies of the notices issued for a period of ten (10) years from the effective date of the notice.

IV. ATTACHMENT(S)

A. Notice of Privacy Practices (NPP)

V. REFERENCE(S)

A. CalOptima Health Compliance Plan
B. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Health PACE Program Agreement
E. CalOptima Health Policy DD.2002: Cultural and Linguistic Services
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P. CalOptima Health Policy HH.3019: De-identification of Protected Health Information (PHI)
Q. Department of Health Care Services (DHCS) All Plan Letter (APL) 06-001: Notice of Privacy Practices and Notification of Breaches
R. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-026: Inoperability and Patient Access Final Rule
S. NCQA Standard MED5 Privacy and Confidentiality: Element A: Adopting Written Policies, Factor 1-2017
T. Patient Protection and Affordable Care Act §1557
U. 45 CFR Part 2
V. 45CFR §160.202
W. 45 CFR §164.105(c)(2)
X. 45 CFR §164.504(a)(2)-(a)(4)
Y. 45 CFR §164.508(b)(5)
Z. 45 CFR §164.520(b)(1)(ii)(A) or (B)
AA. 45 CFR §164.530(g)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
01/19/2022	Department of Health Care Services (DHCS)	Approved as Submitted
05/02/2023	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors

12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/01/2003	HH.3000	Notice of Privacy Practices	Medi-Cal
Revised	07/01/2007	HH.3000	Notice of Privacy Practices	Medi-Cal
Revised	04/01/2009	HH.3000	Notice of Privacy Practices	Medi-Cal
Revised	01/01/2011	HH.3000	Notice of Privacy Practices	Medi-Cal
Revised	01/01/2013	HH.3000	Notice of Privacy Practices	Medi-Cal OneCare
Revised	01/01/2014	HH.3000	Notice of Privacy Practices	Medi-Cal
Revised	09/01/2015	HH.3000	Notice of Privacy Practices	Medi-Cal
Revised	12/01/2016	HH.3000	Notice of Privacy Practices	Medi-Cal OneCare OneCare Connect PACE
Reviewed	03/01/2017	HH.3000	Notice of Privacy Practices	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.3000	Notice of Privacy Practices	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.3000	Notice of Privacy Practices	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.3000	Notice of Privacy Practices	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.3000	Notice of Privacy Practices	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.3000	Notice of Privacy Practices	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	HH.3000	Notice of Privacy Practices	Medi-Cal OneCare PACE
Revised	03/01/2023	HH.3000	Notice of Privacy Practices	Medi-Cal OneCare PACE

Action	Date	Policy	Policy Title	Program(s)
Revised	11/07/2024	HH.3000	Notice of Privacy Practices	Medi-Cal OneCare PACE

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IX. GLOSSARY

Term	Definition
CFR	Means the Code of Federal Regulations.
Disclosure	Has the meaning in 45 CFR Section 160.103, including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
Health Care Operations	Has the meaning given such term in 45 CFR Section 164.501, including activities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities, customer services, resolution of internal grievances, business planning, and development and activities related to compliance with the privacy rule.
Member	A beneficiary enrolled in a CalOptima Health program.
Notice of Privacy Practices (NPP)	Notice provided to a Member that describes Cal Optima's practices in the Use and Disclosure of Protected Health Information, Member rights, and CalOptima Health legal duties with respect to Protected Health Information.
Payment	Has the meaning in 45 CFR Section 164.501, including: activities carried out by CalOptima Health including: 1. Determination of eligibility, risk adjustments based on Member health status and demographics, billing claims management, and collection activities; 2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and, 3. Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.
Personally Identifiable Information (PII)	PII is —any information about an individual maintained by an agency, including (1) any information that can be Used to distinguish or trace an individual's identity, such as name, social security number, date and place of birth, mother's maiden name, biometric records, race, ethnicity, language (REL), sexual orientation and gender identity (SOGI); and (2) any other information that is linked or linkable to an individual, such as medical, educational, financial, and employment information.
Protected Health Information (PHI)	Has the meaning in 45 CFR Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be Used to identify the individual. The information was created or received by CalOptima Health or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.

Term	Definition
Reproductive Health Care	Means health care, as defined at 45 CFR § 160.103, that affects the health of a Member in all matters relating to the reproductive system and to its functions and processes.
Threshold Languages	Medi-Cal: The non-English threshold and concentration standard languages in which Contractor is required to provide written translations of Member Information, as determined by DHCS. OneCare: A threshold language is defined by CMS as the native language of a group who compromises five percent (5%) or more of the people served by the CMS Program.
Treatment	Has the meaning in 45 CFR Section 164.501, including: activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care providers; and coordination with third parties for services related to the management of the Member's health care benefits.
Use	Has the meaning in 45 CFR Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

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Readability Score: 6.0 Method: Fry (HLA) IM 08-21-24
Yellow highlighted text was exempted from readability testing (contact information, proper nouns and defined terms).
All changes made to member informing materials are subject to MMA resubmission. This includes edits made to legal language, disclaimers, medical terminology, proper nouns, defined words, contact information, numerical values, etc.
Reviewed by Mona Chartier (Comms) on 8/22/24. Approved by Fay Ho on 8/22/24.
TO C&L: Please do not translate content in the footer. Only change the first initial for the corresponding translated language (e.g., <Title of Document>_<S> for Spanish).
TO C&L: Please note this content was submitted for both LOBs; avoid duplicative translations if possible. Content is not specific to LOB.

Notice of Privacy Practices

Effective: April 14, 2003 | Updated: August 22, 2024

CalOptima Health offers you access to health care through the Medicare or Medi-Cal program. We are required by state and federal law to protect your health information. After you become eligible and enroll in our health plan, Medicare or Medi-Cal sends your information to us. We also get medical information from your doctors, clinics, labs and hospitals to approve and pay for your health care.
This notice explains how medical information about you may be used and shared and how you can get access to this information. **Please review it carefully.**

Your rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

How we protect your information	• We have controls in place for physical and electronic access to your information, which includes race, ethnicity, language, gender identity and sexual orientation. • Our policies and procedures outline what is allowed and what is not allowed when using your personal health information, including race, ethnicity, language, gender identity and sexual orientation. • Electronic access may include media formats, devices and hardware, and data storage. • We do not discriminate against members based on any sensitive information.

Notice of Privacy Practices

Get a copy of your health and claims records	• You can ask to see or get a copy of your health and claims records and other health information we have about you. You must make this request in writing. You will be sent a form to fill out and we may charge a fair fee for the costs of copying and mailing records. You must provide a valid form of ID to view or get a copy of your health records. • We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. • We may keep you from seeing certain parts of your records for reasons allowed by law. • **CalOptima Health does not have complete copies of your medical records. If you want to look at, get a copy of or change your medical records, please contact your doctor or clinic.**
Ask us to correct health and claims records	• You have the right to send a written request to ask that information in your records be changed if it is not correct or complete. You must make your request in writing. • We may refuse your request if the information is not created or kept by CalOptima Health, or if we believe it is correct and complete, but we will tell you why in writing within 60 days. • If we don't make the changes you asked for, you may ask us to review our decision. You may also send a statement saying why you disagree with our records, and your statement will be kept with your records.
Request confidential communications	• You can ask us to contact you by your preferred method of contact (for example, home or work phone) or to send mail to a different address. • We will consider all fair requests. We must say "yes" if you tell us you would be in danger if we do not.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment or our operations. • We are not required to agree to your request, and we may say "no" if it would affect your care.

Notice of Privacy Practices

Get a list of those with whom we shared information	• You can ask for a list of the times we shared your health information during the past 6 years before the date you asked. • You have the right to request a list of what information was shared, who it was shared with, when it was shared and why. • We will include all disclosures, except for those about your treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make).
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to accept the notice electronically. We will offer you a paper copy in good time. • You can also find this notice on our website at www.caloptimahealth.org.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can use your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• If you feel we have violated your rights, you can complain by contacting us using the information in this notice. • We will not retaliate against you for filing a complaint.
Use a self-pay restriction	• If you pay the whole bill for a service, you can ask your doctor not to share the information about that service with us. If you or your provider submits a claim to CalOptima Health, we do not have to agree to a restriction. If a law requires the disclosure, CalOptima Health does not have to agree to your restriction.

For certain health information, you can tell us your choices about what we share.
If you have a preference for how we share your information in the situations below, please contact us. In most cases, if we use or share your Protected Health Information (PHI) outside of treatment, payment or operations, we must get your written permission first. If you give us your permission, you may take it back in writing at any time. We cannot take back what we used or shared when we had your written permission, but we will stop using or sharing your PHI in the future.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends or others involved in payment for your care • Share information in a disaster-relief situation
In these cases, we *never* share your information unless you give us written permission:	• Substance use disorder (SUD) information: We must obtain your authorization for any use or disclosure of SUD information. • Psychotherapy notes: We must obtain your authorization for any use or disclosure of psychotherapy notes, except to carry out certain treatment, payment or health care operations.

	• Your race, ethnicity, language, gender identity and sexual orientation information, except to carry out treatment, payment or health care operations. • Your race, ethnicity, language, gender identity and sexual orientation information for underwriting, denial of services and coverage, or for benefit determinations. • Marketing purposes. • Sale of your information.

Our responsibilities

- We are required by law to maintain the privacy and security of your PHI.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Our uses and disclosures

Your information may be used or shared by CalOptima Health only for treatment, payment, and health care operations related to the Medicare or Medi-Cal program in which you are enrolled. We may use and share your information in health information exchanges with providers involved in the care you receive. The information we use and share includes, but is not limited to:

- Your name
- Address
- History of care and treatment given to you
- Cost or payment for care

Some examples of how we share your information with those involved with your care:

Help manage the health care treatment you receive	• We can use your health information and share it with professionals who are treating you. This may include your race, ethnicity, language, gender identity and sexual orientation to provide services best suited for your needs.	**Example:** A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services. We will share this information with doctors, hospitals and others to get you the care you need.
Run our organization (health care operations)	• We can use and share your information to run our organization and contact you when necessary. • **We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.**	**Example:** We use your health information to develop better services for you, which may include reviewing the quality of care and services you receive. We may also use this information in audits and fraud investigations.
Pay for your health services	• We can use and share your health information as we pay for your health services.	**Example:** We share information with the doctors, clinics and others who bill us for your care. We may also forward bills to other health plans or organizations for payment.

Administer your plan	• We may share your health information with the Department of Health Care Services (DHCS) or the Centers for Medicare & Medicaid Services (CMS) for plan administration.	**Example:** DHCS contracts with us to provide a health plan, and we provide DHCS with certain statistics.

How else can we use or share your health information?

We are allowed or required to share your information in other ways — usually in ways that promote the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

Help with public health and safety issues	We can share health information about you for certain situations such as: • Preventing disease. • Helping with product recalls. • Reporting adverse reactions to medicines. • Reporting suspected abuse, neglect or domestic violence. • Preventing or reducing a serious threat to anyone's health or safety.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.
Respond to organ and tissue donation requests and work with a medical examiner or funeral director	• We can share health information about you with organ procurement organizations. • We can share health information with a coroner, medical examiner or funeral director when an individual dies.
Address workers' compensation, law enforcement and other government requests	We can use or share health information about you: • For workers' compensation claims. • For law enforcement purposes or with a law enforcement official. • With health oversight agencies for activities authorized by law. • For special government functions, such as military, national security and presidential protective services.
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Comply with special laws	• There are special laws that protect some types of health information, such as mental health services, treatment for substance use disorders, and HIV/AIDS testing and treatment. We will obey these laws when they are stricter than this notice. • There are also laws that limit our use and disclosure to reasons directly connected to the administration of CalOptima Health's programs.

Information about your reproductive health

CalOptima Health is prohibited from sharing, and will not share, information about your reproductive health care for any of the following purposes (Prohibited Purposes) without your written approval. Reproductive health care includes all health care that affects your reproductive system and its functions and processes, for example, contraceptives, abortion and abortion-related services, family planning services, fertility services, and any other care, services or supplies related to your reproductive system.

Prohibited Purposes

To investigate or impose liability for merely seeking, obtaining, providing or facilitating lawful reproductive health care	For example, we will not release your reproductive health information when the information is requested to enforce an out-of-state law prohibiting reproductive health care if that care is legal in California.
To identify a person in order to investigate or impose liability for merely seeking, obtaining, providing or facilitating lawful reproductive health care	For example, we will not release your reproductive health information when it is requested to identify a provider that legally assisted with reproductive health care services in California.

CalOptima Health may share information about your reproductive health for treatment, payment and health care operations purposes or as otherwise permitted by federal and state law if the release is not for 1 of the 2 Prohibited Purposes above. If we disclose your information for the following purposes, we will obtain an attestation from the person asking for your reproductive health information that says they will not use your information for the Prohibited Purposes above:

Health oversight activities	For example, we can share information about your reproductive health with agencies responsible for overseeing health care activities such as investigating whether reproductive health care was actually provided or appropriately billed.
Judicial or administrative proceedings	For example, we can share information about your reproductive health in response to a court subpoena when the reason for the request is not a Prohibited Purpose above.
Law enforcement purposes	For example, we can share information about your reproductive health in response to a law enforcement investigation related to sexual assault, sex trafficking or coercing minors into obtaining reproductive health care.
Disclosures about deceased persons to a coroner or medical examiner	For example, we can share information about your reproductive health for the purpose of identifying a deceased person or determining a cause of death.

Notice of Privacy Practices

Changes to the terms of this notice

CalOptima Health reserves the right to change its privacy notice and the ways we keep your PHI safe. If this happens, we will update the notice and notify you. We will also post the updated notice on our website.

Potential for redisclosure

Information disclosed by CalOptima Health, either authorized by you (or your personal representative) or permitted by applicable privacy laws, may be redisclosed by the person receiving your information if they are not required by law to protect your information.

Notice of Privacy Practices

How to contact us to use your rights

If you want to use any of the privacy rights explained in this notice, please write to us at:

CalOptima Health
Privacy Officer
505 City Parkway West
Orange CA 92868
1-888-587-8088 (TTY **711**)

Or call CalOptima Health Customer Service at: **1-714-246-8500 or toll-free at**
1-888-587-8088 (TTY **711**)

If you believe that we have not protected your privacy and wish to file a complaint or grievance, you may write or call CalOptima Health at the address and phone number above. You may also contact these agencies:

California Department of Health Care Services
Privacy Officer
C/O: Office of HIPAA Compliance
PO Box 997413 MS 4722
Sacramento CA 95899-7413
Email: privacyofficer@dhcs.ca.gov
Phone: 1-916-445-4646
Fax: 1-916-440-7680

U.S. Department of Health and Human Services
Office for Civil Rights
Regional Manager
90 Seventh Street Suite 4-100
San Francisco CA 94103
Email: OCRComplaint@hhs.gov
Phone: 1-800-368-1019
Fax: 1-415-437-8329
TDD: 1-800-537-7697

Use your rights without fear

CalOptima Health cannot take away your health care benefits nor do anything to hurt you in any way if you choose to file a complaint or use any of the privacy rights in this notice. This notice applies to all CalOptima Health's health care programs.

Policy:	HH.3002
Title:	**Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	*/s/*
Effective Date:	04/01/2003
Revised Date:	11/07/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ PACE ☐ Administrative

I. PURPOSE

This policy describes the conditions under which CalOptima Health shall control access to, request of, Use of, or Disclosure of Protected Health Information (PHI) and Personally Identifiable Information (PII) to ensure that the data Used is the Minimum Necessary to fulfill the request or carry out the required function.

II. POLICY

A. CalOptima Health employees shall make every reasonable effort to control unauthorized access to, and to only request, Disclose, or Use the Minimum Necessary data to carry out the required function or to fulfill any request for Member health-related information related to those activities which are for purposes directly connected with the administration of CalOptima Health programs.

B. Minimum Necessary shall apply to all PHI/PII that CalOptima Health receives or creates.

C. Minimum Necessary shall include race~~/~~, ethnicity, language, gender identity ~~and~~, sexual orientation information, and reproductive health care.

D. Minimum Necessary policy shall not apply to:

1. Disclosures to, or requests by, a health care Provider for Treatment;

2. Disclosures made to the Member who is the subject of the PHI/PII, including for the Member's right to access and right to an accounting;

3. Disclosures made pursuant to authorization by the Member;

4. Disclosures to the Department of Health and Human Services (HHS), when Disclosure of information is required under the Privacy Rule for enforcement purposes;

5. Uses or Disclosures that are required for compliance with the Health Insurance Portability and Accountability Act (HIPAA) regulatory requirements; and

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6. Other Uses or Disclosures that are Required by Law.

III. PROCEDURE

A. Minimum Necessary Use of PHI/PII

1. CalOptima Health shall limit staff access to a Member's PHI/PII to those employees who need to Use the data to carry out their specific job-related duties, including those related to Treatment, Payment, and Health Care Operations.

2. The respective department directors, or their Designee, shall determine access to electronic and paper data files. The department director shall assign an employee specific access level for computer systems. The CalOptima Health Information Technology Services-Application Management Department shall manage password control.

3. Within CalOptima Health, ~~the following~~internal departments shall require and maintain ~~the indicated~~limited levels of access to PHI ~~on a routine basis~~ to appropriately accomplish their duties and responsibilities:

~~Department~~	~~FACETS ™ Member Eligibility~~	~~FACETS ™ Customer Service~~	~~FACETS ™ Claims~~	~~FACETS ™ Finance/Cap~~	~~FACETS ™ Accounts Payable~~	~~FACETS ™ C&A~~	~~FACETS ™ UM/CM~~	~~Department Level Hard Copy Databases~~	~~Clinical Support Systems~~	~~In-House Provider Portal~~
~~Behavioral Health~~	~~P~~	~~C~~	~~P~~					~~C~~	~~C~~	~~P~~
~~Case Management~~	~~P~~	~~C~~	~~P~~		~~P~~	~~C~~	~~C~~	~~C~~	~~C~~	~~P~~
~~Claims Administration~~	~~P~~	~~C~~	~~C~~	~~P~~			~~P~~	~~C~~	~~C~~	~~P~~
~~Customer Service~~	~~C~~	~~C~~	~~P~~			~~P~~	~~P~~	~~C~~	~~P~~	~~P~~
~~Executive Office~~	~~P~~	~~P~~	~~P~~	~~P~~	~~P~~	~~P~~	~~P~~			~~P~~
~~Fiscal Services (Accounting, Finance, Encounters)~~	~~P~~		~~P~~	~~C~~	~~C~~		~~P~~	~~C~~		
~~Government Affairs~~	~~P~~	~~P~~	~~P~~				~~P~~	~~C~~		
~~Grievance & Appeals Resolution Services (GARS)~~	~~P~~	~~C~~	~~P~~			~~C~~	~~C~~	~~C~~	~~P~~	~~P~~
~~Information Technology Services~~	~~P~~	~~P~~	~~P~~	~~P~~	~~P~~	~~P~~	~~P~~		~~P~~	~~P~~

~~Department~~	~~FACETS™ Member Eligibility~~	~~FACETS™ Customer Service~~	~~FACETS™ Claims~~	~~FACETS™ Finance/Cap~~	~~FACETS™ Accounts Payable~~	~~FACETS™ G&A~~	~~FACETS™ UM/CM~~	~~Department Level Hard Copy Databases~~	~~Clinical Support Systems~~	~~In House Provider Portal~~
~~MSSP, LTSS~~	~~P~~		~~P~~					~~C~~	~~P~~	~~P~~
~~Office of Compliance~~	~~P~~	~~P~~	~~P~~				~~P~~	~~C~~	~~P~~	~~P~~
~~Pharmacy Management~~	~~P~~			~~P~~				~~C~~	~~C~~	~~P~~
~~Population Health Management~~	~~P~~		~~P~~					~~C~~	~~P~~	~~P~~
~~Provider Relations/ Network Management~~	~~P~~		~~P~~	~~P~~			~~P~~	~~C~~		~~P~~
~~Quality Improvement~~								~~C~~	~~P~~	~~P~~
~~Utilization Management~~	~~P~~						~~C~~	~~C~~	~~C~~	~~P~~
~~KEY:~~	~~C= View & Edit~~ ~~P= View Only~~									

4. The respective department director, or Designee, may grant access to other job categories on a specific "need-to-know" basis, and shall restrict access to Minimum Necessary data to complete the work activity~~.~~ pursuant to CalOptima Health Policy ITS.1201: Technical Safeguards – Access Controls.

B. Minimum Disclosure of PHI and Requests for PHI/PII

1. All routine Disclosures for purposes of Treatment, Payment and Health Care Operations shall contain only the PHI/PII data necessary to achieve the purpose of the disclosure.

2. For external entities, inclusive of other covered entities, Business Associates, or public officials, CalOptima Health shall review requests for disclosure on an individual basis to ensure requests are reasonably necessary.

3. CalOptima Health shall limit the use or disclosure of reproductive health care. Reproductive health care may include (but is not limited to): contraception, management of pregnancy and pregnancy-related conditions, miscarriage management, pregnancy termination, fertility or

infertility diagnosis and treatment, assistive reproductive technology, and other diagnoses, treatment and care that is lawfully obtained which affect the reproductive system.

4. CalOptima Health will restrict the circumstances of the use or disclosure of reproductive health care information if the disclosure may be related to a prohibited purpose. Any investigations against persons seeking, obtaining, providing or facilitating lawful reproductive health care may be such circumstances. -Prohibited purposes may include: investigations (criminal, civil, or administrative), imposition of criminal, civil or administrative liability when it is reasonably determined that one or more of the following scenarios exists:

   a. The reproductive health care is lawful in California under the circumstances the health care is provided.

   b. The reproductive health care is protected, required or authorized by Federal law.

   c. The reproductive health care is presumed lawful in the absence of contrary evidence.

5. Any request that involves reproductive health care Records from a requesting person for non-prohibited purposes, as defined in 45 CFR § 164.512 can only be disclosed if the requestor completes an Attestation Form indicating that the use of the disclosure is not for a prohibited purpose. -Non-prohibited purposes may include health oversight activities, judicial or administrative proceedings, disclosures for law enforcement, and disclosures about decedents to coroners and medical examiners.

   a. CalOptima Health shall cease any use or disclosure of reproductive health care if it is discovered that any representation on the attestation was false.

~~3.~~6. CalOptima Health shall control unauthorized access to PHI/PII in paper form as follows:

   a. CalOptima Health employees shall not leave PHI/PII in paper form unattended at any time, unless it is locked in a file cabinet, file room, desk, or office. Unattended means that the information is not under observation by an employee authorized to access such information.

   b. An authorized CalOptima Health employee shall escort a visitor through an area where PHI/PII is contained and shall keep PHI/PII out of sight while a visitor is in the area, unless the visitor is authorized to view the PHI/PII.

   c. CalOptima Health employees shall dispose of PHI/PII through a Business Associate by shredding, or pulverizing.

   d. CalOptima Health employees shall not remove PHI/PII from the CalOptima Health premises, except for routine business purposes, or with the express written permission of DHCS or CMS.

   e. Facsimile containing PHI/PII

      i. CalOptima Health employees shall not leave an incoming, or outgoing, facsimile containing PHI/PII unattended.

ii. CalOptima Health shall house facsimile machines in a secure area.

iii. An outgoing facsimile shall contain a confidentiality statement notifying an individual receiving a facsimile in error to destroy the facsimile.

iv. CalOptima Health employees shall verify a facsimile number prior to sending the facsimile.

f. Mail containing PHI/PII

i. CalOptima Health employees shall send mail that contains PHI/PII only by a secure method(s).

ii. CalOptima Health shall send a mailing that contains PHI/PII of two thousand five hundred (2,500) Members, or more, by a secure, bonded courier with signature required on the receipt.

iii. CalOptima Health employees shall encrypt all electronic media sent by mail in accordance with CalOptima Health Policy ITS.1202: Technical Safeguards – Data Control.

~~4.~~7. CalOptima Health shall control unauthorized access to PHI/PII in oral form, in accordance with CalOptima Health Policy GA.8050: Confidentiality, and as follows:

a. CalOptima Health employees shall not discuss PHI/PII in public areas.

b. CalOptima Health employees shall not discuss PHI/PII with unauthorized person(s).

~~5.~~8. CalOptima Health shall control unauthorized access to PHI in electronic form (i.e., EPHI) in accordance with CalOptima Health Policy ~~IS.1000 EPHI Security Program:~~ITS.1000: Information Security Program. Electronic media forms may include devices, hardware, mobile applications, laptops, secure portals, and data storage, such as diskettes, USBs, CDs, and tapes.

~~6.~~9. Routine recurring Disclosures, or requests for PHI/PII, include:

a. Membership, Capitation Payments, and Encounter reporting with contracted Health Networks.

b. Payment of claims for services provided to Members.

c. Coordination of care between CalOptima Health and the Health Care Agency (HCA), Regional Center of Orange County (RCOC), Health Networks, and Providers.

d. Complying with regulatory reporting requirements and oversight activities.

e. Requests for PHI to carry out peer review or other Quality Improvement (QI) activities.

f. Business owners responsible for recurring Disclosures or requests for PHI pertaining to the above activities should ensure such PHI/PII requested is limited to the information reasonably necessary to accomplish the stated purpose for which the request is made.

C. Review of Non-Routine Disclosures or Requests for PHI/PII

1. All requests for non-routine Disclosures of PHI/PII shall be routed to the Privacy Officer, or Designee, for review.

2. The Privacy Officer, or Designee, shall review all non-routine Disclosures or requests on an individual basis to determine if the PHI/PII requested is limited to the information reasonably necessary to accomplish the stated purpose for which the request is made. Details on the permissible and impermissible uses of PHI/PII data are found in CalOptima Health Policy HH.3000: Notice of Privacy Practice. Criteria to determine PHI/PII which may be provided in a non-routine Disclosure or request for PHI/PII is detailed in CalOptima Health Policy HH.3006: Tracking and Reporting Disclosures of Protected Health Information.

D. Criteria for Reviewing Non-Routine Requests for PHI/PII Disclosures

1. The requestor(s) clearly states the purpose for which the PHI/PII is requested.

2. All requested information is reasonably necessary to meet the need stated on the request.

3. When applicable, the requestor(s) submits valid authorization with the request for the PHI/PII, in accordance with CalOptima Health Policy HH.3015: Authorization for Release of Protected Health Information.

4. The Disclosure is consistent with CalOptima Health Policy HH.3000: Notice of Privacy Practices.

5. Requests may be accepted as the Minimum Necessary for the stated purpose when requested under the following conditions:

   a. A professional who is a member of the CalOptima Health Workforce, or Business Associate, requests the information in order to provide a professional service to CalOptima Health, and the requestor represents that the request is the Minimum Necessary information for the stated purpose; or

   b. Another Covered Entity requests the information.

E. The Privacy Officer or Designee shall make a determination on the request and authorize, or deny, the request for the release of the PHI/PII, in whole or part, based on the above criteria and relevant Federal and California law including, but not limited to, those related to:

1. Elder abuse;

2. Persons with Human Immunodeficiency Virus (HIV)/Acquired Immunodeficiency Syndrome (AIDS);

3. Family planning;

4. Immunization status;

5. Reproductive health care;

6. Substance Use Disorder (SUD) Patient Records;

~~5.~~7. Child Health and Disability Prevention Program (CHDP) screening, including blood, lead, substance abuse, mental health, and developmental disabilities; or

~~6.~~8. Other sensitive health information, as needed.

F. Knowledge of a violation or potential violation of this policy shall be reported directly to the Privacy Officer, or the CalOptima Health Compliance and Ethics Hotline at 1-855-507-1805.

G. Documentation:

1. CalOptima Health shall record all Disclosures pursuant to the standard Disclosure tracking procedure, in accordance with CalOptima Health Policy HH.3006: Tracking and Reporting Disclosures of Protected Health Information (PHI).

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Health PACE Program Agreement
D. CalOptima Health Policy HH.3000: Notice of Privacy Practices
E. CalOptima Health Policy HH.3006: Tracking and Reporting Disclosures of Protected Health Information (PHI)
F. CalOptima Health Policy HH.3014: Use of Electronic Mail with Protected Health Information
G. CalOptima Health Policy HH.3015: Authorization for Release of Protected Health Information
H. CalOptima Health Policy ~~IS~~ITS.1000: ~~Electronic Protected Health~~ Information ~~(EPHI)~~ Security Program
I. CalOptima Health Policy ITS.1201: Technical Safeguards – Access Controls
J. CalOptima Health Policy ITS.1202 Technical Safeguards – Data Control
~~I.~~K. NCQA Standard ~~MED~~4 Privacy and Confidentiality
~~J.~~L. Title 45, Code of Federal Regulations, §164.501
~~K.~~M. Title 45, Code of Federal Regulations, §164.502(b)
~~L.~~N. Title 45, Code of Federal Regulations, §164.514(d)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
06/12/2014	Department of Health Care Services (DHCS)	Approved as Submitted
01/26/2022	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors

Date	Meeting
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/01/2003	HH.3002	Minimum Necessary Uses and Disclosure of Protected Health Information	Medi-Cal
Revised	04/01/2007	HH.3002	Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls	Medi-Cal
Revised	01/01/2009	HH.3002	Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls	Medi-Cal
Revised	07/01/2011	HH.3002	Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls	Medi-Cal
Revised	01/01/2013	HH.3002	Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls	Medi-Cal OneCare
Revised	01/01/2014	HH.3002	Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls	Medi-Cal OneCare
Revised	04/01/2014	HH.3002	Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls	Medi-Cal
Revised	11/01/2014	HH.3002	Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls	Medi-Cal
Revised	09/01/2015	HH.3002	Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls	Medi-Cal
Revised	12/01/2016	HH.3002	Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.3002	Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.3002	Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls	Medi-Cal OneCare OneCare Connect PACE

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Action	Date	Policy	Policy Title	Program(s)
Revised	12/05/2019	HH.3002	Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.3002	Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.3002	Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	HH.3002	Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls	Medi-Cal OneCare PACE
Revised	09/01/2023	HH.3002	Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls	Medi-Cal OneCare PACE
Revised	11/07/2024	HH.3002	Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls	Medi-Cal OneCare PACE

IX. GLOSSARY

Term	Definition
Aid Code	The two (2) character code, defined by the State of California, which identifies the aid category under which a Member is eligible to receive Medi-Cal Covered Services.
Business Associate	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: 1. On behalf of such Covered Entity or of an organized health care arrangement (as defined in this section) in which the Covered Entity participates, but other than in the capacity of a Member of the workforce of such Covered Entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or 2. Provides, other than in the capacity of a Member of the workforce of such Covered Entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such Covered Entity, or to or for an organized health care arrangement in which the Covered Entity participates, where the provision of the service involves the Disclosure of protected health information from such Covered Entity or arrangement, or from another Business Associate of such Covered Entity or arrangement, to the person. A Covered Entity may be a Business Associate of another Covered Entity. Business Associate includes: 1. A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a Covered Entity and that requires access on a routine basis to such protected health information. 2. A person that offers a personal health record to one or more individuals on behalf of a Covered Entity. 3. A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the Business Associate.
CalOptima Health Workforce	This includes any and all employees of CalOptima Health, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.
Capitation Payments	Medi-Cal: The monthly amount paid to a Health Network by CalOptima Health for the delivery of Covered Services to Members, which is determined by multiplying the applicable Capitation Rate by a Health Network's monthly enrollment based upon Aid Code, age, and gender. OneCare: The monthly amount paid to a Health Network by CalOptima Health for the delivery of Covered Services to Members in that Health Network.

Term	Definition
Capitation Rate	Medi-Cal: The per capita rate set by CalOptima Health for the delivery of Covered Services to Members based upon Aid Code, age, and gender. OneCare: The percent of the gross Capitation Payment and any applicable premiums that CalOptima Health receives from Centers of Medicare & Medicaid Services (CMS) or Members on behalf of Members enrolled in a Health Network that is allocated to the Health Network for the delivery of Covered Services.
Centers for Medicare & Medicaid Services (CMS)	The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.
Covered Entity	A health plan, a health care clearinghouse, or a health care Provider who transmits any health information in electronic form in connection with a transaction covered by Title 45, Code of Federal Regulations, Part 160.
Covered 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 Health's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Enhanced Care Management and Community Supports as part of the California Advancing and Innovating Medi-Cal (CalAIM) Initiative (as set forth in the CalAIM 1115 Demonstration & 1915(b) Waiver, DHCS All Plan Letter (APL) 21-012: Enhanced Care Management Requirements and APL 21-017: Community Supports Requirements, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 5.51, beginning with section 14184.100), or other services as authorized by the CalOptima Health 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 Health is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract. PACE: Those services set for the in California Code of Regulations, title 22, chapter 3, article 4, beginning with section 51301, and title 17, division 1, chapter 4, subchapter 13, beginning with Section 6840, unless otherwise specifically excluded under the terms of the DHCS PACE Contract with CalOptima Health, or other services as authorized by the CalOptima Health Board of Directors.
Department of Health Care Services (DHCS)	The California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.

Term	Definition
Designee	A person selected or designated to carry out a duty or role. The assigned Designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Disclosure	Has the meaning in in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
Encounter	Medi-Cal: Any unit of Covered Services provided to a Member by a Health Network regardless of Health Network reimbursement methodology. Such Covered Services include any service provided to a Member, regardless of the service location or Provider, including out-of-network services and sub-capitated and delegated Covered Services. OneCare: Any unit of Covered Service provided to a Member by a Health Network regardless of Health Network reimbursement methodology. These services include any Covered Services provided to a Member, regardless of the service location or Provider, including out-of-network Covered Services and sub-capitated and delegated Covered Services. Encounter data submitted to CalOptima Health should not include denied, adjusted, or duplicate claims.
FACETS™	Licensed software product that supports administrative, claims processing and adjudication, Membership data, and other information needs of managed care organizations.
Health Care Operations	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations including: activities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities, customer services, resolution of internal grievances, business planning, and development and activities related to compliance with the privacy rule.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, and as subsequently amended.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Member	A beneficiary enrolled in a CalOptima Health program.
Minimum Necessary	The principle that a Covered Entity must make reasonable efforts to Use, disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the Use, Disclosure, or request

Term	Definition
Payment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities carried out by CalOptima Health including: 1. Determination of eligibility, risk adjustments based on Member health status and demographics, billing claims management, and collection activities; 2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and 3. Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.
Personally Identifiable Information (PII)	PII is —any information about an individual maintained by an agency, including (1) any information that can be Used to distinguish or trace an individual's identity, such as name, social security number, date and place of birth, mother's maiden name, biometric records, race, ethnicity, language (REL), sexual orientation and gender identity (SOGI); and (2) any other information that is linked or linkable to an individual, such as medical, educational, financial, and employment information.
Protected Health Information (PHI)	Has the meaning in 45, Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be Used to identify the individual. The information was created or received by Cal Optima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Provider	Medi-Cal: A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, or other person or institution that furnishes Covered Services. OneCare: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B.
Required by Law	Has the meaning in 45 Code of Federal Regulations (CFR) Section 164.103 which specifies a mandate contained in law that compels an entity to make a Use or Disclosure of PHI and that is enforceable in a court of law and which are permissible grounds for a Covered Entity to Use of Disclose PHI under 45 CFR Section 164.512(a) when relevant requirements are met.

Term	Definition
Treatment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care Providers; and coordination with third parties for services related to the management of the Member's health care benefits.
Use	Has the meaning in 45, Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

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Policy:	HH.3002
Title:	**Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	*/s/*
Effective Date:	04/01/2003
Revised Date:	11/07/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ PACE ☐ Administrative

I. PURPOSE

This policy describes the conditions under which CalOptima Health shall control access to, request of, Use of, or Disclosure of Protected Health Information (PHI) and Personally Identifiable Information (PII) to ensure that the data Used is the Minimum Necessary to fulfill the request or carry out the required function.

II. POLICY

A. CalOptima Health employees shall make every reasonable effort to control unauthorized access to, and to only request, Disclose, or Use the Minimum Necessary data to carry out the required function or to fulfill any request for Member health-related information related to those activities which are for purposes directly connected with the administration of CalOptima Health programs.

B. Minimum Necessary shall apply to all PHI/PII that CalOptima Health receives or creates.

C. Minimum Necessary shall include race, ethnicity, language, gender identity, sexual orientation information, and reproductive health care.

D. Minimum Necessary policy shall not apply to:

1. Disclosures to, or requests by, a health care Provider for Treatment;

2. Disclosures made to the Member who is the subject of the PHI/PII, including for the Member's right to access and right to an accounting;

3. Disclosures made pursuant to authorization by the Member;

4. Disclosures to the Department of Health and Human Services (HHS), when Disclosure of information is required under the Privacy Rule for enforcement purposes;

5. Uses or Disclosures that are required for compliance with the Health Insurance Portability and Accountability Act (HIPAA) regulatory requirements; and

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6. Other Uses or Disclosures that are Required by Law.

III. PROCEDURE

A. Minimum Necessary Use of PHI/PII

1. CalOptima Health shall limit staff access to a Member's PHI/PII to those employees who need to Use the data to carry out their specific job-related duties, including those related to Treatment, Payment, and Health Care Operations.

2. The respective department directors, or their Designee, shall determine access to electronic and paper data files. The department director shall assign an employee specific access level for computer systems. The CalOptima Health Information Technology Services-Application Management Department shall manage password control.

3. Within CalOptima Health, internal departments shall require and maintain limited levels of access to PHI to appropriately accomplish their duties and responsibilities:

4. The respective department director, or Designee, may grant access to other job categories on a specific "need-to-know" basis, and shall restrict access to Minimum Necessary data to complete the work activity pursuant to CalOptima Health Policy ITS.1201: Technical Safeguards – Access Controls.

B. Minimum Disclosure of PHI and Requests for PHI/PII

1. All routine Disclosures for purposes of Treatment, Payment and Health Care Operations shall contain only the PHI/PII data necessary to achieve the purpose of the disclosure.

2. For external entities, inclusive of other covered entities, Business Associates, or public officials, CalOptima Health shall review requests for disclosure on an individual basis to ensure requests are reasonably necessary.

3. CalOptima Health shall limit the use or disclosure of reproductive health care. Reproductive health care may include (but is not limited to): contraception, management of pregnancy and pregnancy-related conditions, miscarriage management, pregnancy termination, fertility or infertility diagnosis and treatment, assistive reproductive technology, and other diagnoses, treatment and care that is lawfully obtained which affect the reproductive system.

4. CalOptima Health will restrict the circumstances of the use or disclosure of reproductive health care information if the disclosure may be related to a prohibited purpose. Any investigations against persons seeking, obtaining, providing or facilitating lawful reproductive health care may be such circumstances. Prohibited purposes may include: investigations (criminal, civil, or administrative), imposition of criminal, civil or administrative liability when it is reasonably determined that one or more of the following scenarios exists:

   a. The reproductive health care is lawful in California under the circumstances the health care is provided.

b. The reproductive health care is protected, required or authorized by Federal law.

c. The reproductive health care is presumed lawful in the absence of contrary evidence.

5. Any request that involves reproductive health care Records from a requesting person for non-prohibited purposes, as defined in 45 CFR § 164.512 can only be disclosed if the requestor completes an Attestation Form indicating that the use of the disclosure is not for a prohibited purpose. Non-prohibited purposes may include health oversight activities, judicial or administrative proceedings, disclosures for law enforcement, and disclosures about decedents to coroners and medical examiners.

   a. CalOptima Health shall cease any use or disclosure of reproductive health care if it is discovered that any representation on the attestation was false.

6. CalOptima Health shall control unauthorized access to PHI/PII in paper form as follows:

   a. CalOptima Health employees shall not leave PHI/PII in paper form unattended at any time, unless it is locked in a file cabinet, file room, desk, or office. Unattended means that the information is not under observation by an employee authorized to access such information.

   b. An authorized CalOptima Health employee shall escort a visitor through an area where PHI/PII is contained and shall keep PHI/PII out of sight while a visitor is in the area, unless the visitor is authorized to view the PHI/PII.

   c. CalOptima Health employees shall dispose of PHI/PII through a Business Associate by shredding, or pulverizing.

   d. CalOptima Health employees shall not remove PHI/PII from the CalOptima Health premises, except for routine business purposes, or with the express written permission of DHCS or CMS.

   e. Facsimile containing PHI/PII

      i. CalOptima Health employees shall not leave an incoming, or outgoing, facsimile containing PHI/PII unattended.

      ii. CalOptima Health shall house facsimile machines in a secure area.

      iii. An outgoing facsimile shall contain a confidentiality statement notifying an individual receiving a facsimile in error to destroy the facsimile.

      iv. CalOptima Health employees shall verify a facsimile number prior to sending the facsimile.

   f. Mail containing PHI/PII

      i. CalOptima Health employees shall send mail that contains PHI/PII only by a secure method(s).

ii. CalOptima Health shall send a mailing that contains PHI/PII of two thousand five hundred (2,500) Members, or more, by a secure, bonded courier with signature required on the receipt.

iii. CalOptima Health employees shall encrypt all electronic media sent by mail in accordance with CalOptima Health Policy ITS.1202: Technical Safeguards – Data Control.

7. CalOptima Health shall control unauthorized access to PHI/PII in oral form, in accordance with CalOptima Health Policy GA.8050: Confidentiality, and as follows:

   a. CalOptima Health employees shall not discuss PHI/PII in public areas.

   b. CalOptima Health employees shall not discuss PHI/PII with unauthorized person(s).

8. CalOptima Health shall control unauthorized access to PHI in electronic form (i.e., EPHI) in accordance with CalOptima Health Policy ITS.1000: Information Security Program. Electronic media forms may include devices, hardware, mobile applications, laptops, secure portals, and data storage, such as diskettes, USBs, CDs, and tapes.

9. Routine recurring Disclosures, or requests for PHI/PII, include:

   a. Membership, Capitation Payments, and Encounter reporting with contracted Health Networks.

   b. Payment of claims for services provided to Members.

   c. Coordination of care between CalOptima Health and the Health Care Agency (HCA), Regional Center of Orange County (RCOC), Health Networks, and Providers.

   d. Complying with regulatory reporting requirements and oversight activities.

   e. Requests for PHI to carry out peer review or other Quality Improvement (QI) activities.

   f. Business owners responsible for recurring Disclosures or requests for PHI pertaining to the above activities should ensure such PHI/PII requested is limited to the information reasonably necessary to accomplish the stated purpose for which the request is made.

C. Review of Non-Routine Disclosures or Requests for PHI/PII

1. All requests for non-routine Disclosures of PHI/PII shall be routed to the Privacy Officer, or Designee, for review.

2. The Privacy Officer, or Designee, shall review all non-routine Disclosures or requests on an individual basis to determine if the PHI/PII requested is limited to the information reasonably necessary to accomplish the stated purpose for which the request is made. Details on the permissible and impermissible uses of PHI/PII data are found in CalOptima Health Policy HH.3000: Notice of Privacy Practice. Criteria to determine PHI/PII which may be provided in a non-routine Disclosure or request for PHI/PII is detailed in CalOptima Health Policy HH.3006: Tracking and Reporting Disclosures of Protected Health Information.

D. Criteria for Reviewing Non-Routine Requests for PHI/PII Disclosures

1. The requestor(s) clearly states the purpose for which the PHI/PII is requested.

2. All requested information is reasonably necessary to meet the need stated on the request.

3. When applicable, the requestor(s) submits valid authorization with the request for the PHI/PII, in accordance with CalOptima Health Policy HH.3015: Authorization for Release of Protected Health Information.

4. The Disclosure is consistent with CalOptima Health Policy HH.3000: Notice of Privacy Practices.

5. Requests may be accepted as the Minimum Necessary for the stated purpose when requested under the following conditions:

   a. A professional who is a member of the CalOptima Health Workforce, or Business Associate, requests the information in order to provide a professional service to CalOptima Health, and the requestor represents that the request is the Minimum Necessary information for the stated purpose; or

   b. Another Covered Entity requests the information.

E. The Privacy Officer or Designee shall make a determination on the request and authorize, or deny, the request for the release of the PHI/PII, in whole or part, based on the above criteria and relevant Federal and California law including, but not limited to, those related to:

1. Elder abuse;

2. Persons with Human Immunodeficiency Virus (HIV)/Acquired Immunodeficiency Syndrome (AIDS);

3. Family planning;

4. Immunization status;

5. Reproductive health care;

6. Substance Use Disorder (SUD) Patient Records;

7. Child Health and Disability Prevention Program (CHDP) screening, including blood, lead, substance abuse, mental health, and developmental disabilities; or

8. Other sensitive health information, as needed.

F. Knowledge of a violation or potential violation of this policy shall be reported directly to the Privacy Officer, or the CalOptima Health Compliance and Ethics Hotline at 1-855-507-1805.

G. Documentation:

1. CalOptima Health shall record all Disclosures pursuant to the standard Disclosure tracking procedure, in accordance with CalOptima Health Policy HH.3006: Tracking and Reporting Disclosures of Protected Health Information (PHI).

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

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G. CalOptima Health Policy HH.3015: Authorization for Release of Protected Health Information
H. CalOptima Health Policy ITS.1000: Information Security Program
I. CalOptima Health Policy ITS.1201: Technical Safeguards – Access Controls
J. CalOptima Health Policy ITS.1202 Technical Safeguards – Data Control
K. NCQA Standard MED4 Privacy and Confidentiality
L. Title 45, Code of Federal Regulations, §164.501
M. Title 45, Code of Federal Regulations, §164.502(b)
N. Title 45, Code of Federal Regulations, §164.514(d)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
06/12/2014	Department of Health Care Services (DHCS)	Approved as Submitted
01/26/2022	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
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VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/01/2003	HH.3002	Minimum Necessary Uses and Disclosure of Protected Health Information	Medi-Cal
Revised	04/01/2007	HH.3002	Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls	Medi-Cal

Action	Date	Policy	Policy Title	Program(s)
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Revised	01/01/2013	HH.3002	Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls	Medi-Cal OneCare
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Revised	11/01/2014	HH.3002	Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls	Medi-Cal
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Revised	12/06/2018	HH.3002	Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.3002	Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.3002	Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.3002	Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	HH.3002	Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls	Medi-Cal OneCare PACE

Action	Date	Policy	Policy Title	Program(s)
Revised	09/01/2023	HH.3002	Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls	Medi-Cal OneCare PACE
Revised	11/07/2024	HH.3002	Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls	Medi-Cal OneCare PACE

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IX. GLOSSARY

Term	Definition
Aid Code	The two (2) character code, defined by the State of California, which identifies the aid category under which a Member is eligible to receive Medi-Cal Covered Services.
Business Associate	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: 1. On behalf of such Covered Entity or of an organized health care arrangement (as defined in this section) in which the Covered Entity participates, but other than in the capacity of a Member of the workforce of such Covered Entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or 2. Provides, other than in the capacity of a Member of the workforce of such Covered Entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such Covered Entity, or to or for an organized health care arrangement in which the Covered Entity participates, where the provision of the service involves the Disclosure of protected health information from such Covered Entity or arrangement, or from another Business Associate of such Covered Entity or arrangement, to the person. A Covered Entity may be a Business Associate of another Covered Entity. Business Associate includes: 1. A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a Covered Entity and that requires access on a routine basis to such protected health information. 2. A person that offers a personal health record to one or more individuals on behalf of a Covered Entity. 3. A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the Business Associate.
CalOptima Health Workforce	This includes any and all employees of CalOptima Health, including all senior management, officers, managers, supervisors and other employed personnel, as well as temporary employees and volunteers.
Capitation Payments	Medi-Cal: The monthly amount paid to a Health Network by CalOptima Health for the delivery of Covered Services to Members, which is determined by multiplying the applicable Capitation Rate by a Health Network's monthly enrollment based upon Aid Code, age, and gender. OneCare: The monthly amount paid to a Health Network by CalOptima Health for the delivery of Covered Services to Members in that Health Network.

Term	Definition
Capitation Rate	Medi-Cal: The per capita rate set by CalOptima Health for the delivery of Covered Services to Members based upon Aid Code, age, and gender. OneCare: The percent of the gross Capitation Payment and any applicable premiums that CalOptima Health receives from Centers of Medicare & Medicaid Services (CMS) or Members on behalf of Members enrolled in a Health Network that is allocated to the Health Network for the delivery of Covered Services.
Centers for Medicare & Medicaid Services (CMS)	The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.
Covered Entity	A health plan, a health care clearinghouse, or a health care Provider who transmits any health information in electronic form in connection with a transaction covered by Title 45, Code of Federal Regulations, Part 160.
Covered 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 Health's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Enhanced Care Management and Community Supports as part of the California Advancing and Innovating Medi-Cal (CalAIM) Initiative (as set forth in the CalAIM 1115 Demonstration & 1915(b) Waiver, DHCS All Plan Letter (APL) 21-012: Enhanced Care Management Requirements and APL 21-017: Community Supports Requirements, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 5.51, beginning with section 14184.100), or other services as authorized by the CalOptima Health 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 Health is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract. PACE: Those services set for the in California Code of Regulations, title 22, chapter 3, article 4, beginning with section 51301, and title 17, division 1, chapter 4, subchapter 13, beginning with Section 6840, unless otherwise specifically excluded under the terms of the DHCS PACE Contract with CalOptima Health, or other services as authorized by the CalOptima Health Board of Directors.
Department of Health Care Services (DHCS)	The California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.

Term	Definition
Designee	A person selected or designated to carry out a duty or role. The assigned Designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Disclosure	Has the meaning in in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
Encounter	Medi-Cal: Any unit of Covered Services provided to a Member by a Health Network regardless of Health Network reimbursement methodology. Such Covered Services include any service provided to a Member, regardless of the service location or Provider, including out-of-network services and sub-capitated and delegated Covered Services. OneCare: Any unit of Covered Service provided to a Member by a Health Network regardless of Health Network reimbursement methodology. These services include any Covered Services provided to a Member, regardless of the service location or Provider, including out-of-network Covered Services and sub-capitated and delegated Covered Services. Encounter data submitted to CalOptima Health should not include denied, adjusted, or duplicate claims.
FACETS™	Licensed software product that supports administrative, claims processing and adjudication, Membership data, and other information needs of managed care organizations.
Health Care Operations	Has the meaning given such term in Section 164.501 of Title 45, Code of Federal Regulations including: activities including quality assessment and improvement activities, care management, professional review, compliance and audits, health insurance underwriting, premium rating and other activities related to a contract and health benefits, management and administration activities, customer services, resolution of internal grievances, business planning, and development and activities related to compliance with the privacy rule.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, and as subsequently amended.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Member	A beneficiary enrolled in a CalOptima Health program.
Minimum Necessary	The principle that a Covered Entity must make reasonable efforts to Use, disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the Use, Disclosure, or request

Term	Definition
Payment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities carried out by CalOptima Health including: 1. Determination of eligibility, risk adjustments based on Member health status and demographics, billing claims management, and collection activities; 2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and 3. Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.
Personally Identifiable Information (PII)	PII is —any information about an individual maintained by an agency, including (1) any information that can be Used to distinguish or trace an individual's identity, such as name, social security number, date and place of birth, mother's maiden name, biometric records, race, ethnicity, language (REL), sexual orientation and gender identity (SOGI); and (2) any other information that is linked or linkable to an individual, such as medical, educational, financial, and employment information.
Protected Health Information (PHI)	Has the meaning in 45, Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be Used to identify the individual. The information was created or received by Cal Optima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Provider	Medi-Cal: A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, or other person or institution that furnishes Covered Services. OneCare: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B.
Required by Law	Has the meaning in 45 Code of Federal Regulations (CFR) Section 164.103 which specifies a mandate contained in law that compels an entity to make a Use or Disclosure of PHI and that is enforceable in a court of law and which are permissible grounds for a Covered Entity to Use of Disclose PHI under 45 CFR Section 164.512(a) when relevant requirements are met.

Term	Definition
Treatment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care Providers; and coordination with third parties for services related to the management of the Member's health care benefits.
Use	Has the meaning in 45, Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

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Policy:	HH.3008
Title:	**Member Right to Request Confidential Communications**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	*/s/*
Effective Date:	04/01/2003
Revised Date:	11/07/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ PACE ☐ Administrative

I. PURPOSE

This policy describes the process by which a Member may request to receive Confidential Communications from CalOptima Health regarding Protected Health Information (PHI).

II. POLICY

A. CalOptima Health shall permit Members to request and shall accommodate a reasonable written request to receive communications of PHI by alternative means, such as an alternative phone number or at an alternative address, when there is a risk of personal danger to the Member if, PHI is communicated by telephone, or mail to the Member's home, by CalOptima Health.

B. CalOptima Health shall permit Members to request and shall accommodate a reasonable written request to receive communications of PHI by alternative means, such as an alternative phone number or at an alternative address, for Sensitive Services.

C. CalOptima Health may not require an explanation from PACE Participants as to the basis for the request as a condition of providing communications on a confidential basis.

III. PROCEDURE

A. A Member shall complete and submit a Request for Restriction on Manner/Method of Confidential Communications Form ~~in person~~ to CalOptima Health's Customer Service Department, which will be routed to~~:~~ the Privacy Department for review.

~~Attn: Office of Compliance - Privacy~~
~~CalOptima Health~~
~~505 City Parkway West~~
~~Orange CA 92868~~

B. CalOptima Health's Customer Service Department may assist the Member, or the Member's Personal Representative, in completing the Request for Restriction on Manner/Method of Confidential Communications Form.

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C. With the exclusion of PACE Participants, CalOptima Health shall only grant a request for Confidential Communications in cases in which the Member:

1. Clearly states that the disclosure of all or part of that information could endanger the Member by receiving CalOptima Health information at home; and

2. Provides a valid alternate physical mailing address for written communications, and/or specified phone number for calls and/or voicemail messages from CalOptima Health.

D. The Privacy Officer or Designee shall review all written requests for Confidential Communications and shall be responsible for coordinating the review, logistics of implementing the request, and the response to the Member.

E. The Privacy Officer or Designee shall coordinate requests from Members who are enrolled in a Health Network, or other Business Associates, as appropriate.

F. If the request involves contracted Providers, the Privacy Officer or Designee may ask the Member to submit a separate confidential communication request to the Member's Providers.

G. The Privacy Officer or Designee shall notify the Member of the decision regarding the request for Confidential Communications as expeditiously as possible, but no later than thirty (30) calendar days of the receipt of the request.

H. If the Privacy Officer or Designee approves the request, he or she shall notify the following departments of the Member's Confidential Communications status:

Department	Potential Communication Materials Subject to Confidential Treatment
Customer Service	Newsletters, notices regarding preventive health visits, enrollment, Health Network options, or other mass or individual Member mailings, including surveys.
Grievance and Appeals Resolutions	Communication regarding follow-ups or investigation of a Member, Health Network, or Provider complaints.
Care Coordination, Multipurpose Senior Services Program (MSSP), Long Term Care (LTC)	Any care management, disease interventions, notices of actions, or other communications involving contact with the Member.
Pharmacy	Any notice of actions (NOAs), clinical pharmacy issues, or other direct contact with the Member. Communication regarding Pharmacy Authorization notices, transition letters, Explanation of Benefits and Part D information.
Utilization Management or Member's Health Network	Communication regarding authorization status, approval letters, notice of action letters.
Information Technology Services	Provider Portal

I. If the Privacy Officer or Designee approves the request, he or she shall notify the Information Technology Services (ITS) Department, whereby ITS shall flag the Member's record on the core data systems and/or the healthcare management information system to indicate a Confidential Communication status. Impacted departments will also be notified to ensure appropriate flags are reflected in the relevant information system.

J. All written requests shall be retained for ten (10) years and in accordance with CalOptima Health Policy HH.2022: Record Retention and Access.

IV. ATTACHMENT(S)

A. Request for Restriction on Manner/Method of Confidential Communications Form

V. REFERENCE(S)

A. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Health PACE Program Agreement
D. CalOptima Health Compliance Plan
E. CalOptima Health Privacy Program
F. CalOptima Health Policy HH.2022: Record Retention and Access
G. CalOptima Health Policy HH.3000: Notice of Privacy Practices
H. Department of Managed Health Care (DMHC) APL 22-010 (OPL) Guidance Regarding AB 1184 - Confidentiality of Medical Information
I. Title 45, Code of Federal Regulations (C.F.R), §§164.502(h) and 164.522(b)(1)(2) and (b)(2)(iii)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
03/19/2012	Department of Health Care Services (DHCS)	Approved as Submitted
07/02/2013	Department of Health Care Services (DHCS)	Approved as Submitted
01/19/2022	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
12/01/2022	Regular Meeting of the CalOptima Health Board of Directors
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/01/2003	HH.3008	Member Right to Request Confidential Communications	Medi-Cal
Revised	04/01/2007	HH.3008	Member Right to Request Confidential Communications	Medi-Cal
Revised	02/01/2008	HH.3008	Member Right to Request Confidential Communications	Medi-Cal

Action	Date	Policy	Policy Title	Program(s)
Revised	02/01/2012	HH.3008	Member Right to Request Confidential Communications	Medi-Cal
Revised	02/01/2013	HH.3008	Member Right to Request Confidential Communications	Medi-Cal OneCare
Revised	09/01/2015	HH.3008	Member Right to Request Confidential Communications	Medi-Cal
Revised	12/01/2016	HH.3008	Member Right to Request Confidential Communications	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.3008	Member Right to Request Confidential Communications	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.3008	Member Right to Request Confidential Communications	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.3008	Member Right to Request Confidential Communications	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.3008	Member Right to Request Confidential Communications	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.3008Δ	Member Right to Request Confidential Communications	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	HH.3008	Member Right to Request Confidential Communications	Medi-Cal OneCare PACE
Revised	09/01/2023	HH.3008	Member Right to Request Confidential Communications	Medi-Cal OneCare PACE
Revised	11/07/2024	HH.3008	Member Right to Request Confidential Communications	Medi-Cal OneCare PACE

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IX. GLOSSARY

Term	Definition
Business Associates	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: 1. On behalf of such covered entity or of an organized health care arrangement (as defined in this section) in which the covered entity participates, but other than in the capacity of a Member of the workforce of such covered entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or 2. Provides, other than in the capacity of a Member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of protected health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person. A covered entity may be a business associate of another covered entity. Business associate includes: 1. A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a covered entity and that requires access on a routine basis to such protected health information. 2. A person that offers a personal health record to one or more individuals on behalf of a covered entity. 3. A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the business associate.
Confidential Communications	The provision of communications of Protected Health Information (PHI) by alternative means or at alternative locations based upon a Member's reasonable request.
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.
FACETS	Licensed software product that supports administrative, claims processing and adjudication, Membership data, and other information needs of managed care organizations.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Member	A beneficiary enrolled in a CalOptima Health program.

Term	Definition
Personal Representative	~~Medi-Cal: A person designated by the Member, or a person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors.~~ ~~OneCare:~~ Has the meaning given to the term Personal Representative in section 164.502(g) of Title 45 of, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting in loco parentis who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Health Policy HH.3009: Access by Member's Authorized Representative.
Protected Health Information (PHI)	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. Individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima Health or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Provider	~~Medi-Cal: A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, or other person or institution that furnishes Covered Services.~~ Medi-Cal: Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so. OneCare: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B.
Sensitive Services	Those Covered Services related to family planning, a sexually transmitted disease (STD), abortion, and Human Immunodeficiency Virus (HIV) testing.

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Policy:	HH.3008
Title:	**Member Right to Request Confidential Communications**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	*/s/*
Effective Date:	04/01/2003
Revised Date:	11/07/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ PACE ☐ Administrative

I. PURPOSE

This policy describes the process by which a Member may request to receive Confidential Communications from CalOptima Health regarding Protected Health Information (PHI).

II. POLICY

A. CalOptima Health shall permit Members to request and shall accommodate a reasonable written request to receive communications of PHI by alternative means, such as an alternative phone number or at an alternative address, when there is a risk of personal danger to the Member if, PHI is communicated by telephone, or mail to the Member's home, by CalOptima Health.

B. CalOptima Health shall permit Members to request and shall accommodate a reasonable written request to receive communications of PHI by alternative means, such as an alternative phone number or at an alternative address, for Sensitive Services.

C. CalOptima Health may not require an explanation from PACE Participants as to the basis for the request as a condition of providing communications on a confidential basis.

III. PROCEDURE

A. A Member shall complete and submit a Request for Restriction on Manner/Method of Confidential Communications Form to CalOptima Health's Customer Service Department, which will be routed to the Privacy Department for review.

B. CalOptima Health's Customer Service Department may assist the Member, or the Member's Personal Representative, in completing the Request for Restriction on Manner/Method of Confidential Communications Form.

C. With the exclusion of PACE Participants, CalOptima Health shall only grant a request for Confidential Communications in cases in which the Member:

1. Clearly states that the disclosure of all or part of that information could endanger the Member by receiving CalOptima Health information at home; and

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2. Provides a valid alternate physical mailing address for written communications, and/or specified phone number for calls and/or voicemail messages from CalOptima Health.

D. The Privacy Officer or Designee shall review all written requests for Confidential Communications and shall be responsible for coordinating the review, logistics of implementing the request, and the response to the Member.

E. The Privacy Officer or Designee shall coordinate requests from Members who are enrolled in a Health Network, or other Business Associates, as appropriate.

F. If the request involves contracted Providers, the Privacy Officer or Designee may ask the Member to submit a separate confidential communication request to the Member's Providers.

G. The Privacy Officer or Designee shall notify the Member of the decision regarding the request for Confidential Communications as expeditiously as possible, but no later than thirty (30) calendar days of the receipt of the request.

H. If the Privacy Officer or Designee approves the request, he or she shall notify the following departments of the Member's Confidential Communications status:

Department	Potential Communication Materials Subject to Confidential Treatment
Customer Service	Newsletters, notices regarding preventive health visits, enrollment, Health Network options, or other mass or individual Member mailings, including surveys.
Grievance and Appeals Resolutions	Communication regarding follow-ups or investigation of a Member, Health Network, or Provider complaints.
Care Coordination, Multipurpose Senior Services Program (MSSP), Long Term Care (LTC)	Any care management, disease interventions, notices of actions, or other communications involving contact with the Member.
Pharmacy	Any notice of actions (NOAs), clinical pharmacy issues, or other direct contact with the Member. Communication regarding Pharmacy Authorization notices, transition letters, Explanation of Benefits and Part D information.
Utilization Management or Member's Health Network	Communication regarding authorization status, approval letters, notice of action letters.
Information Technology Services	Provider Portal

I. If the Privacy Officer or Designee approves the request, he or she shall notify the Information Technology Services (ITS) Department, whereby ITS shall flag the Member's record on the core data systems and/or the healthcare management information system to indicate a Confidential Communication status. Impacted departments will also be notified to ensure appropriate flags are reflected in the relevant information system.

J. All written requests shall be retained for ten (10) years and in accordance with CalOptima Health Policy HH.2022: Record Retention and Access.

IV. ATTACHMENT(S)

A. Request for Restriction on Manner/Method of Confidential Communications Form

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V. REFERENCE(S)

A. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Health PACE Program Agreement
D. CalOptima Health Compliance Plan
E. CalOptima Health Privacy Program
F. CalOptima Health Policy HH.2022: Record Retention and Access
G. CalOptima Health Policy HH.3000: Notice of Privacy Practices
H. Department of Managed Health Care (DMHC) APL 22-010 (OPL) Guidance Regarding AB 1184 - Confidentiality of Medical Information
I. Title 45, Code of Federal Regulations (C.F.R), §§164.502(h) and 164.522(b)(1)(2) and (b)(2)(iii)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
03/19/2012	Department of Health Care Services (DHCS)	Approved as Submitted
07/02/2013	Department of Health Care Services (DHCS)	Approved as Submitted
01/19/2022	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
12/01/2022	Regular Meeting of the CalOptima Health Board of Directors
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/01/2003	HH.3008	Member Right to Request Confidential Communications	Medi-Cal
Revised	04/01/2007	HH.3008	Member Right to Request Confidential Communications	Medi-Cal
Revised	02/01/2008	HH.3008	Member Right to Request Confidential Communications	Medi-Cal
Revised	02/01/2012	HH.3008	Member Right to Request Confidential Communications	Medi-Cal
Revised	02/01/2013	HH.3008	Member Right to Request Confidential Communications	Medi-Cal OneCare
Revised	09/01/2015	HH.3008	Member Right to Request Confidential Communications	Medi-Cal

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Action	Date	Policy	Policy Title	Program(s)
Revised	12/01/2016	HH.3008	Member Right to Request Confidential Communications	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.3008	Member Right to Request Confidential Communications	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.3008	Member Right to Request Confidential Communications	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.3008	Member Right to Request Confidential Communications	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.3008	Member Right to Request Confidential Communications	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.3008Δ	Member Right to Request Confidential Communications	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	HH.3008	Member Right to Request Confidential Communications	Medi-Cal OneCare PACE
Revised	09/01/2023	HH.3008	Member Right to Request Confidential Communications	Medi-Cal OneCare PACE
Revised	11/07/2024	HH.3008	Member Right to Request Confidential Communications	Medi-Cal OneCare PACE

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IX. GLOSSARY

Term	Definition
Business Associates	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: 1. On behalf of such covered entity or of an organized health care arrangement (as defined in this section) in which the covered entity participates, but other than in the capacity of a Member of the workforce of such covered entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or 2. Provides, other than in the capacity of a Member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of protected health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person. A covered entity may be a business associate of another covered entity. Business associate includes: 1. A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a covered entity and that requires access on a routine basis to such protected health information. 2. A person that offers a personal health record to one or more individuals on behalf of a covered entity. 3. A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the business associate.
Confidential Communications	The provision of communications of Protected Health Information (PHI) by alternative means or at alternative locations based upon a Member's reasonable request.
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.
FACETS	Licensed software product that supports administrative, claims processing and adjudication, Membership data, and other information needs of managed care organizations.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Member	A beneficiary enrolled in a CalOptima Health program.

Term	Definition
Personal Representative	Has the meaning given to the term Personal Representative in section 164.502(g) of Title 45 of, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting in loco parentis who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Health Policy HH.3009: Access by Member's Authorized Representative.
Protected Health Information (PHI)	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. Individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima Health or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Provider	Medi-Cal: Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so. OneCare: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B.
Sensitive Services	Those Covered Services related to family planning, a sexually transmitted disease (STD), abortion, and Human Immunodeficiency Virus (HIV) testing.

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Request for Restriction on Manner/Method of Confidential Communications Form

Date of Request: _____

Member Name: _____ Date of Birth: _____

Member CIN: _____ Telephone Number: _____

You may request to receive confidential communications of Protected Health Information (PHI) by different ways or to a different address. For instance, you may not want your health records or your member information to go to your home where a family member might see it.

We will agree to these requests when there is a risk of personal harm to you because of Protected Health Information (PHI) sent from CalOptima Health.

☐ **I request that CalOptima Health not to send any communications regarding my Protected Health Information (PHI) to the address or telephone number of record on enrollment information due to the danger to myself.**

The other address or method of reaching me is (you must provide an alternate address in order for CalOptima Health to accommodate your request for Confidential Communication):

Address: _____ Apt. #: _____

City: _____ State: _____ Zip Code: _____

YOUR RIGHTS:

For more information about your privacy rights, please refer to your copy of the CalOptima Health Notice of Privacy Practices. A copy can be found on our website or from CalOptima Health's Customer Service Department by calling **1-714-246-8500** or toll-free at **1-888-587-8088**, Monday through Friday from 8:00 a.m. to 5:30 p.m. Members with hearing or speech impairments can call our TTY at **711**. We have staff who can speak your language.

If you believe your privacy rights have been violated, you may file a complaint with CalOptima Health or with the secretary of the Department of Health and Human Services. To file a complaint with CalOptima Health, contact CalOptima Health Customer Service Department at 1-714-246-8500 or write to:

Attn: Customer Service Department
CalOptima Health
505 City Parkway West
Orange CA 92868

CalOptima Health cannot take away your health care benefits or do anything to hurt you in any way if you choose to file a complaint or use any of the privacy rights in this Notice.

SIGNATURE:

Member Signature: _____

If Authorized Representative (please include legal documentation):

Print Name: _____ Relationship to Member: _____

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Policy:	HH.3010
Title:	**Protected Health Information Disclosures Permitted and Required by Law**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	*/s/*
Effective Date:	04/01/2003
Revised Date:	11/07/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ PACE ☐ Administrative

I. PURPOSE

This policy describes the manner in which CalOptima Health Uses and Discloses Protected Health Information (PHI) as permitted by ~~the Health Insurance Portability and Accountability Act (HIPAA)~~HIPAA and as required by law.

II. POLICY

A. CalOptima Health may not Use or Disclose PHI, except as permitted, or required, by HIPAA.

B. CalOptima Health shall Disclose PHI:

1. To the Member when requested under, and as required by, the Member's access and accounting rights set forth in Title 45, Code of Federal Regulations~~,~~ (CFR), Sections 164.524 and 164.528(i); or

2. When required by the Secretary of the Department of Health and Human Services (HHS) to investigate, or determine, CalOptima Health's compliance with HIPAA.

C. CalOptima Health may Use or Disclose PHI to the extent that such Use or Disclosure is required by law and the Use or Disclosure is limited to the relevant requirements of such law and complies with HIPAA requirements specifically related to such Uses or Disclosures, as provided in Title 45~~, Code of Federal Regulations,~~ CFR Section 164.512(a)(2).

D. CalOptima Health shall comply with the Welfare and Institutions Code, Section 14100.2 and Title 22, California Code of Regulations (CCR), Section 51009 in making permitted Uses or Disclosures required by law under Title 45~~, Code of Federal Regulations,~~ CFR Section 164.512(a). Compliance with these laws extends beyond Member PHI and includes all confidential Member information (e.g., the fact that the Member is a Medi-Cal/Medicare recipient). In the event that CalOptima Health makes a Use or Disclosure required by law, it must first determine that the Use or Disclosure is for the purpose directly connected with the administration of the Medi-Cal/Medicare program.

E. Except for Uses and Disclosures described under Section III.B., Uses and Disclosures of Member PHI sought, demanded, or otherwise requested by any non-Member party by any

means including through subpoenas, document requests, court orders, informal inquiries, etc. that fall within this Policy shall be immediately referred to CalOptima Health's Legal Counsel for review and handling.

F. CalOptima Health will not Use or Disclose PHI related to lawful Reproductive Health Care for the purpose of:

1. Conducting a criminal, civil, or administrative investigation into any person for the mere act of seeking, obtaining, providing, or facilitating Reproductive Health Care;

2. Imposing criminal, civil, or administrative liability on any person for the mere act of seeking, obtaining, providing, or facilitating Reproductive Health Care; or

3. To identify any person for any purpose previously described (each a prohibited purpose) without Member authorization, in accordance Title 45 CFR, Section 164.502(a)(5)(iii).

III. PROCEDURE

A. HIPAA required Uses and Disclosures

1. Member requests involving the Use or Disclosure of PHI under the Member's HIPAA access and accounting rights shall be governed by CalOptima Health Policies HH.3001: Member Access to Designated Record Set and HH.3005: Member Request for an Accounting of Disclosures.

2. If CalOptima Health receives a request from Department of Health and Human Services (DHHS) for Member PHI to investigate, or determine, CalOptima Health's compliance with HIPAA, such requests, or demands, shall be immediately referred to CalOptima Health's Privacy Officer. CalOptima Health's Privacy Officer shall notify CalOptima Health's Legal Counsel of such requests and seek guidance in order to comply with such requests.

B. Permitted Uses and Disclosures required by Law

1. CalOptima Health shall comply with requirements to maintain the confidentiality of all types of information concerning a Member which information shall not be open for examination, except as directly connected with the administration of CalOptima Health programs.

2. Purposes directly connected to the administration of the CalOptima Health's programs encompasses those administrative activities and responsibilities in which the Centers for Medicare and Medicaid (CMS) and/or the Department of Health Care Services (DHCS) and CalOptima Health are required to engage in order to ensure effective program operations including, without limitation:

a. Establishing eligibility and methods of reimbursement;

b. Determining the amount of medical assistance;

c. Providing services;

d. Conducting or assisting in investigations, prosecution, or civil or criminal proceedings related to the administration of CalOptima Health's programs; and

e. Conducting or assisting a legislative investigation, or audit, related to the administration of CalOptima Health's programs.

3. CalOptima Health may Disclose Member confidential information including PHI and other identifying information, without the Member's Authorization only if and to the extent that CalOptima Health first determines that the Disclosure is directly related to the administration of CalOptima Health's programs and is otherwise permitted under Welfare & Institutions Code~~,~~ Section 14100.2 and Title 22, California Code of Regulations, 51009. The Disclosure must also meet the following requirements, as applicable to the Use or Disclosure:~~-~~

   a. In the course of any judicial proceeding, in response to a court order, provided that the PHI Disclosed is limited to that specifically authorized by the court order.

   b. In the course of any administrative proceeding, in response to an order of an administrative tribunal, provided that the PHI Disclosed is limited to that specifically authorized by the administrative tribunal order.

   c. In response to a subpoena, discovery request, or other lawful process, that is not accompanied by an order of a court or administrative tribunal if:

      i. In connection with a state civil action, or proceeding, and certain administrative proceedings, the party seeking the PHI by civil subpoena duces tecum has complied with the service and notice requirements of California Code of Civil Procedure (CCP) Section 1985.3, which requires actual notice to the individual. In such cases, CalOptima Health shall examine the subpoena for compliance with CCP Section 1987.3; or~~-~~

      ii. In cases where CCP Section 1985.3 is not applicable, CalOptima Health has received satisfactory assurance as defined by HIPAA from the party seeking the PHI that it has notified the Member that is the subject of the PHI, with enough information about the litigation, or proceeding, so that the Member can raise an objection to the court or administrative tribunal; and the time for the Member to raise an objection with the court or tribunal has expired, and that there were no objections, or all objections were resolved by the court of administrative tribunal, and the PHI requested is consistent with that resolution. ~~-~~In such cases, CalOptima Health shall review the written statement and accompanying documentation submitted by the party seeking the PHI to determine compliance with these requirements; or~~-~~

      iii. CalOptima Health receives satisfactory assurance from the party seeking the PHI that the parties to the dispute, or proceeding, have agreed to a qualified protective order, within the meaning of Title 45~~, Code of Federal Regulations~~ CFR , Section 164.512(e), and have presented it to the court or administrative tribunal, or the party seeking the PHI provides proof that a qualified protective order, within the meaning of Title 45, ~~Code of Federal Regulations,~~CFR Section 164.512(e), has been issued by the court, or administrative tribunal. In such cases, CalOptima Health shall review the written statement and accompanying documentation submitted by the party seeking the PHI to determine compliance with these requirements.

   d. In compliance with and as limited by the relevant requirements of an administrative

request, including an administrative subpoena or summons, a civil or authorized investigative demand, or a similar process authorized under law, provided that:

i. The information sought is relevant and material to a legitimate law enforcement inquiry;

ii. The request is specific, and limited in scope to the extent reasonable for which the information is sought; and

iii. De-identified information could not reasonably be Used.

e. In compliance with, and as limited by, the relevant requirements of a court-ordered search warrant, or a grand jury subpoena;

f. For other law enforcement purposes such as:

i. Limited information for identification and location purposes;

ii. A law enforcement official's request for information related to victims of a crime;

iii. About a person who has died to alert law enforcement of the death, if the death is suspected to have resulted from criminal conduct; and-

iv. To report crimes in emergencies.

v. Disclosures under this Section shall comply with the applicable provisions of Title ~~42, Code of Federal Regulations,~~45 CFR Section 164.512(f)(2) and any relevant State laws that are more protective of the individual.

g. Disclosures about victims of Abuse, neglect, or domestic violence are addressed in CalOptima Health Policies GG.1320: Elder or Dependent Adult Abuse Reporting and GG.1706: Child Abuse Report.

h. Other circumstances when specifically required by law provided that such Uses and Disclosures are in compliance with such law and limited to the relevant requirements of such law.

4. CalOptima Health will require an attestation for a Use or Disclose of Reproductive Health Care related PHI for a non-prohibited purpose if the requested release of Reproductive Health Care-related information is for: (i) health oversight activities under Title 45 CFR Section 164.512(d); (ii) judicial or administrative proceedings under Title 45 CFR Section 164.512(e); (iii) disclosures for law enforcement purposes under Title 45 CFR Section 164.512(f); or (iv) disclosures about decedents to coroners and medical examiners under Title 45 CFR Section 164.512(g)(1). The attestation will comply with the following requirements:

a. The attestation will be in plain language and include the following elements:

i. A description of the information requested that identifies either:

a) The name of the individual(s) whose PHI is sought, if practicable; or

b) A description of the class of individuals whose PHI is sought.

ii. A name or other specific identification of the person(s), or class of persons, that are requested to make the Use or Disclosure (i.e., CalOptima Health).

iii. A name or other specific identification of the person(s), or class of persons, to whom the Use or Disclosure is made.

iv. A clear statement that the Use or Disclosure is not for a prohibited purpose.

v. A statement that a person may be subject to criminal penalties pursuant to Title 42 United States Code (USC) 1320d-6 if that person knowingly and in violation of HIPAA obtains individually identifiable health information relating to an individual or discloses individually identifiable health information to another person.

vi. A signature (either electronic or handwritten) of the person requesting the PHI and a date of signature. If the attestation is signed by a representative of the person requesting the information, a description of such representative's authority to act for the person must also be provided.

b. The attestation must not contain statements or other information not required by Title 45 CFR Section 164.509.

c. CalOptima Health will immediately stop any Uses or Disclosures made pursuant to an attestation if it discovers information reasonably showing that any representation in the attestation was materially false, leading to a Use or Disclosure for a prohibited purpose.

~~4.~~5. State and Federal laws governing Uses and Disclosures required by law including those related to Disclosure of PHI to law enforcement are complex and may implicate multiple laws relevant to the particular circumstances. In responding to any requests, demands, orders or requests under Section III.B.3., CalOptima Health shall also comply with state and federal laws governing specially protected categories of PHI including mental health and developmental disability information, HIV test results, substance Abuse records, and psychotherapy notes.

~~5.~~6. CalOptima Health shall also comply with other state requirements relevant to the release of PHI in the context of civil and criminal state and federal proceedings, or to law enforcement.

~~6.~~7. All Uses and Disclosures of Member PHI and/or other confidential information sought, demanded, or otherwise requested by any non-Member party shall be immediately referred to CalOptima Health's Legal Counsel for review and handling.

~~7.~~8. All Uses and Disclosures made under this policy shall be referred to the Privacy Officer and shall be recorded, in accordance with CalOptima Health Policy HH.3006: Tracking Disclosures of Protected Health Information.

IV. ATTACHMENT(S)

~~Not Applicable~~

A. Attestation Regarding Requested Use or Disclosure of Protected Health Information Potentially Related to Reproductive Health Care

V. REFERENCE(S)

A. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Health PACE Program Agreement
D. CalOptima Health Compliance Plan
E. CalOptima Health Policy GG.1320: Elder or Dependent Adult Abuse Reporting
F. CalOptima Health Policy GG.1706: Child Abuse Report
G. CalOptima Health Policy HH.3001: Member Access to Designated Record Set
H. CalOptima Health Policy HH.3005: Member Request for an Accounting of Disclosures
I. CalOptima Health Policy HH.3006: Tracking Disclosures of Protected Health Information
J. California Code of Civil Procedure §1985.3 & §1987.3
K. Civil Code §56.30(b)
L. Title 22, California Code of Regulations (C.C.R.), §51009
M. Title 45, Code of Federal Regulations, §§164.501; 164.502(a), (b); 164.509; 164.512(a), (c), (e) and (f); ~~1654~~164.524 and 164.528(i) or (ii)
N. Welfare & Institutions Code, §14100.2
O. Title 42 United States Code (USC) 1320d-6

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/01/2003	HH.3010	Protected Health Information-Disclosures Required by Law	Medi-Cal
Revised	07/01/2007	HH.3010	Protected Health Information Disclosures Required by Law	Medi-Cal
Revised	09/01/2015	HH.3010	Protected Health Information-Disclosures Required by Law	Medi-Cal
Revised	12/01/2016	HH.3010	Protected Health Information-Disclosures Required by Law	Medi-Cal OneCare OneCare Connect PACE

Action	Date	Policy	Policy Title	Program(s)
Revised	12/07/2017	HH.3010	Protected Health Information- Disclosures Required by Law	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.3010	Protected Health Information- Disclosures Required by Law	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.3010	Protected Health Information Disclosures Required by Law	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.3010	Protected Health Information Disclosures Required by Law	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.3010	Protected Health Information Disclosures Required by Law	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	HH.3010	Protected Health Information- Disclosures Required by Law	Medi-Cal OneCare PACE
Revised	09/01/2023	HH.3010	Protected Health Information Disclosures Required by Law	Medi-Cal OneCare PACE
Revised	11/07/2024	HH.3010	Protected Health Information Disclosures Permitted and Required by Law	Medi-Cal OneCare PACE

IX. GLOSSARY

Term	Definition
Abuse	Medi-Cal: A Provider practice that is inconsistent with sound fiscal, business, or medical practice, and results in an unnecessary cost to CalOptima Health and the Medi-Cal program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to CalOptima Health and the Medi-Cal program. OneCare: A Provider practice that is inconsistent with sound fiscal, business, or medical practice, and results in an unnecessary cost to CalOptima Health and the OneCare program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to CalOptima Health and the OneCare program.
Centers for Medicare & Medicaid Services (CMS)	The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.
Department of Health Care Services (DHCS)	The California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.
Disclosure	Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information as subsequently amended.
Member	A beneficiary enrolled in a CalOptima Health Program.
~~Minimum Necessary~~Protected Health Information (PHI)	~~The principle that a covered entity must make reasonable efforts to Use, Disclose, and request only~~Has the ~~minimum amount~~meaning in 45 Code of ~~protected~~Federal Regulations Section 160.103, including the following: individually identifiable health information ~~needed to accomplish the intended purpose of the Use, Disclose~~transmitted by electronic media, maintained in electronic media, or ~~request for Treatment, Payment,~~transmitted or maintained in any other form or medium. This information identifies the individual or there is a reasonable basis to believe the information can be Used to identify the individual. The information was created or received by CalOptima Health or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; ~~1.~~2.The provision of health care to a Member; or ~~2.~~3.Past, present, or future Payment for the provision of health care to a Member.~~Care Operations.~~

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Term	Definition
~~Protected~~Reproductive Health ~~Information (PHI)~~Care	Has the meaning in Title 45 (Code of Federal Regulations) CFR, Section 160.103, including the following: ~~individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium.~~ ~~This information identifies~~health care, as defined at Title 45 CFR, Section 160.103, that affects the health of an individual ~~or there is a reasonable basis~~in all matters relating to ~~believe~~ the ~~information can be Used to identify the individual. The information was created or received by CalOptima Health or Business Associates~~reproductive system and ~~relates to:~~ ~~The past, present, or future physical or mental health or condition of a Member;~~ ~~The provision of health care to a Member; or~~ to its functions and processes. ~~Past, present, or future Payment for the provision of health care to a Member.~~
Use	Has the meaning in Title 45 Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

Policy:	HH.3010
Title:	**Protected Health Information Disclosures Permitted and Required by Law**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	*/s/*
Effective Date:	04/01/2003
Revised Date:	11/07/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ PACE ☐ Administrative

I. PURPOSE

This policy describes the manner in which CalOptima Health Uses and Discloses Protected Health Information (PHI) as permitted by HIPAA and as required by law.

II. POLICY

A. CalOptima Health may not Use or Disclose PHI, except as permitted, or required, by HIPAA.

B. CalOptima Health shall Disclose PHI:

1. To the Member when requested under, and as required by, the Member's access and accounting rights set forth in Title 45, Code of Federal Regulations (CFR), Sections 164.524 and 164.528(i); or

2. When required by the Secretary of the Department of Health and Human Services (HHS) to investigate, or determine, CalOptima Health's compliance with HIPAA.

C. CalOptima Health may Use or Disclose PHI to the extent that such Use or Disclosure is required by law and the Use or Disclosure is limited to the relevant requirements of such law and complies with HIPAA requirements specifically related to such Uses or Disclosures, as provided in Title 45 CFR Section 164.512(a)(2).

D. CalOptima Health shall comply with the Welfare and Institutions Code, Section 14100.2 and Title 22, California Code of Regulations (CCR), Section 51009 in making permitted Uses or Disclosures required by law under Title 45 CFR Section 164.512(a). Compliance with these laws extends beyond Member PHI and includes all confidential Member information (e.g., the fact that the Member is a Medi-Cal/Medicare recipient). In the event that CalOptima Health makes a Use or Disclosure required by law, it must first determine that the Use or Disclosure is for the purpose directly connected with the administration of the Medi-Cal/Medicare program.

E. Except for Uses and Disclosures described under Section III.B., Uses and Disclosures of Member PHI sought, demanded, or otherwise requested by any non-Member party by any means including through subpoenas, document requests, court orders, informal inquiries, etc. that fall within this Policy shall be immediately referred to CalOptima Health's Legal Counsel

for review and handling.

F. CalOptima Health will not Use or Disclose PHI related to lawful Reproductive Health Care for the purpose of:

1. Conducting a criminal, civil, or administrative investigation into any person for the mere act of seeking, obtaining, providing, or facilitating Reproductive Health Care;

2. Imposing criminal, civil, or administrative liability on any person for the mere act of seeking, obtaining, providing, or facilitating Reproductive Health Care; or

3. To identify any person for any purpose previously described (each a prohibited purpose) without Member authorization, in accordance Title 45 CFR, Section 164.502(a)(5)(iii).

III. PROCEDURE

A. HIPAA required Uses and Disclosures

1. Member requests involving the Use or Disclosure of PHI under the Member's HIPAA access and accounting rights shall be governed by CalOptima Health Policies HH.3001: Member Access to Designated Record Set and HH.3005: Member Request for an Accounting of Disclosures.

2. If CalOptima Health receives a request from Department of Health and Human Services (DHHS) for Member PHI to investigate, or determine, CalOptima Health's compliance with HIPAA, such requests, or demands, shall be immediately referred to CalOptima Health's Privacy Officer. CalOptima Health's Privacy Officer shall notify CalOptima Health's Legal Counsel of such requests and seek guidance in order to comply with such requests.

B. Permitted Uses and Disclosures required by Law

1. CalOptima Health shall comply with requirements to maintain the confidentiality of all types of information concerning a Member which information shall not be open for examination, except as directly connected with the administration of CalOptima Health programs.

2. Purposes directly connected to the administration of the CalOptima Health's programs encompasses those administrative activities and responsibilities in which the Centers for Medicare and Medicaid (CMS) and/or the Department of Health Care Services (DHCS) and CalOptima Health are required to engage in order to ensure effective program operations including, without limitation:

a. Establishing eligibility and methods of reimbursement;

b. Determining the amount of medical assistance;

c. Providing services;

d. Conducting or assisting in investigations, prosecution, or civil or criminal proceedings related to the administration of CalOptima Health's programs; and

e. Conducting or assisting a legislative investigation, or audit, related to the administration of CalOptima Health's programs.

3. CalOptima Health may Disclose Member confidential information including PHI and other identifying information, without the Member's Authorization only if and to the extent that CalOptima Health first determines that the Disclosure is directly related to the administration of CalOptima Health's programs and is otherwise permitted under Welfare & Institutions Code Section 14100.2 and Title 22, California Code of Regulations, 51009. The Disclosure must also meet the following requirements, as applicable to the Use or Disclosure:

   a. In the course of any judicial proceeding, in response to a court order, provided that the PHI Disclosed is limited to that specifically authorized by the court order.

   b. In the course of any administrative proceeding, in response to an order of an administrative tribunal, provided that the PHI Disclosed is limited to that specifically authorized by the administrative tribunal order.

   c. In response to a subpoena, discovery request, or other lawful process, that is not accompanied by an order of a court or administrative tribunal if:

      i. In connection with a state civil action, or proceeding, and certain administrative proceedings, the party seeking the PHI by civil subpoena duces tecum has complied with the service and notice requirements of California Code of Civil Procedure (CCP) Section 1985.3, which requires actual notice to the individual. In such cases, CalOptima Health shall examine the subpoena for compliance with CCP Section 1987.3; or

      ii. In cases where CCP Section 1985.3 is not applicable, CalOptima Health has received satisfactory assurance as defined by HIPAA from the party seeking the PHI that it has notified the Member that is the subject of the PHI, with enough information about the litigation, or proceeding, so that the Member can raise an objection to the court or administrative tribunal; and the time for the Member to raise an objection with the court or tribunal has expired, and that there were no objections, or all objections were resolved by the court of administrative tribunal, and the PHI requested is consistent with that resolution. In such cases, CalOptima Health shall review the written statement and accompanying documentation submitted by the party seeking the PHI to determine compliance with these requirements; or

      iii. CalOptima Health receives satisfactory assurance from the party seeking the PHI that the parties to the dispute, or proceeding, have agreed to a qualified protective order, within the meaning of Title 45 CFR , Section 164.512(e), and have presented it to the court or administrative tribunal, or the party seeking the PHI provides proof that a qualified protective order, within the meaning of Title 45, CFR Section 164.512(e), has been issued by the court, or administrative tribunal. In such cases, CalOptima Health shall review the written statement and accompanying documentation submitted by the party seeking the PHI to determine compliance with these requirements.

   d. In compliance with and as limited by the relevant requirements of an administrative request, including an administrative subpoena or summons, a civil or authorized investigative demand, or a similar process authorized under law, provided that:

      i. The information sought is relevant and material to a legitimate law

enforcement inquiry;

ii. The request is specific, and limited in scope to the extent reasonable for which the information is sought; and

iii. De-identified information could not reasonably be Used.

e. In compliance with, and as limited by, the relevant requirements of a court-ordered search warrant, or a grand jury subpoena;

f. For other law enforcement purposes such as:

i. Limited information for identification and location purposes;

ii. A law enforcement official's request for information related to victims of a crime;

iii. About a person who has died to alert law enforcement of the death, if the death is suspected to have resulted from criminal conduct; and

iv. To report crimes in emergencies.

v. Disclosures under this Section shall comply with the applicable provisions of Title 45 CFR Section 164.512(f)(2) and any relevant State laws that are more protective of the individual.

g. Disclosures about victims of Abuse, neglect, or domestic violence are addressed in CalOptima Health Policies GG.1320: Elder or Dependent Adult Abuse Reporting and GG.1706: Child Abuse Report.

h. Other circumstances when specifically required by law provided that such Uses and Disclosures are in compliance with such law and limited to the relevant requirements of such law.

4. CalOptima Health will require an attestation for a Use or Disclose of Reproductive Health Care related PHI for a non-prohibited purpose if the requested release of Reproductive Health Care-related information is for: (i) health oversight activities under Title 45 CFR Section 164.512(d); (ii) judicial or administrative proceedings under Title 45 CFR Section 164.512(e); (iii) disclosures for law enforcement purposes under Title 45 CFR Section 164.512(f); or (iv) disclosures about decedents to coroners and medical examiners under Title 45 CFR Section 164.512(g)(1). The attestation will comply with the following requirements:

a. The attestation will be in plain language and include the following elements:

i. A description of the information requested that identifies either:

a) The name of the individual(s) whose PHI is sought, if practicable; or

b) A description of the class of individuals whose PHI is sought.

ii. A name or other specific identification of the person(s), or class of persons, that are requested to make the Use or Disclosure (i.e., CalOptima Health).

iii. A name or other specific identification of the person(s), or class of persons, to whom the Use or Disclosure is made.

iv. A clear statement that the Use or Disclosure is not for a prohibited purpose.

v. A statement that a person may be subject to criminal penalties pursuant to Title 42 United States Code (USC) 1320d-6 if that person knowingly and in violation of HIPAA obtains individually identifiable health information relating to an individual or discloses individually identifiable health information to another person.

vi. A signature (either electronic or handwritten) of the person requesting the PHI and a date of signature. If the attestation is signed by a representative of the person requesting the information, a description of such representative's authority to act for the person must also be provided.

b. The attestation must not contain statements or other information not required by Title 45 CFR Section 164.509.

c. CalOptima Health will immediately stop any Uses or Disclosures made pursuant to an attestation if it discovers information reasonably showing that any representation in the attestation was materially false, leading to a Use or Disclosure for a prohibited purpose.

5. State and Federal laws governing Uses and Disclosures required by law including those related to Disclosure of PHI to law enforcement are complex and may implicate multiple laws relevant to the particular circumstances. In responding to any requests, demands, orders or requests under Section III.B.3., CalOptima Health shall also comply with state and federal laws governing specially protected categories of PHI including mental health and developmental disability information, HIV test results, substance Abuse records, and psychotherapy notes.

6. CalOptima Health shall also comply with other state requirements relevant to the release of PHI in the context of civil and criminal state and federal proceedings, or to law enforcement.

7. All Uses and Disclosures of Member PHI and/or other confidential information sought, demanded, or otherwise requested by any non-Member party shall be immediately referred to CalOptima Health's Legal Counsel for review and handling.

8. All Uses and Disclosures made under this policy shall be referred to the Privacy Officer and shall be recorded, in accordance with CalOptima Health Policy HH.3006: Tracking Disclosures of Protected Health Information.

IV. ATTACHMENT(S)

A. Attestation Regarding Requested Use or Disclosure of Protected Health Information Potentially Related to Reproductive Health Care

V. REFERENCE(S)

A. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage

B. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Health PACE Program Agreement
D. CalOptima Health Compliance Plan
E. CalOptima Health Policy GG.1320: Elder or Dependent Adult Abuse Reporting
F. CalOptima Health Policy GG.1706: Child Abuse Report
G. CalOptima Health Policy HH.3001: Member Access to Designated Record Set
H. CalOptima Health Policy HH.3005: Member Request for an Accounting of Disclosures
I. CalOptima Health Policy HH.3006: Tracking Disclosures of Protected Health Information
J. California Code of Civil Procedure §1985.3 & §1987.3
K. Civil Code §56.30(b)
L. Title 22, California Code of Regulations (C.C.R.), §51009
M. Title 45, Code of Federal Regulations, §§164.501; 164.502(a), (b); 164.509; 164.512(a), (c), (e) and (f); 164.524 and 164.528(i) or (ii)
N. Welfare & Institutions Code, §14100.2
O. Title 42 United States Code (USC) 1320d-6

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/01/2003	HH.3010	Protected Health Information Disclosures Required by Law	Medi-Cal
Revised	07/01/2007	HH.3010	Protected Health Information Disclosures Required by Law	Medi-Cal
Revised	09/01/2015	HH.3010	Protected Health Information Disclosures Required by Law	Medi-Cal
Revised	12/01/2016	HH.3010	Protected Health Information Disclosures Required by Law	Medi-Cal OneCareOneCare Connect PACE
Revised	12/07/2017	HH.3010	Protected Health Information Disclosures Required by Law	Medi-Cal OneCareOneCare Connect PACE
Revised	12/06/2018	HH.3010	Protected Health Information Disclosures Required by Law	Medi-Cal OneCare OneCare ConnectPACE

Action	Date	Policy	Policy Title	Program(s)
Revised	12/05/2019	HH.3010	Protected Health Information Disclosures Required by Law	Medi-CalOneCareOneCare Connect PACE
Revised	12/03/2020	HH.3010	Protected Health Information Disclosures Required by Law	Medi-CalOneCareOneCare Connect PACE
Revised	12/20/2021	HH.3010	Protected Health Information Disclosures Required by Law	Medi-CalOneCareOneCare Connect PACE
Revised	12/31/2022	HH.3010	Protected Health Information Disclosures Required by Law	Medi-Cal OneCarePACE
Revised	09/01/2023	HH.3010	Protected Health Information Disclosures Required by Law	Medi-CalOneCare PACE
Revised	11/07/2024	HH.3010	Protected Health Information Disclosures Permitted and Required by Law	Medi-Cal OneCare PACE

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IX. GLOSSARY

Term	Definition
Abuse	Medi-Cal: A Provider practice that is inconsistent with sound fiscal, business, or medical practice, and results in an unnecessary cost to CalOptima Health and the Medi- Cal program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to CalOptima Health and the Medi-Cal program. OneCare: A Provider practice that is inconsistent with sound fiscal, business, or medical practice, and results in an unnecessary cost to CalOptima Health and the OneCare program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to CalOptima Health and the OneCare program.
Centers for Medicare & Medicaid Services (CMS)	The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.
Department of Health Care Services (DHCS)	The California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as Medi-Cal.
Disclosure	Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information as subsequently amended.
Member	A beneficiary enrolled in a CalOptima Health Program.
Protected Health Information (PHI)	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is a reasonable basis to believe the information can be Used to identify the individual. The information was created or received by CalOptima Health or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Reproductive Health Care	Has the meaning in Title 45 (Code of Federal Regulations) CFR, Section 160.103, including the following: health care, as defined at Title 45 CFR, Section 160.103, that affects the health of an individual in all matters relating to the reproductive system and to its functions and processes.

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Term	Definition
Use	Has the meaning in Title 45 Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

Attestation Regarding Requested Use or Disclosure of Protected Health Information Potentially Related to Reproductive Health Care

When CalOptima Health receives a request for protected health information (PHI) potentially related to reproductive health care, it must obtain a signed attestation that clearly states the requested use or disclosure is not for the prohibited purposes described below, where the request is for PHI for any of the following purposes:

- Health oversight activities
- Judicial or administrative proceedings
- Law enforcement
- Regarding decedents, disclosures to coroners and medical examiners

Prohibited Purposes. CalOptima Health and its business associates may not use or disclose PHI for the following purposes:

(1) To conduct a criminal, civil, or administrative investigation into any person for the mere act of seeking, obtaining, providing, or facilitating lawful reproductive health care.[1]
(2) To impose criminal, civil, or administrative liability on any person for the mere act of seeking, obtaining, providing, or facilitating lawful reproductive health care.
(3) To identify any person for any purpose described in (1) or (2).

The prohibition applies when the reproductive health care at issue (1) is lawful under the law of the state in which such health care is provided under the circumstances in which it is provided, (2) is protected, required, or authorized by Federal law, including the United States Constitution, under the circumstances in which such health care is provided, regardless of the state in which it is provided, or (3) is provided by another person and presumed lawful.

Instructions

Information for the Person Requesting the PHI

- By signing this attestation, you are verifying that you are not requesting PHI for a prohibited purpose and acknowledging that criminal penalties may apply if untrue.
- You may not add content that is not required or combine this form with another document except where another document is needed to support your statement that the requested disclosure is not for a prohibited purpose. For example, if the requested PHI is potentially related to reproductive health care that was provided by someone other than the covered entity or business associate from whom you are requesting the PHI, you may submit a document that supplies information that demonstrates a substantial factual basis that the reproductive health care in question was not lawful under the specific circumstances in which it was provided.

[1] Reproductive health care means health care that affects the health of an individual in all matters relating to the reproductive system and to its functions and processes.

Information for the Covered Entity or Business Associate

- You may not rely on the attestation to disclose the requested PHI if any of the following is true:
  - It is missing any required element or statement or contains other content that is not required.
  - It is combined with other documents, except for documents provided to support the attestation.
  - You know that material information in the attestation is false.
  - A reasonable covered entity or business associate in the same position would not believe the requestor's statement that the use or disclosure is not for a prohibited purpose as described above.
- If you later discover information that reasonably shows that any representation made in the attestation is materially false, leading to a use or disclosure for a prohibited purpose as described above, you must stop making the requested use or disclosure.
- You may not make a disclosure if the reproductive health care was provided by a person other than yourself and the requestor indicates that the PHI requested is for a prohibited purpose as described above, unless the requestor supplies information that demonstrates a substantial factual basis that the reproductive health care was not lawful under the specific circumstances in which it was provided.
- You must obtain a new attestation for each specific use or disclosure request.
- You must maintain a written copy of the completed attestation and any relevant supporting documents.

Attestation Regarding a Requested Use or Disclosure of Protected Health Information Potentially Related to Reproductive Health Care

The entire form must be completed for the attestation to be valid.

Name of person(s) or specific identification of the class of persons to receive the requested PHI.
Name or other specific identification of the person or class of persons from whom you are requesting the use or disclosure (i.e., CalOptima Health or PACE).
Description of specific PHI requested, including name(s) of individual(s), if practicable, or a description of the class of individuals, whose protected health information you are requesting.

I attest that the use or disclosure of PHI that I am requesting is not for a purpose prohibited by the HIPAA Privacy Rule at 45 CFR 164.502(a)(5)(iii) because of one of the following (check one box):

☐ The purpose of the use or disclosure of protected health information is **not** to investigate or impose liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care or to identify any person for such purposes.

☐ The purpose of the use or disclosure of protected health information **is** to investigate or impose liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care, or to identify any person for such purposes, but the reproductive health care at issue was **not lawful** under the circumstances in which it was provided.

I understand that I may be subject to criminal penalties pursuant to 42 U.S.C. 1320d-6 if I knowingly and in violation of HIPAA obtain individually identifiable health information relating to an individual or disclose individually identifiable health information to another person.

Signature of the person requesting the PHI

_____ Date _____

If you have signed as a representative of the person requesting PHI*, provide a description of your authority to act for that person.*

_____

This attestation document may be provided in electronic format, and electronically signed by the person requesting protected health information when the electronic signature is valid under applicable Federal and state law.

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Policy:	HH.3014
Title:	**Use of Electronic Mail with Protected Health Information (PHI) and Personally Identifiable Information (PII)**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	*/s/*
Effective Date:	04/01/2003
Revised Date:	11/07/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ PACE ☐ Administrative

I. PURPOSE

This policy describes CalOptima Health's procedures related to the Use of electronic mail (email) to send information containing Protected Health Information (PHI) and Personally Identifiable Information (PII).

II. POLICY

A. CalOptima Health, its Business Associates, and First Tier, Downstream, and Related Entities (FDRs) shall send email containing PHI/PII as follows:

1. Internal email

~~a.~~ Email sent within CalOptima Health's mail system may contain PHI/PII that is limited to the Use and Disclosure of the Minimum Necessary data to complete the required message, in accordance with CalOptima Health Policy HH.3002: Minimum Necessary ~~Use~~Uses and Disclosure of Protected Health Information~~.~~

a. (PHI) and Document Controls.

b. PHI/PII (e.g., Member name, Social Security Number, Client Index Number [CIN]) shall not be included in the subject line of the email.

2. External email sent on the Internet

a. Email that CalOptima Health or a Business Associate sends to an external entity via the open Internet shall not contain PHI/PII unless the email, or attachment, has been encrypted to prevent anyone, other than the intended receiver, from reading the contents.

b. Email that CalOptima Health or a Business Associate sends to an outside entity may contain PHI/PII that is limited to the Use and Disclosure of the Minimum Necessary data to complete the required message, in accordance with CalOptima Health Policy HH.3002: Minimum Necessary ~~Use~~Uses and Disclosure of Protected Health Information and Document Controls.

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c. PHI/PII (e.g., Member name, Social Security Number, Client Index Number [CIN]) shall not be included in the subject line of the email.

B. CalOptima Health staff shall appropriately use information and Information Technology (IT) resources and security of those resources when performing procedures related to the Use of email to send information containing PHI/PII, in accordance with CalOptima Health Policy GA.5005a: Acceptable Use of Technology Resources.

~~B.~~C. CalOptima Health staff shall follow instructions for Use of email, as set forth in CalOptima Health Policy GA.5005b: ~~E-mail~~Email and Internet Use.

III. PROCEDURE

A. Communications via email sent through the open Internet requires Encryption to prevent unauthorized access to PHI/PII, in accordance with CalOptima Health Policy ~~IS~~ITS.1202: ~~EPHI~~ Technical Safeguards – Data Controls.

B. CalOptima Health employees and Business Associates shall immediately report any suspected or known Security Incidents, Breach, and/or other unauthorized access, Use or Disclosure of PHI/~~PI~~PII to the CalOptima Health Privacy Officer, or Designee, in accordance with CalOptima Health Policy HH.3020: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/~~PI~~PII or other Unauthorized Use or Disclosure of PHI/~~PI~~PII.

C. CalOptima Health employees shall not save or store data files in an electronic format that contain PHI/PII on public or private computers, unencrypted personal removable storage devices, personal cloud storage, and/or personal email accounts, in accordance with CalOptima Health Policy HH.3016: Guidelines for Handling Protected Health Information (PHI) Off-site.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Health PACE Program Agreement
D. CalOptima Health Compliance Plan
E. CalOptima Health Policy GA.5005a: Acceptable Use of Technology Resources
F. CalOptima Health Policy GA.5005b: E-mail and Internet Use
G. CalOptima Health Policy HH.3002: Minimum Necessary ~~Use~~Uses and Disclosure of Protected Health Information (PHI) and Document Controls
H. CalOptima Health Policy HH.3016: Guidelines for Handling Protected Health Information (PHI) Off-site
I. CalOptima Health Policy HH.3020: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/~~PI~~PII or other Unauthorized Use or Disclosure of PHI/~~PI~~PII
J. CalOptima Health Policy ~~IS~~ITS.1202: ~~EPHI~~ Technical Safeguards – Data Controls

VI. REGULATORY AGENCY APPROVAL(S)

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Date	Regulatory Agency	Response
09/17/2009	Department of Health Care Services (DHCS)	Approved as Submitted
07/16/2010	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/01/2003	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal
Revised	04/01/2007	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal
Revised	01/01/2008	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal
Revised	01/01/2009	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal
Revised	06/01/2010	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal
Revised	01/01/2011	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal
Revised	04/01/2013	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal OneCare
Revised	05/01/2014	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal
Revised	09/01/2015	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal
Revised	12/01/2016	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal OneCare OneCare Connect PACE

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Action	Date	Policy	Policy Title	Program(s)
Revised	12/05/2019	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal OneCare PACE
Revised	09/01/2023	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal OneCare PACE
Revised	11/07/2024	HH.3014	Use of Electronic Mail with Protected Health Information (PHI) and Personally Identifiable Information (PII)	Medi-Cal OneCare PACE

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IX. GLOSSARY

Term	Definition
Breach	Has the meaning in 45, Code of Federal Regulations Section 164.402. The acquisition, access, Use, or Disclosure of protected health information in a manner not permitted under subpart E of this part which compromises the security or privacy of the protected health information. ~~(1)~~ Breach excludes: 1. ~~(i)~~ Any unintentional acquisition, access, or Use of protected health information by a workforce member or person acting under the authority of a covered entity or a Business Associate, if such acquisition, access, or Use was made in good faith and within the scope of authority and does not result in further Use or Disclosure in a manner not permitted under subpart E of this part. 2. ~~(ii)~~ Any inadvertent Disclosure by a person who is authorized to access protected health information at a covered entity or Business Associate to another person authorized to access protected health information at the same covered entity or Business Associate, or organized health care arrangement in which the covered entity participates, and the information received as a result of such Disclosure is not further Used or Disclosed in a manner not permitted under subpart E of this part. 3. ~~(iii)~~ A Disclosure of protected health information where a covered entity or Business Associate has a good faith belief that an unauthorized person to whom the Disclosure was made would not reasonably have been able to retain such information
Business Associate	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: 1. On behalf of such covered entity or of an organized health care arrangement (as defined in this section) in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or 2. Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the Disclosure of protected health information from such covered entity or arrangement, or from another Business Associate of such covered entity or arrangement, to the person. A covered entity may be a Business Associate of another covered entity.

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Term	Definition
	Business Associate includes: 1. A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a covered entity and that requires access on a routine basis to such protected health information. 2. A person that offers a personal health record to one or more individuals on behalf of a covered entity. 3. A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the Business Associate
Disclosure	Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
Encryption	The Use of an algorithmic process to transform data into a form in which there is a low probability of assigning meaning without Use of a confidential process or key or a method of converting an original message of regular text into encoded or unreadable text that is eventually decrypted into plan comprehensible text.
First Tier, Downstream and Related Entities (FDR)	For purposes of this policy, FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
Health Network	For purposes of this policy, the contracted Health Networks of CalOptima Health, including Physician Hospital Consortia ("PHCs"), Shared Risk Medical Groups ("SRGs"), and Health Maintenance Organizations ("HMOs").
Member	A beneficiary enrolled in a CalOptima Health Program.
Minimum Necessary	The principle that a covered entity must make reasonable efforts to Use, Disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the Use, Disclosure, or request for Treatment, Payment or Health Care Operations.
~~Personally Identifiable Information (PII)~~	~~PII is —any information about an individual maintained by an agency, including (1) any information that can be Used to distinguish or trace an individual's identity, such as name, social security number, date and place of birth, mother's maiden name, or biometric records; and (2) any other information that is linked or linkable to an individual, such as medical, educational, financial, and employment information.~~
Protected Health Information (PHI)	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. Individually identifiable health information identifies the individual or there is reasonable basis to believe the information can be Used to identify the individual. The information was created or received by ~~Cal Optima~~CalOptima Health or Business Associates and relates to:

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Term	Definition
	1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Security Incident	Has the meaning in 45 Code of Federal Regulations Section 164.304. The attempted or successful unauthorized access, Use, Disclosure, modification, or destruction of information or interference with system operations in an information system.
Unsecured PHI/~~PI~~PII	Has the meaning in 45 Code of Federal Regulations Section 164.402. Protected Health Information that is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the Use of a technology or methodology specified by the Secretary in the guidance issued under section 13402(h)(2) of Public Law 111-5.
Personally Identifiable Information (PII)	Any information about an individual maintained by an agency, including (1) any information that can be Used to distinguish or trace an individual's identity, such as name, social security number, date and place of birth, mother's maiden name, biometric records, race, ethnicity, language (REL), sexual orientation and gender identity (SOGI); and (2) any other information that is linked or linkable to an individual, such as medical, educational, financial, and employment information.
Use	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

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Policy:	HH.3014
Title:	**Use of Electronic Mail with Protected Health Information (PHI) and Personally Identifiable Information (PII)**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	*/s/*
Effective Date:	04/01/2003
Revised Date:	11/07/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ PACE ☐ Administrative

I. PURPOSE

This policy describes CalOptima Health's procedures related to the Use of electronic mail (email) to send information containing Protected Health Information (PHI) and Personally Identifiable Information (PII).

II. POLICY

A. CalOptima Health, its Business Associates, and First Tier, Downstream, and Related Entities (FDRs) shall send email containing PHI/PII as follows:

1. Internal email

   a. Email sent within CalOptima Health's mail system may contain PHI/PII that is limited to the Use and Disclosure of the Minimum Necessary data to complete the required message, in accordance with CalOptima Health Policy HH.3002: Minimum Necessary Uses and Disclosure of Protected Health Information (PHI) and Document Controls.

   b. PHI/PII (e.g., Member name, Social Security Number, Client Index Number [CIN]) shall not be included in the subject line of the email.

2. External email sent on the Internet

   a. Email that CalOptima Health or a Business Associate sends to an external entity via the open Internet shall not contain PHI/PII unless the email, or attachment, has been encrypted to prevent anyone, other than the intended receiver, from reading the contents.

   b. Email that CalOptima Health or a Business Associate sends to an outside entity may contain PHI/PII that is limited to the Use and Disclosure of the Minimum Necessary data to complete the required message, in accordance with CalOptima Health Policy HH.3002: Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls.

   c. PHI/PII (e.g., Member name, Social Security Number, Client Index Number [CIN]) shall not be included in the subject line of the email.

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B. CalOptima Health staff shall appropriately use information and Information Technology (IT) resources and security of those resources when performing procedures related to the Use of email to send information containing PHI/PII, in accordance with CalOptima Health Policy GA.5005a: Acceptable Use of Technology Resources.

C. CalOptima Health staff shall follow instructions for Use of email, as set forth in CalOptima Health Policy GA.5005b: Email and Internet Use.

III. PROCEDURE

A. Communications via email sent through the open Internet requires Encryption to prevent unauthorized access to PHI/PII, in accordance with CalOptima Health Policy ITS.1202: Technical Safeguards – Data Controls.

B. CalOptima Health employees and Business Associates shall immediately report any suspected or known Security Incidents, Breach, and/or other unauthorized access, Use or Disclosure of PHI/PII to the CalOptima Health Privacy Officer, or Designee, in accordance with CalOptima Health Policy HH.3020: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PII or other Unauthorized Use or Disclosure of PHI/PII.

C. CalOptima Health employees shall not save or store data files in an electronic format that contain PHI/PII on public or private computers, unencrypted personal removable storage devices, personal cloud storage, and/or personal email accounts, in accordance with CalOptima Health Policy HH.3016: Guidelines for Handling Protected Health Information (PHI) Off-site.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Health PACE Program Agreement
D. CalOptima Health Compliance Plan
E. CalOptima Health Policy GA.5005a: Acceptable Use of Technology Resources
F. CalOptima Health Policy GA.5005b: E-mail and Internet Use
G. CalOptima Health Policy HH.3002: Minimum Necessary Uses and Disclosure of Protected Health Information (PHI) and Document Controls
H. CalOptima Health Policy HH.3016: Guidelines for Handling Protected Health Information (PHI) Off-site
I. CalOptima Health Policy HH.3020: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PII or other Unauthorized Use or Disclosure of PHI/PII
J. CalOptima Health Policy ITS.1202: Technical Safeguards – Data Controls

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
09/17/2009	Department of Health Care Services (DHCS)	Approved as Submitted

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07/16/2010	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/01/2003	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal
Revised	04/01/2007	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal
Revised	01/01/2008	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal
Revised	01/01/2009	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal
Revised	06/01/2010	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal
Revised	01/01/2011	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal
Revised	04/01/2013	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal OneCare
Revised	05/01/2014	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal
Revised	09/01/2015	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal
Revised	12/01/2016	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal OneCare OneCare Connect PACE

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Action	Date	Policy	Policy Title	Program(s)
Revised	12/03/2020	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal OneCare PACE
Revised	09/01/2023	HH.3014	Use of Electronic Mail with Protected Health Information	Medi-Cal OneCare PACE
Revised	11/07/2024	HH.3014	Use of Electronic Mail with Protected Health Information (PHI) and Personally Identifiable Information (PII)	Medi-Cal OneCare PACE

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IX. GLOSSARY

Term	Definition
Breach	Has the meaning in 45, Code of Federal Regulations Section 164.402. The acquisition, access, Use, or Disclosure of protected health information in a manner not permitted under subpart E of this part which compromises the security or privacy of the protected health information. Breach excludes: 1. Any unintentional acquisition, access, or Use of protected health information by a workforce member or person acting under the authority of a covered entity or a Business Associate, if such acquisition, access, or Use was made in good faith and within the scope of authority and does not result in further Use or Disclosure in a manner not permitted under subpart E of this part. 2. Any inadvertent Disclosure by a person who is authorized to access protected health information at a covered entity or Business Associate to another person authorized to access protected health information at the same covered entity or Business Associate, or organized health care arrangement in which the covered entity participates, and the information received as a result of such Disclosure is not further Used or Disclosed in a manner not permitted under subpart E of this part. 3. A Disclosure of protected health information where a covered entity or Business Associate has a good faith belief that an unauthorized person to whom the Disclosure was made would not reasonably have been able to retain such information
Business Associate	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: 1. On behalf of such covered entity or of an organized health care arrangement (as defined in this section) in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or 2. Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the Disclosure of protected health information from such covered entity or arrangement, or from another Business Associate of such covered entity or arrangement, to the person. A covered entity may be a Business Associate of another covered entity.

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Term	Definition
	Business Associate includes: 1. A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a covered entity and that requires access on a routine basis to such protected health information. 2. A person that offers a personal health record to one or more individuals on behalf of a covered entity. 3. A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the Business Associate
Disclosure	Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
Encryption	The Use of an algorithmic process to transform data into a form in which there is a low probability of assigning meaning without Use of a confidential process or key or a method of converting an original message of regular text into encoded or unreadable text that is eventually decrypted into plan comprehensible text.
First Tier, Downstream and Related Entities (FDR)	For purposes of this policy, FDR includes delegated entities, contracted providers, Health Networks, Physician Medical Groups, Physician Hospital Consortia, and Health Maintenance Organizations.
Health Network	For purposes of this policy, the contracted Health Networks of CalOptima Health, including Physician Hospital Consortia ("PHCs"), Shared Risk Medical Groups ("SRGs"), and Health Maintenance Organizations ("HMOs").
Member	A beneficiary enrolled in a CalOptima Health Program.
Minimum Necessary	The principle that a covered entity must make reasonable efforts to Use, Disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the Use, Disclosure, or request for Treatment, Payment or Health Care Operations.
Protected Health Information (PHI)	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. Individually identifiable health information identifies the individual or there is reasonable basis to believe the information can be Used to identify the individual. The information was created or received by CalOptima Health or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.

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Term	Definition
Security Incident	Has the meaning in 45 Code of Federal Regulations Section 164.304. The attempted or successful unauthorized access, Use, Disclosure, modification, or destruction of information or interference with system operations in an information system.
Unsecured PHI/PII	Has the meaning in 45 Code of Federal Regulations Section 164.402. Protected Health Information that is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the Use of a technology or methodology specified by the Secretary in the guidance issued under section 13402(h)(2) of Public Law 111-5.
Personally Identifiable Information (PII)	Any information about an individual maintained by an agency, including (1) any information that can be Used to distinguish or trace an individual's identity, such as name, social security number, date and place of birth, mother's maiden name, biometric records, race, ethnicity, language (REL), sexual orientation and gender identity (SOGI); and (2) any other information that is linked or linkable to an individual, such as medical, educational, financial, and employment information.
Use	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

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Policy:	HH.3016
Title:	**Guidelines for Handling Protected Health Information Off-site**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	*/s/*
Effective Date:	04/01/2003
Revised Date:	11/07/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ PACE ☐ Administrative

I. PURPOSE

This policy describes the process for handling Protected Health Information (PHI) created, accessed, or taken off-site from CalOptima Health offices.

II. POLICY

A. CalOptima Health employees shall exercise precautions according to the regulations and standards set by the Health Insurance Portability and Accountability Act (HIPAA) and CalOptima Health policies when handling PHI, or EPHI, created, accessed, or taken off-site from the main office.

III. PROCEDURE

A. General guidelines

1. Staff shall adhere to Minimum Necessary requirements when viewing, documenting, and/or recording information during any work activities that require the Use of Medical Records in facilities.

2. Staff shall not access, use, or disclose any Member PHI via CalOptima Health system without a business need.

~~2.~~3. Staff shall collect all data relative to a Member, whether by interview, observation, or review of documents, in a setting that provides reasonable privacy and protects the information from unauthorized Disclosure.

~~3.~~4. Staff shall protect all physical documents that contain Member PHI from the view, or access, by an unauthorized person during transport from and to the office through Use of:

a. Binders; and/or

b. Folders, or other protective cover; and/or

c. Appropriate vehicle safeguards (e.g., locked in trunk of the vehicle); or

d. Personal possession of Member PHI such that it is in sight at all times.

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~~4.~~5. Staff shall not leave any paper documents containing PHI, or other data collection forms including, without limitation, audit or other data collection forms unattended in areas accessible by an unauthorized person.

~~5.~~6. Staff shall not store confidential, personal, or sensitive information unattended in vehicles at any time.

~~6.~~7. Staff shall not store confidential, personal, or sensitive information unattended in baggage, at any time, during travel.

~~7.~~8. Staff shall not save or store data files in an electronic format that contain PHI on public, or private, computers, unencrypted personal removable storage devices, personal cloud storage, and/or personal email accounts.

~~8.~~9. Staff shall not Use mobile devices of any kind to take and save photos of information and/or images containing PHI.

~~9.~~10. Staff shall maintain physical control of CalOptima Health laptops, cell phones, tablets, USB drives, and all other mobile devices at all times.

~~10.~~11. Staff shall only Use CalOptima Health-issued encrypted storage devices to store files containing PHI, in accordance with CalOptima Health Policy GA.5005a: Use of Technology Resources.

~~11.~~12. Staff shall shred PHI documents, or files, prior to disposal. If necessary, staff shall return documents, or files, to the main office for disposal.

B. Use of Personal Computer (PC) from remote locations

1. If applicable, employees granted access to CalOptima Health's networks are required to adhere to the following procedures:

   a. Maintain the Confidentiality of his or her user sign-on identification code and password;

   b. Keep the PC secure at all times and do not leave it unattended during travel to, or working off-site at, public places (e.g., hospitals, Long Term Care (LTC) facilities, conferences, etc.);

   c. Log off the CalOptima Health network, or lock computer, when the PC will be left inactive, or unattended; and

   d. Ensure that passwords, or operating instructions for accessing the CalOptima Health systems, are not stored with the computer.

C. CalOptima Health employees, Business Associates, and First Tier, Downstream, and Related Entities (FDRs) shall report any Security Incidents, Breaches of Unsecured PHI/PI and/or other unauthorized access, Use, or Disclosure, of PHI/PI immediately after discovery during a workweek to the CalOptima Health Privacy Officer, in accordance with CalOptima Health Policy HH.3020: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other unauthorized Use or Disclosure of PHI/PI.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Health PACE Program Agreement
D. CalOptima Health Compliance Plan
E. CalOptima Health Policy GA.5005a: Use of Technology Resources
F. CalOptima Health Policy HH.3020: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI
G. CalOptima Health Policy IS.1102: Electronic Media, Electronic Storage Device and Hardware Controls
H. CalOptima Health Policy IS.1201: EPHI Technical Safeguards - Access Controls
I. Health Administrative Manual
J. Title 45, Code of Federal Regulations (C.F.R.), §164.103
K. Title 45, Code of Federal Regulations (C.F.R.), §164.502(b)
L. Title 45, Code of Federal Regulations (C.F.R.), §164.530(c)(1)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
09/21/2009	Department of Health Care Services (DHCS)	Approved as Submitted
07/16/2010	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program
Effective	04/01/2003	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal
Revised	04/01/2007	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal
Revised	01/01/2009	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal
Revised	06/01/2010	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal

Action	Date	Policy	Policy Title	Program
Revised	04/01/2013	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal
Revised	09/01/2015	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal
Revised	12/01/2016	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal OneCare PACE
Revised	09/01/2023	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal OneCare PACE
Revised	11/07/2024	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal OneCare PACE

IX. GLOSSARY

Term	Definition
Access Controls	Controls that identify and authenticate a User to allow access to confidential information and Protected Health Information (PHI) based on a business need to know. Access Controls protect the computer systems from unauthorized access as well as determine the type of access a User is entitled to have.
Breach	Has the meaning in 45, Code of Federal Regulations Section 164.402. The acquisition, access, Use, or Disclosure of protected health information in a manner not permitted under subpart E of this part which compromises the security or privacy of the protected health information. Breach excludes: 1. Any unintentional acquisition, access, or Use of protected health information by a workforce Member or person acting under the authority of a covered entity or a Business Associate, if such acquisition, access, or Use was made in good faith and within the scope of authority and does not result in further Use or Disclosure in a manner not permitted under subpart E of this part. 2. Any inadvertent Disclosure by a person who is authorized to access protected health information at a covered entity or Business Associate to another person authorized to access protected health information at the same covered entity or Business Associate, or organized health care arrangement in which the covered entity participates, and the information received as a result of such Disclosure is not further Used or disclosed in a manner not permitted under subpart E of this part. 3. A Disclosure of protected health information where a covered entity or Business Associate has a good faith belief that an unauthorized person to whom the Disclosure was made would not reasonably have been able to retain such information
Business Associate	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: 1. On behalf of such covered entity or of an organized health care arrangement (as defined in this section) in which the covered entity participates, but other than in the capacity of a Member of the workforce of such covered entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or 2. Provides, other than in the capacity of a Member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the Disclosure of protected health information from such covered entity or arrangement, or

Term	Definition
	from another Business Associate of such covered entity or arrangement, to the person. A covered entity may be a Business Associate of another covered entity. Business Associate includes: 1. A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a covered entity and that requires access on a routine basis to such protected health information. 2. A person that offers a personal health record to one or more individuals on behalf of a covered entity. 3. A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the Business Associate
Designee	A person selected or designated to carry out a duty or role. The assigned Designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Disclosure	Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
Downstream Entity	Any party that enters into an acceptable written arrangement below the level of the arrangement between a Medicare Advantage (MA) organization (and contract applicant) and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.
Electronic Protected Health Information (EPHI)	Has the meaning in 45, Code of Federal Regulations Section 160.103. Individually identifiable health information transmitted by electronic media or maintained in electronic media.
Facility	Off-site, CalOptima Health-affiliated locations; any site outside of the 505 City Parkway West building.
First Tier, Downstream, and Related Entities (FDR~~s~~)	Means First Tier, Downstream or Related Entity, as separately defined herein.
First Tier Entity	Any party that enters into a written arrangement, acceptable to CMS, with an MAO or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare eligible individual under the MA program or Part D program.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, and as subsequently amended.
Intrusion	The act of wrongfully (without authorization) entering upon, seizing, or taking possession of computerized data that compromises the security, confidentiality, or integrity of personal information maintained by CalOptima Health or its Business Associates.

Term	Definition
Long Term Care (LTC)	Medi-Cal: Care provided in a skilled nursing facility and sub-acute care services that lasts longer than 60 days. OneCare: A variety of services that help Members with health or personal needs and activities of daily living over a period of time. Long Term Care (LTC) may be provided at home, in the community or in various types of facilities, including nursing homes and assisted living facilities.
Medical Record	Medi-Cal: Any single, complete record kept or required to be kept by any Provider that documents all the medical services received by the Member, including, but not limited to, inpatient, outpatient, and emergency care, referral requests, authorizations, or other documentation as indicated by CalOptima Health policy. OneCare: A Medical Record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is Used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical Records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.
Member	A beneficiary enrolled in a CalOptima Health program.
Minimum Necessary	The principle that covered entity must make reasonable efforts to Use, disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the Use, Disclosure, or request for Treatment, Payment or Health Care Operations.
Prior Authorization	Medi-Cal: A formal process requiring a health care Provider to obtain advance approval of Medically Necessary Covered Services, including the amount, duration and scope of services, except in the case of an emergency. OneCare: A process through which a physician or other health care provider is required to obtain advance approval, from CalOptima Health and/or a delegated entity, that payment will be made for a service or item furnished to a Member. PACE: A formal process requiring a health care provider to obtain advance approval to provide specific services or procedures, or the process by which an IDT approves a member to receive a specific service or procedure.
Personally Identifiable Information (PII)	PII is ―any information about an individual maintained by an agency, including (1) any information that can be Used to distinguish or trace an individual's identity, such as name, social security number, date and place of birth, mother's maiden name, or biometric records; and (2) any other information that is linked or linkable to an individual, such as medical, educational, financial, and employment information.

Term	Definition
Protected Health Information (PHI)	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. Individually identifiable health information identifies the individual or there is reasonable basis to believe the information can be Used to identify the individual. The information was created or received by CalOptima Health or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Related Entity	Any entity that is related to CalOptima Health by common ownership or control and that: performs some of CalOptima Health's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima Health at a cost of more than $2,500 during a contract period.
Security Incident	Has the meaning in 45 Code of Federal Regulations Section 164.304. The attempted or successful unauthorized access, Use, Disclosure, modification, or destruction of information or interference with system operations in an information system.
Unsecured PHI/PI	Has the meaning in 45 Code of Federal Regulations Section 164.402. Protected Health Information that is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of a technology or methodology specified by the Secretary in the guidance issued under Section 13402(h)(2) of Public Law 111-5.
Use	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

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Policy:	HH.3016
Title:	**Guidelines for Handling Protected Health Information Off-site**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	*/s/*
Effective Date:	04/01/2003
Revised Date:	11/07/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ PACE ☐ Administrative

I. PURPOSE

This policy describes the process for handling Protected Health Information (PHI) created, accessed, or taken off-site from CalOptima Health offices.

II. POLICY

A. CalOptima Health employees shall exercise precautions according to the regulations and standards set by the Health Insurance Portability and Accountability Act (HIPAA) and CalOptima Health policies when handling PHI, or EPHI, created, accessed, or taken off-site from the main office.

III. PROCEDURE

A. General guidelines

1. Staff shall adhere to Minimum Necessary requirements when viewing, documenting, and/or recording information during any work activities that require the Use of Medical Records in facilities.

2. Staff shall not access, use, or disclose any Member PHI via CalOptima Health system without a business need.

3. Staff shall collect all data relative to a Member, whether by interview, observation, or review of documents, in a setting that provides reasonable privacy and protects the information from unauthorized Disclosure.

4. Staff shall protect all physical documents that contain Member PHI from the view, or access, by an unauthorized person during transport from and to the office through Use of:

   a. Binders; and/or

   b. Folders, or other protective cover; and/or

   c. Appropriate vehicle safeguards (e.g., locked in trunk of the vehicle); or

   d. Personal possession of Member PHI such that it is in sight at all times.

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5. Staff shall not leave any paper documents containing PHI, or other data collection forms including, without limitation, audit or other data collection forms unattended in areas accessible by an unauthorized person.

6. Staff shall not store confidential, personal, or sensitive information unattended in vehicles at any time.

7. Staff shall not store confidential, personal, or sensitive information unattended in baggage, at any time, during travel.

8. Staff shall not save or store data files in an electronic format that contain PHI on public, or private, computers, unencrypted personal removable storage devices, personal cloud storage, and/or personal email accounts.

9. Staff shall not Use mobile devices of any kind to take and save photos of information and/or images containing PHI.

10. Staff shall maintain physical control of CalOptima Health laptops, cell phones, tablets, USB drives, and all other mobile devices at all times.

11. Staff shall only Use CalOptima Health-issued encrypted storage devices to store files containing PHI, in accordance with CalOptima Health Policy GA.5005a: Use of Technology Resources.

12. Staff shall shred PHI documents, or files, prior to disposal. If necessary, staff shall return documents, or files, to the main office for disposal.

B. Use of Personal Computer (PC) from remote locations

1. If applicable, employees granted access to CalOptima Health's networks are required to adhere to the following procedures:

   a. Maintain the Confidentiality of his or her user sign-on identification code and password;

   b. Keep the PC secure at all times and do not leave it unattended during travel to, or working off-site at, public places (e.g., hospitals, Long Term Care (LTC) facilities, conferences, etc.);

   c. Log off the CalOptima Health network, or lock computer, when the PC will be left inactive, or unattended; and

   d. Ensure that passwords, or operating instructions for accessing the CalOptima Health systems, are not stored with the computer.

C. CalOptima Health employees, Business Associates, and First Tier, Downstream, and Related Entities (FDRs) shall report any Security Incidents, Breaches of Unsecured PHI/PI and/or other unauthorized access, Use, or Disclosure, of PHI/PI immediately after discovery during a workweek to the CalOptima Health Privacy Officer, in accordance with CalOptima Health Policy HH.3020: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other unauthorized Use or Disclosure of PHI/PI.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Health PACE Program Agreement
D. CalOptima Health Compliance Plan
E. CalOptima Health Policy GA.5005a: Use of Technology Resources
F. CalOptima Health Policy HH.3020: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI
G. CalOptima Health Policy IS.1102: Electronic Media, Electronic Storage Device and Hardware Controls
H. CalOptima Health Policy IS.1201: EPHI Technical Safeguards - Access Controls
I. Health Administrative Manual
J. Title 45, Code of Federal Regulations (C.F.R.), §164.103
K. Title 45, Code of Federal Regulations (C.F.R.), §164.502(b)
L. Title 45, Code of Federal Regulations (C.F.R.), §164.530(c)(1)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
09/21/2009	Department of Health Care Services (DHCS)	Approved as Submitted
07/16/2010	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program
Effective	04/01/2003	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal
Revised	04/01/2007	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal
Revised	01/01/2009	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal
Revised	06/01/2010	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal
Revised	04/01/2013	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal

Action	Date	Policy	Policy Title	Program
Revised	09/01/2015	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal
Revised	12/01/2016	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal OneCare PACE
Revised	09/01/2023	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal OneCare PACE
Revised	11/07/2024	HH.3016	Guidelines for Handling Protected Health Information Offsite	Medi-Cal OneCare PACE

IX. GLOSSARY

Term	Definition
Access Controls	Controls that identify and authenticate a User to allow access to confidential information and Protected Health Information (PHI) based on a business need to know. Access Controls protect the computer systems from unauthorized access as well as determine the type of access a User is entitled to have.
Breach	Has the meaning in 45, Code of Federal Regulations Section 164.402. The acquisition, access, Use, or Disclosure of protected health information in a manner not permitted under subpart E of this part which compromises the security or privacy of the protected health information. Breach excludes: 1. Any unintentional acquisition, access, or Use of protected health information by a workforce Member or person acting under the authority of a covered entity or a Business Associate, if such acquisition, access, or Use was made in good faith and within the scope of authority and does not result in further Use or Disclosure in a manner not permitted under subpart E of this part. 2. Any inadvertent Disclosure by a person who is authorized to access protected health information at a covered entity or Business Associate to another person authorized to access protected health information at the same covered entity or Business Associate, or organized health care arrangement in which the covered entity participates, and the information received as a result of such Disclosure is not further Used or disclosed in a manner not permitted under subpart E of this part. 3. A Disclosure of protected health information where a covered entity or Business Associate has a good faith belief that an unauthorized person to whom the Disclosure was made would not reasonably have been able to retain such information
Business Associate	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: 1. On behalf of such covered entity or of an organized health care arrangement (as defined in this section) in which the covered entity participates, but other than in the capacity of a Member of the workforce of such covered entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or 2. Provides, other than in the capacity of a Member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the Disclosure of protected health information from such covered entity or arrangement, or

Term	Definition
	from another Business Associate of such covered entity or arrangement, to the person. A covered entity may be a Business Associate of another covered entity. Business Associate includes: 1. A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a covered entity and that requires access on a routine basis to such protected health information. 2. A person that offers a personal health record to one or more individuals on behalf of a covered entity. 3. A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the Business Associate
Designee	A person selected or designated to carry out a duty or role. The assigned Designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Disclosure	Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
Downstream Entity	Any party that enters into an acceptable written arrangement below the level of the arrangement between a Medicare Advantage (MA) organization (and contract applicant) and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.
Electronic Protected Health Information (EPHI)	Has the meaning in 45, Code of Federal Regulations Section 160.103. Individually identifiable health information transmitted by electronic media or maintained in electronic media.
Facility	Off-site, CalOptima Health-affiliated locations; any site outside of the 505 City Parkway West building.
First Tier, Downstream, and Related Entities (FDR)	Means First Tier, Downstream or Related Entity, as separately defined herein.
First Tier Entity	Any party that enters into a written arrangement, acceptable to CMS, with an MAO or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare eligible individual under the MA program or Part D program.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, and as subsequently amended.
Intrusion	The act of wrongfully (without authorization) entering upon, seizing, or taking possession of computerized data that compromises the security, confidentiality, or integrity of personal information maintained by CalOptima Health or its Business Associates.

Term	Definition
Long Term Care (LTC)	Medi-Cal: Care provided in a skilled nursing facility and sub-acute care services that lasts longer than 60 days. OneCare: A variety of services that help Members with health or personal needs and activities of daily living over a period of time. Long Term Care (LTC) may be provided at home, in the community or in various types of facilities, including nursing homes and assisted living facilities.
Medical Record	Medi-Cal: Any single, complete record kept or required to be kept by any Provider that documents all the medical services received by the Member, including, but not limited to, inpatient, outpatient, and emergency care, referral requests, authorizations, or other documentation as indicated by CalOptima Health policy. OneCare: A Medical Record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is Used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical Records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.
Member	A beneficiary enrolled in a CalOptima Health program.
Minimum Necessary	The principle that covered entity must make reasonable efforts to Use, disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the Use, Disclosure, or request for Treatment, Payment or Health Care Operations.
Prior Authorization	Medi-Cal: A formal process requiring a health care Provider to obtain advance approval of Medically Necessary Covered Services, including the amount, duration and scope of services, except in the case of an emergency. OneCare: A process through which a physician or other health care provider is required to obtain advance approval, from CalOptima Health and/or a delegated entity, that payment will be made for a service or item furnished to a Member. PACE: A formal process requiring a health care provider to obtain advance approval to provide specific services or procedures, or the process by which an IDT approves a member to receive a specific service or procedure.
Personally Identifiable Information (PII)	PII is ―any information about an individual maintained by an agency, including (1) any information that can be Used to distinguish or trace an individual's identity, such as name, social security number, date and place of birth, mother's maiden name, or biometric records; and (2) any other information that is linked or linkable to an individual, such as medical, educational, financial, and employment information.

Term	Definition
Protected Health Information (PHI)	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. Individually identifiable health information identifies the individual or there is reasonable basis to believe the information can be Used to identify the individual. The information was created or received by CalOptima Health or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Related Entity	Any entity that is related to CalOptima Health by common ownership or control and that: performs some of CalOptima Health's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima Health at a cost of more than $2,500 during a contract period.
Security Incident	Has the meaning in 45 Code of Federal Regulations Section 164.304. The attempted or successful unauthorized access, Use, Disclosure, modification, or destruction of information or interference with system operations in an information system.
Unsecured PHI/PI	Has the meaning in 45 Code of Federal Regulations Section 164.402. Protected Health Information that is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of a technology or methodology specified by the Secretary in the guidance issued under Section 13402(h)(2) of Public Law 111-5.
Use	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.

Policy:	HH.3020
Title:	**Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PII or other Unauthorized Use or Disclosure of PHI/PII**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	*/s/*
Effective Date:	07/01/2007
Revised Date:	11/07/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ PACE ☐ Administrative

I. PURPOSE

This policy describes CalOptima Health's policies and procedures for reporting Security Incidents, Breaches of Unsecured Protected Health Information/~~Personal~~Personally Identifiable Information (PHI/~~PI~~PII) and/or other unauthorized access, Use, or Disclosure of PHI/~~PI~~PII to its regulators and providing notice to affected Members and media of Breaches of Unsecured PHI in accordance with contractual and regulatory requirements.

II. POLICY

A. CalOptima Health Employees shall immediately and no later than twenty-four (24) hours from time of discovery report any suspected or known Security Incidents, Breaches of Unsecured PHI/~~PI~~PII and/or other unauthorized access, Use, or Disclosure of PHI/~~PI~~PII to the CalOptima Health Privacy Officer, or Designee, in accordance with this Policy.

B. Business Associates shall notify CalOptima Health of discovery of any known or suspected Security Incidents, Breaches of Unsecured PHI/~~PI~~PII and/or other unauthorized access, Use, or Disclosure of PHI/~~PI~~PII immediately and no later than twenty-four (24) hours from time of discovery. Business Associates shall submit a written report to CalOptima Health of suspected, or known, Security Incidents, Breaches of Unsecured PHI/~~PI~~PII, and/or other unauthorized access, Use or Disclosure of PHI/~~PI~~PII, in accordance with this Policy.

C. CalOptima Health shall investigate such a Security Incident, Breach of Unsecured PHI/~~PI~~PII, and/or other unauthorized access, Use, or Disclosure of PHI/~~PI~~PII and provide a written report of the investigation to the Department of Health Care Services (DHCS) in accordance with this Policy.

D. CalOptima Health shall report Security Incidents, Breaches of Unsecured PHI/~~PI~~PII, or other unauthorized access, Use or Disclosure of PHI/~~PI~~PII to regulators, as required by its regulatory contracts and applicable state and federal laws.

E. CalOptima Health shall notify individual Members whose Unsecured PHI/~~PI~~PII has been or

believed to have been accessed, acquired, Used, or Disclosed as a result of a Breach caused by CalOptima Health, which compromises the security or privacy of the PHI/PII.

F. CalOptima Health shall take appropriate actions to mitigate any harmful effect known to be caused by a Breach of Unsecured PHI/~~PI~~PII in accordance with CalOptima Health policy.

G. Except as otherwise provided in 45 CFR section 164.530(e)(1), CalOptima Health management, at its discretion, shall issue corrective action to Employees and persons in CalOptima Health's Workforce responsible for intentional or negligent actions that result in Security Incidents, Breaches of Unsecured PHI/~~PI~~PII, and/or other unauthorized access, Use, or Disclosure of PHI/~~PI~~PII in accordance with the HIPAA Violation Guidelines Matrix. CalOptima Health shall document any corrective actions that are applied.

H. Business Associates shall comply with CalOptima Health Business Associate Agreement reporting and notice requirements when a Security Incident, or Breach of Unsecured PHI/~~PI~~PII or other unauthorized access, Use, or Disclosure of PHI/~~PI~~PII involves DHCS and/or CalOptima Health PHI/~~PI~~PII.

III. PROCEDURE

A. Discovery

1. CalOptima Health Employees, Health Networks, with the exception of a Health Maintenance Organization (HMO) that satisfies the requirements of Section III.B.2. of this Policy, and Business Associates shall report any Security Incidents, Breaches of Unsecured PHI/~~PI~~PII, and/or other unauthorized access, Use, or Disclosure of PHI/~~PI~~PII immediately and no later than twenty-four (24) hours from time of discovery to the CalOptima Health Privacy Officer or Designee by telephone, fax, or email Privacy@caloptima.org.

   a. Examples of reportable Security Incidents or Breaches are:

      i. Lost or stolen unencrypted electronic devices that contain PHI or ~~PI~~PII;

      ii. Posting PHI or ~~PI~~PII on social media;

      iii. Emailing or saving EPHI to personal accounts and/or publicly accessible accounts;

      iv. Emailing EPHI that is not encrypted;

      v. Cybersecurity or hacking;

      vi. Downloading EPHI to a portable device in violation of CalOptima Health's policies (e.g., without expressed authority and required safeguards (encryption));

      vii. Faxes or emails that contain CalOptima Health PHI are misdirected to an unintended third party due to incorrect fax numbers or emails; and

      viii. Theft of paper records with CalOptima Health PHI from an Employee's vehicle.

B. The CalOptima Health Privacy Officer or Designee shall notify and report the discovery of any known or suspected Security Incidents, Breaches, Unsecured PHI/~~PI~~PII and/or other

unauthorized access, Use, or Disclosure of PHI/~~PI~~PII to DHCS, in accordance with the following guidelines:

1. Notification to DHCS:

   a. CalOptima Health shall notify DHCS immediately and no later than twenty-four (24) hours from the time of discovery of a suspected Breach, Security Incident, or unauthorized access, Use, or disclosure that involves SSA data. This notification will be provided through the DHCS Privacy Incident Reporting Portal . If CalOptima Health is unable to provide notification via the DHCS Privacy Incident Reporting Portal, then CalOptima Health shall provide notice by email or telephone to DHCS.

   b. CalOptima Health shall notify DHCS within twenty-four (24) hours via the DHCS Privacy Incident Reporting Portal (by email or telephone if necessary) of the discovery of:

      i. Unsecured PHI if the PHI is reasonably believed to have been accessed or acquired by an unauthorized person;

      ii. Any suspected Security Incident which risks unauthorized access to PHI and/or other confidential information;

      iii. Any Intrusion or unauthorized access, Use or disclosure of PHI in violation of CalOptima Health's Business Associate Agreement with DHCS; or

      iv. Potential loss of confidential data affecting CalOptima Health's Business Associate Agreement with DHCS;

   c. Notice shall be made via the DHCS Privacy Incident Reporting Portal and shall include all information known at the time the incident is reported.

   d. The CalOptima Health Privacy Officer or Designee shall notify the DHCS Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer via the DHCS Privacy Incident Reporting Portal (by email or telephone, if necessary), as required and within twenty-four (24) hours.

2. Investigation and written report to DHCS:

   a. Within ten (10) working days of the initial discovery, the CalOptima Health Privacy Officer or Designee shall submit a complete investigation report to the DHCS Contract Manager, DHCS Privacy Officer, and DHCS Information Security Officer by using the DHCS Privacy Incident Reporting Portal .

C. CalOptima Health shall notify Members whose Unsecured PHI/PII has been, or is believed to have been, accessed, acquired, Used, or Disclosed as a result of a Breach which compromises the security or privacy of the PHI. All notifications shall be provided without unreasonable delay and no later than sixty (60) calendar days from ~~-~~the date of discovery, which is the first day the Breach is known by a Covered Entity~~,~~ or would have been known by exercising reasonable diligence. CalOptima Health shall provide notification as specified below.

1. CalOptima Health shall write the notification in plain language and include, to the

extent possible:

a. A brief description of what occurred, including the date of the Breach and the date of the discovery of the Breach, if known;

b. A description of the types of Unsecured PHI/~~PI~~PII that were involved in the Breach (e.g., full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information involved);

c. Any steps Members should take to protect themselves from potential harm resulting from the Breach;

d. A brief description of what the Covered Entity is doing to investigate the Breach, to mitigate harm to Members, and to protect against any further Breaches; and

e. Contact procedures for Members to ask questions or learn additional information, which shall include a toll-free telephone number, an email address, website, or postal address.

2. CalOptima Health shall provide notification in the following form:

a. CalOptima Health shall send written notification by first-class mail to the Member at the last known address. CalOptima Health may send written notification by electronic mail if the Member has agreed to receive notice by electronic mail and such agreement has not been withdrawn. CalOptima Health may provide notification in one (1) or more mailings as information is available.

i. If the Member is deceased, CalOptima Health shall provide written notification by first- class mail to either the next of kin, or personal representative of the Member, if contact information is known.

ii. If current contact information is unavailable for fewer than ten (10) Members, CalOptima Health may provide a substitute notice by an alternative form of written notice, telephone, or other means.

iii. If current contact information is unavailable for ten (10) or more Members, CalOptima Health shall provide a substitute notice by a readily visible posting on the homepage of CalOptima Health's website for ninety (90) calendar days or by a readily visible notice in a major print or broadcast media in the geographic areas where the Members affected by the Breach likely reside. The notice shall include a toll-free telephone number that remains active for at least ninety (90) calendar days for Members to obtain information regarding the Breach.

b. If CalOptima Health deems a Breach incident to require urgency because of a possible imminent misuse of Unsecured PHI/~~PI~~PII, CalOptima Health may provide Breach notification to Members by telephone or other means, in addition to written notice.

3. 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.

D. The CalOptima Health Privacy Officer, or Designee, shall notify the Secretary of the U.S. Department of Health and Human Services (HHS) and Centers for Medicare & Medicaid Services (CMS) Account Manager immediately following the discovery of a Breach of Unsecured PHI /~~PI~~PII as follows:

1. For Breaches of Unsecured PHI/~~PI~~PII involving five hundred (500) or more Members, the CalOptima Health Privacy Officer, or Designee, shall provide notification to the Secretary of HHS.

2. For Breaches of Unsecured PHI/~~PI~~PII involving less than five hundred (500) Members, the CalOptima Health Privacy Officer, or Designee, shall submit a log of such Breaches for the preceding calendar year, no later than sixty (60) calendar days after the end of each calendar year.

~~E. Security Incidents, Breaches, or unauthorized access, Use, or disclosures of PHI/PII involving Medicare Members must be reported to the CMS IT Service Desk (CMS_IT_Service_desk@cms.hhs.gov) within one (1) hour of initial discovery using the "CMS Security and Privacy Incident Report Form". CalOptima Health shall copy the Regulatory Affairs and Compliance (RAC) Medicare and the CMS Account Manager when making the initial report. CalOptima Health shall work with the CMS Incident Management Team (IMT) to update the report as the incident is resolved.~~

E. For CMS reporting, CalOptima Health is required to follow the directions provided by HHS' Office for Civil Rights (OCR) related to the Health Information and Technology for Economic and Clinical Health (HITECH) breach notification regulations. Additional information, including a description of breach notification requirements, instructions for covered entities to submit breach notifications to the Secretary, and links to the online breach notification forms, can be found at: http://www.hhs.gov/ocr/privacy/hipaa/administrative/breachnotificationrule

F. The CalOptima Health Privacy Officer, or Designee, shall notify the CMS Account Manager if there is the potential for significant Member harm (i.e., a high likelihood that the information was Used inappropriately) or situations that may have heightened public, or media, scrutiny (i.e., high number of Members affected, or particularly egregious Breaches). A "CMS Security and Privacy Incident Report" should be submitted for high-risk CalOptima Health breaches by email to CMS_IT_Service_desk@cms.hhs.gov. CalOptima Health shall report to the CMS Account Manager within two (2) business days of learning of a Breach that falls into these categories. The CalOptima Health Privacy department (Privacy) will include the Regulatory Affairs & Compliance (RAC) Medicare department (RAC Medicare) in this correspondence. In cases where CalOptima Health has notified OCR of the breach within this timeframe, CalOptima Health can send a copy of the breach report to the CMS Account Manager.

G. On a monthly basis, Privacy shall provide reported breaches to RAC Medicare via the CalOptima Health Compliance Log. If there were no breaches during a given month, a notification email shall be sent to RAC Medicare confirming that no breaches have occurred. RAC Medicare should provide updated reports to the CMS Account Manager as necessary.

H. The CalOptima Health Privacy Officer, or Designee shall notify the PACE Account Managers, and copy RAC Medicare, regarding security and privacy breaches involving PACE Participants. Breaches must be reported as soon as practical via email, using the "PACE Privacy Breach Notification Timeline and Summary" form.

I. For a Breach of Unsecured PHI/~~PI~~PII affecting more than five hundred (500) individuals,

CalOptima Health shall notify prominent media outlets serving Orange County, in addition to providing individual written notices without unreasonable delay, but no later than sixty (60) calendar days from the date of discovery.

J. If a law enforcement official states to CalOptima Health that a notification, notice, or posting required under the Breach Notification Rule (45 CFR §§ 164.400-414) would impede a criminal investigation or cause damage to national security, CalOptima Health shall take the following action:

1. If the law enforcement official's statement is in writing and specifies the time for which a delay is required, CalOptima Health staff shall delay such notification, notice, or posting for the time period specified by the law enforcement official; or

2. If the law enforcement official's statement is made orally, CalOptima Health staff shall:

a. Document the statement, including the identity of the official making the statement; and

b. Delay the notification, notice, or posting temporarily and no longer than thirty (30) calendar days from the date of the oral statement, unless a written statement described in Section III.~~G.1~~I. of this Policy is submitted during that time.

IV. ATTACHMENT(S)

A. HIPAA Violation Guidelines Matrix
B. CMS Security and Privacy Incident Report Form
C. PACE Privacy Breach Notification Timeline and Summary Form

V. REFERENCE(S)

A. CalOptima Health Business Associates Agreement
B. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Health PACE Program Agreement
E. CalOptima Health Privacy Program
F. CalOptima Health Compliance Plan
G. CDA Program Memorandum PM 07-18(P): Protection of Information Assets
H. Department of Health Care Services (DHCS) All Plan Letter (APL) 06-001: HIPAA Requirements: Notice of Privacy Practices and Notification of Breaches
I. Department of Health Care Services (DHCS) All Plan Letter (APL) 06-005: Protected Health Information (PHI) and Notification of Breaches
~~H.~~J. Health Information and Technology for Economic and Clinical Health Act ("HITECH Act")
~~I. MMCD All Plan Letter 06-001: HIPAA Requirements: Notice of Privacy Practices and Notification of Breaches~~
~~J. MMCD All Plan Letter 06-005: Protected Health Information (PHI) and Notification of Breaches~~
K. "Security and Privacy Reminders and Clarification of Reporting Procedures," Health Plan Management System (HPMS) Memorandum, Issued 12/16/2008
L. Title 45, Code of Federal Regulations §164.400 - 414 et seq.
M. Title 45, Code of Federal Regulations §164.502
N. Title 45, Code of Federal Regulations §164.514
O. Title 45, Code of Federal Regulations §164.530(e)(1)

P. Title 42 United State Code (U.S.C) §17932(h)
Q. "Update on Security and Privacy Breach Reporting Procedures," Health Plan Management System (HPMS) Memorandum, Issued 09/28/2010

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
07/22/2013	Department of Health Care Services (DHCS)	Approved as Submitted
04/04/2022	Department of Health Care Services (DHCS)	Approved as Submitted
10/23/2023	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
10/05/2023	Regular Meeting of the CalOptima Health Board of Directors
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	07/01/2007	HH.3020	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	Medi-Cal
Revised	01/01/2010	HH.3020	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	Medi-Cal
Revised	09/01/2011	HH.3020	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	Medi-Cal
Revised	01/01/2013	HH.3020	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	Medi-Cal
Revised	01/01/2014	HH.3020	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	Medi-Cal
Revised	11/01/2014	HH.3020	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	Medi-Cal
Revised	09/01/2015	HH.3020	Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information	Medi-Cal

Action	Date	Policy	Policy Title	Program(s)
Revised	12/01/2016	HH.3020	Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.3020	Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.3020	Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI	Medi-Cal OneCare OneCare Connect PACE
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Revised	09/01/2023	HH.3020	Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI	Medi-Cal OneCare PACE
Revised	11/07/2024	HH.3020	Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PII	Medi-Cal OneCare PACE

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IX. GLOSSARY

Term	Definition
Breach	Has the meaning in 45, Code of Federal Regulations Section 164.402. Breach means the acquisition, access, Use, or Disclosure of protected health information in a manner not permitted under subpart E of this part which compromises the security or privacy of the protected health information. (1) Breach excludes: (i) Any unintentional acquisition, access, or Use of protected health information by a Workforce Member or person acting under the authority of a Covered Entity or a Business Associate, if such acquisition, access, or Use was made in good faith and within the scope of authority and does not result in further Use or Disclosure in a manner not permitted under subpart E of this part. (ii) Any inadvertent Disclosure by a person who is authorized to access protected health information at a Covered Entity or Business Associate to another person authorized to access protected health information at the same Covered Entity or Business Associate, or organized health care arrangement in which the Covered Entity participates, and the information received as a result of such Disclosure is not further Used or Disclosed in a manner not permitted under subpart E of this part. (iii) A Disclosure of protected health information where a Covered Entity or Business Associate has a good faith belief that an unauthorized person to whom the Disclosure was made would not reasonably have been able to retain such information.
Business Associate	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: 1. On behalf of such Covered Entity or of an organized health care arrangement (as defined in this section) in which the Covered Entity participates, but other than in the capacity of a Member of the Workforce of such Covered Entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or 2. Provides, other than in the capacity of a Member of the Workforce of such Covered Entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such Covered Entity, or to or for an organized health care arrangement in which the Covered Entity participates, where the provision of the service involves the Disclosure of protected health information from such Covered Entity or arrangement, or from another Business Associate of such Covered Entity or arrangement, to the person.

Term	Definition
	A Covered Entity may be a Business Associate of another Covered Entity. Business Associate includes: 1. A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a Covered Entity and that requires access on a routine basis to such protected health information. 2. A person that offers a personal health record to one or more individuals on behalf of a Covered Entity. 3. A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the Business Associate.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima Health, the Centers for Medicare & Medicaid Services (CMS), or designated representatives. FDRs and/or CalOptima Health departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima Health and its regulators.
Covered Entity	A health plan, a health care clearinghouse, or a health care provider who transmits any health information in electronic form in connection with a transaction covered by Title 45, Code of Federal Regulations, Part 160.
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi-Cal program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), ~~Child Health and Disabilities Prevention (CHDP), and~~and other health related programs as provided by statute and/or regulation.
Designee	A person selected or designated to carry out a duty or role. The assigned Designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Disclosure	Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
Employee	See below for definition of Workforce Member.
EPHI	Has the meaning in 45, Code of Federal Regulations Section 160.103. Individually identifiable health information transmitted by electronic media or maintained in electronic media.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, and as subsequently amended.
Health Maintenance Organization (HMO)	A health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975, as amended, commencing with Section 1340 of the California Health and Safety Code.

Term	Definition
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Intrusion	The act of wrongfully (without authorization) entering upon, seizing, or taking possession of computerized data that compromises the security, confidentiality, or integrity of personal information maintained by CalOptima Health or its Business Associates.
Member	A beneficiary enrolled in a CalOptima Health program.
Personally Identifiable Information (PII)	PII is ―any information about an individual maintained by an agency, including (1) any information that can be Used to distinguish or trace an individual's identity, such as name, social security number, date and place of birth, mother's maiden name, ~~or~~ biometric records~~:~~, race, ethnicity, language (REL), sexual orientation and gender identity (SOGI); and (2) any other information that is linked or linkable to an individual, such as medical, educational, financial, and employment information.
Protected Health Information (PHI)	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be Used to identify the individual. The information was created or received by CalOptima Health or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Security Incident	Has the meaning in 45 Code of Federal Regulations Section 164.304. The attempted or successful unauthorized access, Use, Disclosure, modification, or destruction of information or interference with system operations in an information system.
Unsecured Protected Health Information/Personal Information (PHI/PII)	Has the meaning in 45 Code of Federal Regulations Section 164.402. Protected Health Information that is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the Use of a technology or methodology specified by the Secretary in the guidance issued under section 13402(h)(2) of Public Law 111-5.
Use	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.
Workforce	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. Employees, volunteers, trainees, and other persons whose conduct, in the performance of work for CalOptima Health is under the direct control of CalOptima Health, whether or not they are paid by CalOptima Health.

Term	Definition
Workforce Member	Has the meaning in 45, Code of Federal Regulations Section 160.103 including: Employees, volunteers, trainees, and other persons whose conduct, in the performance of work for a Covered Entity or Business Associate, is under the direct control of such Covered Entity or Business Associate, whether or not they are paid by the Covered Entity or Business Associate.

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Policy:	HH.3020
Title:	**Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PII or other Unauthorized Use or Disclosure of PHI/PII**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	*/s/*
Effective Date:	07/01/2007
Revised Date:	11/07/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ PACE ☐ Administrative

I. PURPOSE

This policy describes CalOptima Health's policies and procedures for reporting Security Incidents, Breaches of Unsecured Protected Health Information/Personally Identifiable Information (PHI/PII) and/or other unauthorized access, Use, or Disclosure of PHI/PII to its regulators and providing notice to affected Members and media of Breaches of Unsecured PHI in accordance with contractual and regulatory requirements.

II. POLICY

A. CalOptima Health Employees shall immediately and no later than twenty-four (24) hours from time of discovery report any suspected or known Security Incidents, Breaches of Unsecured PHI/PII and/or other unauthorized access, Use, or Disclosure of PHI/PII to the CalOptima Health Privacy Officer, or Designee, in accordance with this Policy.

B. Business Associates shall notify CalOptima Health of discovery of any known or suspected Security Incidents, Breaches of Unsecured PHI/PII and/or other unauthorized access, Use, or Disclosure of PHI/PII immediately and no later than twenty-four (24) hours from time of discovery. Business Associates shall submit a written report to CalOptima Health of suspected, or known, Security Incidents, Breaches of Unsecured PHI/PII, and/or other unauthorized access, Use or Disclosure of PHI/PII, in accordance with this Policy.

C. CalOptima Health shall investigate such a Security Incident, Breach of Unsecured PHI/PII, and/or other unauthorized access, Use, or Disclosure of PHI/PII and provide a written report of the investigation to the Department of Health Care Services (DHCS) in accordance with this Policy.

D. CalOptima Health shall report Security Incidents, Breaches of Unsecured PHI/PII, or other unauthorized access, Use or Disclosure of PHI/PII to regulators, as required by its regulatory contracts and applicable state and federal laws.

E. CalOptima Health shall notify individual Members whose Unsecured PHI/PII has been or believed

to have been accessed, acquired, Used, or Disclosed as a result of a Breach caused by CalOptima Health, which compromises the security or privacy of the PHI/PII.

F. CalOptima Health shall take appropriate actions to mitigate any harmful effect known to be caused by a Breach of Unsecured PHI/PII in accordance with CalOptima Health policy.

G. Except as otherwise provided in 45 CFR section 164.530(e)(1), CalOptima Health management, at its discretion, shall issue corrective action to Employees and persons in CalOptima Health's Workforce responsible for intentional or negligent actions that result in Security Incidents, Breaches of Unsecured PHI/PII, and/or other unauthorized access, Use, or Disclosure of PHI/PII in accordance with the HIPAA Violation Guidelines Matrix. CalOptima Health shall document any corrective actions that are applied.

H. Business Associates shall comply with CalOptima Health Business Associate Agreement reporting and notice requirements when a Security Incident, or Breach of Unsecured PHI/PII or other unauthorized access, Use, or Disclosure of PHI/PII involves DHCS and/or CalOptima Health PHI/PII.

III. PROCEDURE

A. Discovery

1. CalOptima Health Employees, Health Networks, with the exception of a Health Maintenance Organization (HMO) that satisfies the requirements of Section III.B.2. of this Policy, and Business Associates shall report any Security Incidents, Breaches of Unsecured PHI/PII, and/or other unauthorized access, Use, or Disclosure of PHI/PII immediately and no later than twenty-four (24) hours from time of discovery to the CalOptima Health Privacy Officer or Designee by telephone, fax, or email Privacy@caloptima.org.

   a. Examples of reportable Security Incidents or Breaches are:

      i. Lost or stolen unencrypted electronic devices that contain PHI or PII;

      ii. Posting PHI or PII on social media;

      iii. Emailing or saving EPHI to personal accounts and/or publicly accessible accounts;

      iv. Emailing EPHI that is not encrypted;

      v. Cybersecurity or hacking;

      vi. Downloading EPHI to a portable device in violation of CalOptima Health's policies (e.g., without expressed authority and required safeguards (encryption));

      vii. Faxes or emails that contain CalOptima Health PHI are misdirected to an unintended third party due to incorrect fax numbers or emails; and

      viii. Theft of paper records with CalOptima Health PHI from an Employee's vehicle.

B. The CalOptima Health Privacy Officer or Designee shall notify and report the discovery of any known or suspected Security Incidents, Breaches, Unsecured PHI/PII and/or other

unauthorized access, Use, or Disclosure of PHI/PII to DHCS, in accordance with the following guidelines:

1. Notification to DHCS:

   a. CalOptima Health shall notify DHCS immediately and no later than twenty-four (24) hours from the time of discovery of a suspected Breach, Security Incident, or unauthorized access, Use, or disclosure that involves SSA data. This notification will be provided through the DHCS Privacy Incident Reporting Portal . If CalOptima Health is unable to provide notification via the DHCS Privacy Incident Reporting Portal, then CalOptima Health shall provide notice by email or telephone to DHCS.

   b. CalOptima Health shall notify DHCS within twenty-four (24) hours via the DHCS Privacy Incident Reporting Portal (by email or telephone if necessary) of the discovery of:

      i. Unsecured PHI if the PHI is reasonably believed to have been accessed or acquired by an unauthorized person;

      ii. Any suspected Security Incident which risks unauthorized access to PHI and/or other confidential information;

      iii. Any Intrusion or unauthorized access, Use or disclosure of PHI in violation of CalOptima Health's Business Associate Agreement with DHCS; or

      iv. Potential loss of confidential data affecting CalOptima Health's Business Associate Agreement with DHCS;

   c. Notice shall be made via the DHCS Privacy Incident Reporting Portal and shall include all information known at the time the incident is reported.

   d. The CalOptima Health Privacy Officer or Designee shall notify the DHCS Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer via the DHCS Privacy Incident Reporting Portal (by email or telephone, if necessary), as required and within twenty-four (24) hours.

2. Investigation and written report to DHCS:

   a. Within ten (10) working days of the initial discovery, the CalOptima Health Privacy Officer or Designee shall submit a complete investigation report to the DHCS Contract Manager, DHCS Privacy Officer, and DHCS Information Security Officer by using the DHCS Privacy Incident Reporting Portal .

C. CalOptima Health shall notify Members whose Unsecured PHI/PII has been, or is believed to have been, accessed, acquired, Used, or Disclosed as a result of a Breach which compromises the security or privacy of the PHI. All notifications shall be provided without unreasonable delay and no later than sixty (60) calendar days from the date of discovery, which is the first day the Breach is known by a Covered Entity or would have been known by exercising reasonable diligence. CalOptima Health shall provide notification as specified below.

1. CalOptima Health shall write the notification in plain language and include, to the

extent possible:

a. A brief description of what occurred, including the date of the Breach and the date of the discovery of the Breach, if known;

b. A description of the types of Unsecured PHI/PII that were involved in the Breach (e.g., full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information involved);

c. Any steps Members should take to protect themselves from potential harm resulting from the Breach;

d. A brief description of what the Covered Entity is doing to investigate the Breach, to mitigate harm to Members, and to protect against any further Breaches; and

e. Contact procedures for Members to ask questions or learn additional information, which shall include a toll-free telephone number, an email address, website, or postal address.

2. CalOptima Health shall provide notification in the following form:

a. CalOptima Health shall send written notification by first-class mail to the Member at the last known address. CalOptima Health may send written notification by electronic mail if the Member has agreed to receive notice by electronic mail and such agreement has not been withdrawn. CalOptima Health may provide notification in one (1) or more mailings as information is available.

i. If the Member is deceased, CalOptima Health shall provide written notification by first- class mail to either the next of kin, or personal representative of the Member, if contact information is known.

ii. If current contact information is unavailable for fewer than ten (10) Members, CalOptima Health may provide a substitute notice by an alternative form of written notice, telephone, or other means.

iii. If current contact information is unavailable for ten (10) or more Members, CalOptima Health shall provide a substitute notice by a readily visible posting on the homepage of CalOptima Health's website for ninety (90) calendar days or by a readily visible notice in a major print or broadcast media in the geographic areas where the Members affected by the Breach likely reside. The notice shall include a toll-free telephone number that remains active for at least ninety (90) calendar days for Members to obtain information regarding the Breach.

b. If CalOptima Health deems a Breach incident to require urgency because of a possible imminent misuse of Unsecured PHI/PII, CalOptima Health may provide Breach notification to Members by telephone or other means, in addition to written notice.

3. 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.

D. The CalOptima Health Privacy Officer, or Designee, shall notify the Secretary of the U.S. Department of Health and Human Services (HHS) and Centers for Medicare & Medicaid Services (CMS) Account Manager immediately following the discovery of a Breach of Unsecured PHI /PII as follows:

1. For Breaches of Unsecured PHI/PII involving five hundred (500) or more Members, the CalOptima Health Privacy Officer, or Designee, shall provide notification to the Secretary of HHS.

2. For Breaches of Unsecured PHI/PII involving less than five hundred (500) Members, the CalOptima Health Privacy Officer, or Designee, shall submit a log of such Breaches for the preceding calendar year, no later than sixty (60) calendar days after the end of each calendar year.

E. For CMS reporting, CalOptima Health is required to follow the directions provided by HHS' Office for Civil Rights (OCR) related to the Health Information and Technology for Economic and Clinical Health (HITECH) breach notification regulations. Additional information, including a description of breach notification requirements, instructions for covered entities to submit breach notifications to the Secretary, and links to the online breach notification forms, can be found at: http://www.hhs.gov/ocr/privacy/hipaa/administrative/breachnotificationrule

F. The CalOptima Health Privacy Officer, or Designee, shall notify the CMS Account Manager if there is the potential for significant Member harm (i.e., a high likelihood that the information was Used inappropriately) or situations that may have heightened public, or media, scrutiny (i.e., high number of Members affected, or particularly egregious Breaches). A "CMS Security and Privacy Incident Report" should be submitted for high-risk CalOptima Health breaches by email to CMS_IT_Service_desk@cms.hhs.gov. CalOptima Health shall report to the CMS Account Manager within two (2) business days of learning of a Breach that falls into these categories. The CalOptima Health Privacy department (Privacy) will include the Regulatory Affairs & Compliance (RAC) Medicare department (RAC Medicare) in this correspondence. In cases where CalOptima Health has notified OCR of the breach within this timeframe, CalOptima Health can send a copy of the breach report to the CMS Account Manager.

G. On a monthly basis, Privacy shall provide reported breaches to RAC Medicare via the CalOptima Health Compliance Log. If there were no breaches during a given month, a notification email shall be sent to RAC Medicare confirming that no breaches have occurred. RAC Medicare should provide updated reports to the CMS Account Manager as necessary.

H. The CalOptima Health Privacy Officer, or Designee shall notify the PACE Account Managers, and copy RAC Medicare, regarding security and privacy breaches involving PACE Participants. Breaches must be reported as soon as practical via email, using the "PACE Privacy Breach Notification Timeline and Summary" form.

I. For a Breach of Unsecured PHI/PII affecting more than five hundred (500) individuals, CalOptima Health shall notify prominent media outlets serving Orange County, in addition to providing individual written notices without unreasonable delay, but no later than sixty (60) calendar days from the date of discovery.

J. If a law enforcement official states to CalOptima Health that a notification, notice, or posting required under the Breach Notification Rule (45 CFR §§ 164.400-414) would impede a criminal investigation or cause damage to national security, CalOptima Health

shall take the following action:

1. If the law enforcement official's statement is in writing and specifies the time for which a delay is required, CalOptima Health staff shall delay such notification, notice, or posting for the time period specified by the law enforcement official; or

2. If the law enforcement official's statement is made orally, CalOptima Health staff shall:

   a. Document the statement, including the identity of the official making the statement; and

   b. Delay the notification, notice, or posting temporarily and no longer than thirty (30) calendar days from the date of the oral statement, unless a written statement described in Section III.I. of this Policy is submitted during that time.

IV. ATTACHMENT(S)

A. HIPAA Violation Guidelines Matrix
B. CMS Security and Privacy Incident Report Form
C. PACE Privacy Breach Notification Timeline and Summary Form

V. REFERENCE(S)

A. CalOptima Health Business Associates Agreement
B. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Health PACE Program Agreement
E. CalOptima Health Privacy Program
F. CalOptima Health Compliance Plan
G. CDA Program Memorandum PM 07-18(P): Protection of Information Assets
H. Department of Health Care Services (DHCS) All Plan Letter (APL) 06-001: HIPAA Requirements: Notice of Privacy Practices and Notification of Breaches
I. Department of Health Care Services (DHCS) All Plan Letter (APL) 06-005: Protected Health Information (PHI) and Notification of Breaches
J. Health Information and Technology for Economic and Clinical Health Act ("HITECH Act")
K. "Security and Privacy Reminders and Clarification of Reporting Procedures," Health Plan Management System (HPMS) Memorandum, Issued 12/16/2008
L. Title 45, Code of Federal Regulations §164.400 - 414 et seq.
M. Title 45, Code of Federal Regulations §164.502
N. Title 45, Code of Federal Regulations §164.514
O. Title 45, Code of Federal Regulations §164.530(e)(1)
P. Title 42 United State Code (U.S.C) §17932(h)
Q. "Update on Security and Privacy Breach Reporting Procedures," Health Plan Management System (HPMS) Memorandum, Issued 09/28/2010

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
07/22/2013	Department of Health Care Services (DHCS)	Approved as Submitted
04/04/2022	Department of Health Care Services (DHCS)	Approved as Submitted

Date	Regulatory Agency	Response
10/23/2023	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
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Term	Definition
Breach	Has the meaning in 45, Code of Federal Regulations Section 164.402. Breach means the acquisition, access, Use, or Disclosure of protected health information in a manner not permitted under subpart E of this part which compromises the security or privacy of the protected health information. (1) Breach excludes: (i) Any unintentional acquisition, access, or Use of protected health information by a Workforce Member or person acting under the authority of a Covered Entity or a Business Associate, if such acquisition, access, or Use was made in good faith and within the scope of authority and does not result in further Use or Disclosure in a manner not permitted under subpart E of this part. (ii) Any inadvertent Disclosure by a person who is authorized to access protected health information at a Covered Entity or Business Associate to another person authorized to access protected health information at the same Covered Entity or Business Associate, or organized health care arrangement in which the Covered Entity participates, and the information received as a result of such Disclosure is not further Used or Disclosed in a manner not permitted under subpart E of this part. (iii) A Disclosure of protected health information where a Covered Entity or Business Associate has a good faith belief that an unauthorized person to whom the Disclosure was made would not reasonably have been able to retain such information.
Business Associate	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: 1. On behalf of such Covered Entity or of an organized health care arrangement (as defined in this section) in which the Covered Entity participates, but other than in the capacity of a Member of the Workforce of such Covered Entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or 2. Provides, other than in the capacity of a Member of the Workforce of such Covered Entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such Covered Entity, or to or for an organized health care arrangement in which the Covered Entity participates, where the provision of the service involves the Disclosure of protected health information from such Covered Entity or arrangement, or from another Business Associate of such Covered Entity or arrangement, to the person.

Term	Definition
	A Covered Entity may be a Business Associate of another Covered Entity. Business Associate includes: 1. A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a Covered Entity and that requires access on a routine basis to such protected health information. 2. A person that offers a personal health record to one or more individuals on behalf of a Covered Entity. 3. A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the Business Associate.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima Health, the Centers for Medicare & Medicaid Services (CMS), or designated representatives. FDRs and/or CalOptima Health departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima Health and its regulators.
Covered Entity	A health plan, a health care clearinghouse, or a health care provider who transmits any health information in electronic form in connection with a transaction covered by Title 45, Code of Federal Regulations, Part 160.
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi-Cal program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health related programs as provided by statute and/or regulation.
Designee	A person selected or designated to carry out a duty or role. The assigned Designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Disclosure	Has the meaning in 45, Code of Federal Regulations Section 160.103 including the following: the release, transfer, provision of access to, or divulging in any manner of information outside of the entity holding the information.
Employee	See below for definition of Workforce Member.
EPHI	Has the meaning in 45, Code of Federal Regulations Section 160.103. Individually identifiable health information transmitted by electronic media or maintained in electronic media.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, and as subsequently amended.
Health Maintenance Organization (HMO)	A health care service plan, as defined in the Knox-Keene Health Care Service Plan Act of 1975, as amended, commencing with Section 1340 of the California Health and Safety Code.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.

Term	Definition
Intrusion	The act of wrongfully (without authorization) entering upon, seizing, or taking possession of computerized data that compromises the security, confidentiality, or integrity of personal information maintained by CalOptima Health or its Business Associates.
Member	A beneficiary enrolled in a CalOptima Health program.
Personally Identifiable Information (PII)	PII is —any information about an individual maintained by an agency, including (1) any information that can be Used to distinguish or trace an individual's identity, such as name, social security number, date and place of birth, mother's maiden name, biometric records, race, ethnicity, language (REL), sexual orientation and gender identity (SOGI); and (2) any other information that is linked or linkable to an individual, such as medical, educational, financial, and employment information.
Protected Health Information (PHI)	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be Used to identify the individual. The information was created or received by CalOptima Health or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Security Incident	Has the meaning in 45 Code of Federal Regulations Section 164.304. The attempted or successful unauthorized access, Use, Disclosure, modification, or destruction of information or interference with system operations in an information system.
Unsecured Protected Health Information/Personal Information (PHI/PII)	Has the meaning in 45 Code of Federal Regulations Section 164.402. Protected Health Information that is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the Use of a technology or methodology specified by the Secretary in the guidance issued under section 13402(h)(2) of Public Law 111-5.
Use	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: the sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.
Workforce	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. Employees, volunteers, trainees, and other persons whose conduct in the performance of work for CalOptima Health is under the direct control of CalOptima Health, whether or not they are paid by CalOptima Health.

Term	Definition
Workforce Member	Has the meaning in 45, Code of Federal Regulations Section 160.103 including: Employees, volunteers, trainees, and other persons whose conduct, in the performance of work for a Covered Entity or Business Associate, is under the direct control of such Covered Entity or Business Associate, whether or not they are paid by the Covered Entity or Business Associate.

1

PRIVACY INCIDENT REPORTING FORM

The information reported in this form will be strictly confidential and will be used in part to determine whether a breach has occurred. **DO NOT include specific PHI or PI in this form**.

1- CASE IDENTIFYING INFORMATION

DHCS Privacy Case Number:

Reporting Entity:

☐DHCS Internal ☐Health Plan ☐County ☐Other (specify)

Reporting Entity's Privacy Incident Case Number:

Contact Name:

Contact Email:

Contact Telephone Number:

2- SUMMARY OF PRIVACY INCIDENT

Return completed form to: privacyofficer@dhcs.ca.gov

3 – BREAKDOWN OF SUMMARY

Date(s) of Privacy Incident: **Date of Discovery:** **Date Reported to DHCS:**

Number of DHCS/CDSS Program Beneficiaries Impacted; Please Specify which Program(s) They Belong To:

How Many of the Impacted Beneficiaries Are Minors:

Title of Person Who Caused the Incident and Relationship to Reporting Entity:

Title of Unintended Recipient:

Suspected Malicious Intent: ◯Yes ◯No

4 – DATA ELEMENTS

DEMOGRAPHIC INFORMATION (Check all that Apply)

☐First Name or Initial
☐Last Name
☐Address/Zip
☐Date of Birth
☐CIN or Medi-Cal #
☐Social Security Number
☐Driver's License
☐Membership #
☐Health Plan Name
☐Mother's Maiden Name
☐Image
☐Password
☐User Name/Email Address
☐Program Name:
☐Other:

FINANCIAL INFORMATION (Check all that Apply)

☐Credit Card/Bank Acct #
☐EBT Card Pin #
☐Claims Information
☐EBT Card #
☐Other:

CLINICAL INFORMATION (Check all that Apply)

☐Diagnosis/Condition
☐Diagnosis Codes (Dx)
☐Procedure Codes (CPT)
☐Medications
☐Lab Results
☐Provider Demographics
☐TAR #
☐Psychotherapy Notes
☐Mental Health Data
☐Substance Use/Alcohol Data
☐Other:

Please List All Data Elements Provided by DHCS:

Please List All Data Elements Verified by SSA:

Return completed form to: privacyofficer@dhcs.ca.gov

5 - LOCATION OF DISCLOSED DATA

☐Laptop	☐Network Server	☐Desktop Computer
☐Portable Electronic Device	☐Email	☐Electronic Record
☐Paper Data	☐Smart Phone	☐Hard Drive
☐CD/DVD	☐USB Thumb Drive	☐Fax
☐Social Media	☐Other:	

6 – SAFEGUARDS/MITIGATIONS/ACTIONS TAKEN IN RESPONSE TO EVENT

Was Involved Staff Trained in HIPAA Privacy Security Within the Past Year:

◉Yes ○No

Was Malicious Code/Malware Involved? ○Yes ○No ○N/A

Was the Data Encrypted Per NIST Standards? ○Yes ○No ○N/A

Status of Data? (i.e. Recovered, Destroyed, etc.):

Was an Attestation of Nondisclosure/Destruction Obtained? ○Yes ○No

(NOTE: If Written Attestation is Not Attached It Will be Considered Verbal)

Was a police report filed? ○Yes ○No

Police Report # and Department Name:

MITIGATION SUMMARY (Example: The data was destroyed/returned, etc.)

Return completed form to: privacyofficer@dhcs.ca.gov

7 - CORRECTIVE ACTION PLAN (CAP) - Please Include Implementation Date
A CAP is implemented in an attempt to prevent this type of Privacy Incident from reoccurring).

8 - DETERMINATION

Has Your Entity Determined This to be a (check all that apply):

☐**Federal Breach** ☐**State Breach** ☐**Non-Breach**

In the Event DHCS Determines Notification is Not Legally Required, Do You Still Intend to Send Written Notification (Note: Review & approval by DHCS is still required prior to dissemination of *all* notification letters.): ◯Yes ◯No

An Incident is presumed to be a Breach. If you Have Evidence under 45 CFR 164.402(2)(1)(I-IV), Please Provide the Evidence and the HIPAA Provision That Applies to Find That a Breach Does Not Exist. HITECH BREACH DEFINITION AND EXCEPTIONS

Return completed form to: privacyofficer@dhcs.ca.gov

HIPAA Violation Guidelines Matrix

Violations of Privacy or Security of Protected Health Information (PHI) Or Other Confidential Information

The HIPAA (Health Insurance Portability and Accountability Act) Violation Guidelines Matrix is intended to be used as a guide for selecting the appropriate level of corrective action for policy and/or regulatory violations. The Guidelines include specific examples of violations or breaches of HIPAA/Privacy regulations.

Therefore, the following are guidelines for potential corrective action for violations of HIPAA/Privacy regulations and related CalOptima Health policies. The offenses listed are not an exhaustive list of violations or possible corrective actions that may be taken. CalOptima Health may elect to follow the Guidelines, skip any of the steps, or immediately terminate an employee, as all CalOptima Health employees are at-will. Nothing in these guidelines modifies – or should be interpreted to modify – the at-will employment status of employees. As at-will employees, CalOptima Health employees are not guaranteed a right to corrective action prior to termination and can be terminated at any time, with or without cause, and with or without notice. (CalOptima Health Policy GA.8022: Performance and Behavior Standards).

CalOptima Health will evaluate the facts and circumstances of each incident on a case-by-case basis and will consider the severity and potential harm associated with each incident. The Office of Compliance and Human Resources will review all cases before corrective action is implemented. The Legal Affairs Office will review termination cases before implemented.

Level of Violation	Example	Possible Corrective Action	Mitigating/Aggravating Factors to Consider
Level I	• Misdirected faxes, emails & mail. • Failure to log -off or lock a computer containing PHI when leaving the computer unattended. • Leaving paper PHI unattended in a publicly accessible area. • Dictating or discussing PHI in a non-secure area (lobby, hallway, cafeteria, and elevator). • Sending PHI from a CalOptima Health email account to an outside entity without using "send secure". • Storing files with PHI on a public network folder without a password.	• First Offense - Verbal Coaching/Coaching Memo • Second Offense - Documented Counseling Memo • Repeated Offenses – Further corrective action up to and including termination • Notify Privacy Officer of all incidents immediately • Repeat HIPAA and Information Security Online Training	**Mitigating Factors** • The recipient was a covered entity and attested to shredding/deleting/destroying the information. • The PHI was retrieved, deleted or made inaccessible **before it was viewed** (opened, read) by an unauthorized individual. • Employee self-reported incident after mistake occurred. • Employee has a legitimate business reason for transmitting/disclosing the PHI. • This was a first-time violation.

Level of Violation	Example	Possible Corrective Action	Mitigating/Aggravating Factors to Consider
Level II	• Improper disposal of PHI. • Transmission of PHI/Confidential information to or from a personal email account without proper encryption, impacting fewer than 500 members. • For teleworkers, printing member PHI to a non-CalOptima Health issued printer. • Inappropriately sharing ID/password with others (e.g., co-workers or friends & family) or encouraging others to share ID/password. • Leaving laptops, cell phones, portable electronic devices unattended when traveling. • Failing to properly verify that an individual is authorized to manage the member's PHI on the phone before disclosing PHI.	• First Offense - Documented Counseling Memo/Final Written Warning • Second Offense - Termination, certain mitigating/aggravating factors may be considered for outcome of corrective action, including, but not limited to: 1. Documentation of training 2. Prior counseling(s)/corrective action • Notify Privacy Officer and Chief Information Officer	**Aggravating Factors** • The recipient of the PHI is unknown or is an individual who may have reason/cause to use the information in a malicious or harmful manner or for personal/financial gain. • The information disclosed/ accessed could not be retrieved/returned/shredded. This would include situations where PHI is sent via email and the email was opened. • The information accessed or disclosed included sensitive data (i.e., mental/behavioral health data, substance abuse, STD/HIV information) or financial data (HICN, SSN, bank account numbers, etc.). • The number of members impacted is more than 500. • The employee was deceptive or uncooperative during the investigation or regarding disclosure or access of PHI. • The employee has previously received training or corrective actions for a prior or similar violation. • The current misconduct found or acknowledged by the employee evidences multiple acts of wrongdoing or demonstrates a pattern of misconduct. • The violation occurred during the employee's resignation period. • There was no legitimate business reason for the employee to transmit and/or disclose the PHI.
Level III	• Requesting another coworker to inappropriately access and/or disclose PHI. • Intentionally accessing or allowing access to PHI without having a legitimate business reason and authorization. • Accessing member information such as a family member, friend, neighbor, coworker due to curiosity or concern. • Posting PHI to social media absent any aggravating factor. • Downloading/Uploading PHI/PII to external non-approved share site, website or external storage sites without	• Termination-no mitigation • Notify Privacy Officer and Chief Information Officer.	

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Level of Violation	Example	Possible Corrective Action	Mitigating/Aggravating Factors to Consider
	prior written authorization from IS and business leaders. • Intentionally or with gross negligence, downloads malware onto CalOptima Health's system that may result in a reported security breach incident. • Failure to report a breach, retaliating for reporting a breach, or hampering an investigation of a breach.		
Level IV	• Accessing or disclosing PHI or PII for financial or personal gain. • Malicious disclosure or malicious use of PHI. • Tampering with, modification of, and/or unauthorized destruction of PHI. • Falsifying documentation. • Posting PHI to social media in conjunction with any aggravating factor. • Acts that result in criminal or civil prosecution, where appropriate.	• Termination – no mitigation • Violation will be reported to licensing boards, law enforcement and/or third-party agencies, where appropriate or required. • Notify Privacy Officer and Chief Information Officer	

Privacy Breach Notification Timeline and Summary Form

Region:	IX
Date:	
Contract Number(s):	H7501
Parent Organization:	Orange County Health Authority, dba CalOptima Health PACE
Reported by:	
Date of breach occurrence:	
Date of breach discovery:	
Date when the breach was reported to CMS/Account Manager:	
Date the plan/account reported the breach:	
Entity to which the plan/account reported the breach (HHS/OCR and/or any CMS staff; please indicate name(s) and organization(s)):	
Provide a description of the types of personal information involved in the breach (e.g., full name, Social Security number, date of birth, place of birth, home address, account number, disability code, etc.)	
Was the information encrypted or protected?	
Is the plan offering credit protection?	
Is the plan sending out specific letters? If so, when?	
Total number of members affected:	
Total number of MA members affected:	
Total number of PDP members affected:	
Total number of ACA members affected:	
Total number of PACE members affected:	
Total number of dual eligible members affected:	
Who should affected individual(s) contact at the plan for additional information, including a toll-free telephone number, e-mail address, and postal address?	
What steps individuals should take to protect themselves from potential harm, if any?	

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Policy:	HH.3022
Title:	**Business Associate Agreements**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	*/s/*
Effective Date:	12/20/2021
Revised Date:	11/07/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ PACE ☒ Administrative

I. PURPOSE

This policy establishes guidelines related to CalOptima Health's Business Associate Agreements (BAA) with individuals or entities who are considered Business Associates ~~(BA)~~.

II. POLICY

A. As part of any Services Agreement where a ~~BA~~Business Associate performs a service or function on behalf of CalOptima Health, CalOptima Health shall execute a BAA, in addition to the Service Agreement, that meets the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and the Department of Health Care Services (DHCS) Contract.

B. CalOptima Health shall not Disclose, transmit or share PHI with an individual or business that performs a service or function using CalOptima Health member PHI without an executed BAA.

C. CalOptima Health shall only contract with individuals or businesses that meet the requirements outlined in CalOptima Health's BAA template.

D. CalOptima Health's Provider Contracting and/or Vendor Management Departments, as applicable, shall use CalOptima Health's BAA template, unless prior written approval is given by the Information Security Officer, Privacy Officer and Legal Counsel to use the proposed Business Associate's template based on the proposed Business Associate's template meeting all of the HIPAA Privacy and Security requirements.

E. Any proposed edit or modification to the BAA requested by the proposed Business Associate shall be reviewed by the Vendor Management or Contracting Departments, as applicable, and must be approved by the appropriate CalOptima Health staff (e.g., CalOptima Health Security Officer, Privacy Officer, and Legal Counsel, as appropriate) before executing the BAA.

1. CalOptima Health cannot accept any revisions to the BAA that conflict with the DHCS Contract or the underlying Service Agreement.

2. CalOptima Health cannot accept any revisions that would allow the ~~BA~~Business Associate to Use or Disclose PHI in a manner that would violate the HIPAA Privacy and Security requirements.

F. If the ~~BA~~Business Associate requires access to CalOptima Health member PHI in order to perform

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the function or service provided in the Service Agreement on behalf of CalOptima Health, and the ~~BA~~Business Associate refuses to sign the BAA, CalOptima Health may not disclose any CalOptima Health member PHI to the ~~BA~~Business Associate and cannot contract with the ~~BA~~Business Associate for the services.

G. The CalOptima Health Privacy Officer, in collaboration with Information Technology Services, will maintain and update the BAA template based on statutory, regulatory and/or DHCS Contract changes.

1. Any new BAA templates (or amendments) must include specified core elements and requirements in accordance with Title 45, Code of Federal Regulations ~~§164~~, Sections164.502 (e)(1-2) and ~~§~~164.504 (e)(1-2), which shall include, but not be limited to, the following provisions:

   a. Use and Disclosure;

   b. Minimum Necessary Requirement;

   c. Use Appropriate Safeguards;

   d. Reporting of Any Unauthorized Use or Disclosure;

   e. Subcontractor Requirements;

   f. Right of Access;

   g. Right of Amendment;

   h. Right to an Accounting of Disclosures;

   i. Books and Records Available;

   j. Termination; and

   k. Effect of Termination.

2. Updates to the BAA templates (or amendments) must be submitted to the Legal Counsel for review.

H. CalOptima Health reserves the right to automatically amend BAAs at any time when such modifications are necessary to comply with changes in:

1. Applicable laws;

2. CalOptima Health's contracts with government regulators; or

3. In any requirements and conditions with which CalOptima must comply pursuant to its federally-approved Section 1915(b) waiver ("Regulatory Change").

I. CalOptima Health's BAA will require that its Business Associates comply with privacy laws that

provide for more restrictive protections than HIPAA.

III. PROCEDURE

A. Assessing potential Business Associate Relationships

~~3.~~1. Prior to issuing a Request for Proposal (RFP) or negotiating or entering into an underlying Service Agreement with an individual or business, the Provider Contracting or Vendor Management Department, in collaboration with the Contract Owner and the Privacy Officer, will determine whether a Business Associate relationship exists.

a. Examples of Business Associates include, but are not limited to individuals or entities that:

i. Create, receive, maintain, or transmit PHI for claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing;

ii. Provide legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services to or for CalOptima Health, where the provision of the service involves the Disclosure of PHI to the individual or entity;

iii. Are a Health Information Organization/Exchange, E-prescribing Gateway, or that provide data transmission services with respect to PHI to CalOptima Health and that requires access on a routine basis to such PHI including, but not limited to cloud providers; and/or

iv. Are providers of personal health records to individuals on behalf of CalOptima Health.

b. Examples of individuals and entities that are not considered Business Associates:

i. Workforce members, such as employees, interns and CalOptima Health volunteers.

ii. Treatment providers, unless they are providing administrative services (which involve PHI) on behalf of CalOptima Health in addition to providing Member care.

~~4.~~2.~~2.~~ The information Disclosed to the ~~BA~~Business Associate by CalOptima Health must be restricted to the minimum amount necessary to enable the ~~BA~~Business Associate to perform the function or provide the services for which CalOptima Health has contracted with the BA.

B. Maintenance of the BAA

1. The CalOptima Health Contracting and Vendor Management Departments shall maintain a current inventory of BAAs within the contract management system managed by the respective department.

2. The CalOptima Health Contracting and Vendor Management Departments shall be responsible for ensuring Business Associates have signed the most current (DHCS- approved) version of the BAA template.

3. The CalOptima Health Contracting and Vendor Management Departments shall be responsible for obtaining the required signatures for all BAAs and maintaining the original signed BAA and any amendments and/or addendums thereto within the contract management system managed by the respective department.

4. CalOptima Health may terminate any BAA and applicable Service Agreement when patterns of material breaches or violations of the BAA or Service Agreement occur, or where reasonable measures to remediate non-compliant issues are unsuccessful in accordance with those agreements.

5. The BAA shall remain in effect throughout the term of any associated Service Agreement and shall extend beyond the termination of any Service Agreement(s) until such time as all the PHI provided by CalOptima Health to the BA, or created or received by the ~~BA~~Business Associate on behalf of CalOptima Health, is destroyed or returned to CalOptima Health as specified in the Service Agreement and outlined in the BAA.

6. Whenever a Service Agreement that included a BAA expires by its own terms or is terminated before the end of its term, the Contracting or Vendor Management Department, as applicable, must obtain written certification from the ~~BA~~Business Associate that all PHI received from or created or received by the ~~BA~~Business Associate has either been returned, destroyed, or otherwise accounted for in accordance with the terms of the Service Agreement.

7. The ~~BA~~Business Associate shall comply with the disposition of PHI requirements as specified in the BAA Template section 15.

C. Regulatory Amendments to the BAA

1. CalOptima Health will promptly notify its Business Associates, in writing, of any Regulatory Change in accordance with applicable federal and/or state requirements. CalOptima Health will require its Business Associates to comply with the new Regulatory Change requirements within thirty (30) days of the effective date of the Regulatory Change, unless otherwise instructed by a CalOptima Health government regulator.

D. CalOptima Health's BAA will require that Business Associates comply with applicable laws that provide more protections to Member Medical Information.

1. CalOptima Health requires that businesses described in California Civil Code, Section 56.06 that maintain Member electronic Medical Information comply with the following requirements regarding Sensitive Services:

a. Limit access privileges to information systems containing Medical Records related to Gender Affirming Care, abortion, abortion-related services, and contraception ("Restricted Information") only to persons authorized to access that specified information,

b. Prevent disclosure, access, transfer, transmission, or processing (and provide the ability to automatically disable access) of Restricted Information by other persons and entities outside of California; and

c. Segregate restricted information from the rest of the Member's records.

~~1.~~2. CalOptima Health will also require that contractors that maintain Member Medical Information do not cooperate with any inquiry or investigation by, or provide Medical Information to, any individual, agency, or department from another state or, to the extent permitted by federal law, to a federal law enforcement agency regarding Abortion Services, unless the request for Medical Information is authorized under California Civil Code, Section 56.110.

IV. ATTACHMENT(S)

A. Business Associate Disposition of Protected Health Information Form
B. Business Associate Retention of Protected Health Information Form
C. CalOptima Health Business Associate Agreement Template ~~2022~~

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health PACE Program Agreement
C. Title 45, Code of Federal Regulations §160.103
D. Title 45, Code of Federal Regulations §164.502 (a)(1-4) & (e)(1-2)
E. Title 45, Code of Federal Regulations §164.504 (e)(1-2)
F. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
02/04/2022	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
12/20/2021	Special Meeting of the CalOptima Board of Directors
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	12/20/2021	HH.3022	Business Associate Agreements	Medi-Cal OneCare OneCare Connect PACE Administrative
Revised	12/31/2022	HH.3022	Business Associate Agreements	Medi-Cal OneCare PACE Administrative

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Action	Date	Policy	Policy Title	Program(s)
Revised	09/01/2023	HH.3022	Business Associate Agreements	Medi-Cal OneCare PACE Administrative
Revised	11/01/2023	HH.3022	Business Associate Agreements	Medi-Cal OneCare PACE Administrative
Revised	11/07/2024	HH.3022	Business Associate Agreements	Medi-Cal OneCare PACE Administrative

IX. GLOSSARY

Term	Definition
Business Associate (BA)	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: 1. On behalf of such covered entity or of an organized health care arrangement (as defined in this section) in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or 2. Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of protected health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person. A covered entity may be a business associate of another covered entity. Business associate includes: 1. A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a covered entity and that requires access on a routine basis to such protected health information. 2. A person that offers a personal health record to one or more individuals on behalf of a covered entity. 3. A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the business associate.
Business Associate Agreement (BAA)	A covered entity's contract or other written arrangement with its business associate, which includes the elements specified at 45 CFR 164.504(e).

Term	Definition
Contract Owner	The one individual within CalOptima Health with ultimate responsibility for the relationship between CalOptima Health and the Delegated Entity. Contract Owner responsibilities include, but are not limited to, initial contact, procurement, negotiation of contract terms, compliance remediation, on-going entity relations, site closings, hours of operations, etc. The Contract Owner is the individual with responsibility for ensuring that the documentation regarding the relationship between CalOptima Health and the Delegated Entity is complete and accurate.
DHCS Contract	The written instrument between CalOptima Health and the Department of Health Care Services (DHCS) pursuant to which CalOptima Health is obligated to arrange and pay for the provision of Covered Services to Members in the Service Area.
Covered Entity	A health plan, a health care clearinghouse, or a health care provider who transmits any health information in electronic form in connection with a transaction covered by Title 45, Code of Federal Regulations, Part 160.
Disclosure	Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations including the following: the release, transfer, provision of access to, or divulging in any other manner of information outside of the entity holding the information.
Electronic Protected Health Information (EPHI)	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. Individually identifiable health information that is transmitted by Electronic Media or maintained in Electronic Media
Gender Affirming Care	Medically necessary health care or gender affirming mental health care that respects the gender identity of the patient, as experienced and defined by the patient, and may include, but is not limited to: 1. Interventions to suppress the development of endogenous secondary sex characteristics; 2. Interventions to align the patient's appearance or physical body with the patient's gender identity; and 3. Interventions to alleviate symptoms of clinically significant distress resulting from gender dysphoria, as defined in the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition. Welfare and Institutions Code § 16010.2(b).
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, and as subsequently amended.

Term	Definition
Medical Information	Has the meaning in Civil Code § 56.05(j): Any individually identifiable information, in electronic or physical form, in possession of or derived from a provider of health care, health care service plan, pharmaceutical company, or contractor regarding a patient's medical history, mental health application information, Reproductive or Sexual Health Application Information, mental or physical condition, or treatment. For purposes of this definition, "Individually Identifiable" means that the Medical Information includes or contains any element of personal identifying information sufficient to allow identification of the individual, such as the patient's name, address, electronic mail address, telephone number, or social security number, or other information that, alone or in combination with other publicly available information, reveals the identity of the individual. For purposes of this definition, "Reproductive or Sexual Health Application Information" means information about an individual's reproductive health, menstrual cycle, fertility, pregnancy, pregnancy outcome, plans to conceive, or type of sexual activity collected by a reproductive or sexual health digital service, including, but not limited to, information from which one can infer someone's pregnancy status, menstrual cycle, fertility, hormone levels, birth control use, sexual activity, or gender identity. Civ. Code § 56.05(q).
Member	A beneficiary enrolled in a CalOptima Health program.
Payment	Has the meaning in Title 42 of the Code of Federal Regulations, Section 164.501, including: activities carried out by CalOptima Health including: 1. Determination of eligibility, risk adjustments based on Member health status and demographics, billing claims management, and collection activities; 2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and 3. Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.
Protected Health Information (PHI)	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima Health or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member

Term	Definition
Sensitive Services	All health care services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence, and includes services described in Family Code, Sections 6924, 6925, 6926, 6927, 6928, 6929, and 6930, and Health and Safety Code, Sections 121020 and 124260, obtained by a patient at or above the minimum age specified for consenting to the service, in accordance with California Civil Code, Section 56.05(s).
Service Agreement	A service agreement is a written agreement whereby a Business Associate agrees to provide services to CalOptima Health, and the Business Associate creates, receives, maintains, uses or transmits Protected Health Information in order to provide those services.
Treatment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care Providers; and coordination with third parties for services related to the management of the Member's health care benefits.
Use	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. The sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.
Workforce	Has the meaning in 45 Code of Federal Regulations Section 160.103 Workforce means employees, volunteers, trainees, and other persons whose conduct, in the performance of work for a covered entity or business associate, is under the direct control of such covered entity or business associate, whether or not they are paid by the covered entity or business associate.

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Policy:	HH.3022
Title:	**Business Associate Agreements**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	*/s/*
Effective Date:	12/20/2021
Revised Date:	11/07/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ PACE ☒ Administrative

I. PURPOSE

This policy establishes guidelines related to CalOptima Health's Business Associate Agreements (BAA) with individuals or entities who are considered Business Associates.

II. POLICY

A. As part of any Services Agreement where a Business Associate performs a service or function on behalf of CalOptima Health, CalOptima Health shall execute a BAA, in addition to the Service Agreement, that meets the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and the Department of Health Care Services (DHCS) Contract.

B. CalOptima Health shall not Disclose, transmit or share PHI with an individual or business that performs a service or function using CalOptima Health member PHI without an executed BAA.

C. CalOptima Health shall only contract with individuals or businesses that meet the requirements outlined in CalOptima Health's BAA template.

D. CalOptima Health's Provider Contracting and/or Vendor Management Departments, as applicable, shall use CalOptima Health's BAA template, unless prior written approval is given by the Information Security Officer, Privacy Officer and Legal Counsel to use the proposed Business Associate's template based on the proposed Business Associate's template meeting all of the HIPAA Privacy and Security requirements.

E. Any proposed edit or modification to the BAA requested by the proposed Business Associate shall be reviewed by the Vendor Management or Contracting Departments, as applicable, and must be approved by the appropriate CalOptima Health staff (e.g., CalOptima Health Security Officer, Privacy Officer, and Legal Counsel, as appropriate) before executing the BAA.

1. CalOptima Health cannot accept any revisions to the BAA that conflict with the DHCS Contract or the underlying Service Agreement.

2. CalOptima Health cannot accept any revisions that would allow the Business Associate to Use or Disclose PHI in a manner that would violate the HIPAA Privacy and Security requirements.

F. If the Business Associate requires access to CalOptima Health member PHI in order to perform the function or service provided in the Service Agreement on behalf of CalOptima Health, and the

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Business Associate refuses to sign the BAA, CalOptima Health may not disclose any CalOptima Health member PHI to the Business Associate and cannot contract with the Business Associate for the services.

G. The CalOptima Health Privacy Officer, in collaboration with Information Technology Services, will maintain and update the BAA template based on statutory, regulatory and/or DHCS Contract changes.

1. Any new BAA templates (or amendments) must include specified core elements and requirements in accordance with Title 45, Code of Federal Regulations, Sections164.502 (e)(1-2) and 164.504 (e)(1-2), which shall include, but not be limited to, the following provisions:

   a. Use and Disclosure;

   b. Minimum Necessary Requirement;

   c. Use Appropriate Safeguards;

   d. Reporting of Any Unauthorized Use or Disclosure;

   e. Subcontractor Requirements;

   f. Right of Access;

   g. Right of Amendment;

   h. Right to an Accounting of Disclosures;

   i. Books and Records Available;

   j. Termination; and

   k. Effect of Termination.

2. Updates to the BAA templates (or amendments) must be submitted to the Legal Counsel for review.

H. CalOptima Health reserves the right to automatically amend BAAs at any time when such modifications are necessary to comply with changes in:

1. Applicable laws;

2. CalOptima Health's contracts with government regulators; or

3. In any requirements and conditions with which CalOptima must comply pursuant to its federally-approved Section 1915(b) waiver ("Regulatory Change").

I. CalOptima Health's BAA will require that its Business Associates comply with privacy laws that provide for more restrictive protections than HIPAA.

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III. PROCEDURE

A. Assessing potential Business Associate Relationships

1. Prior to issuing a Request for Proposal (RFP) or negotiating or entering into an underlying Service Agreement with an individual or business, the Provider Contracting or Vendor Management Department, in collaboration with the Contract Owner and the Privacy Officer, will determine whether a Business Associate relationship exists.

    a. Examples of Business Associates include, but are not limited to individuals or entities that:

        i. Create, receive, maintain, or transmit PHI for claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing;

        ii. Provide legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services to or for CalOptima Health, where the provision of the service involves the Disclosure of PHI to the individual or entity;

        iii. Are a Health Information Organization/Exchange, E-prescribing Gateway, or that provide data transmission services with respect to PHI to CalOptima Health and that requires access on a routine basis to such PHI including, but not limited to cloud providers; and/or

        iv. Are providers of personal health records to individuals on behalf of CalOptima Health.

    b. Examples of individuals and entities that are not considered Business Associates:

        i. Workforce members, such as employees, interns and CalOptima Health volunteers.

        ii. Treatment providers, unless they are providing administrative services (which involve PHI) on behalf of CalOptima Health in addition to providing Member care.

2. The information Disclosed to the Business Associate by CalOptima Health must be restricted to the minimum amount necessary to enable the Business Associate to perform the function or provide the services for which CalOptima Health has contracted with the BA.

B. Maintenance of the BAA

1. The CalOptima Health Contracting and Vendor Management Departments shall maintain a current inventory of BAAs within the contract management system managed by the respective department.

2. The CalOptima Health Contracting and Vendor Management Departments shall be responsible for ensuring Business Associates have signed the most current (DHCS- approved) version of the BAA template.

3. The CalOptima Health Contracting and Vendor Management Departments shall be responsible for obtaining the required signatures for all BAAs and maintaining the original signed BAA and

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any amendments and/or addendums thereto within the contract management system managed by the respective department.

4. CalOptima Health may terminate any BAA and applicable Service Agreement when patterns of material breaches or violations of the BAA or Service Agreement occur, or where reasonable measures to remediate non-compliant issues are unsuccessful in accordance with those agreements.

5. The BAA shall remain in effect throughout the term of any associated Service Agreement and shall extend beyond the termination of any Service Agreement(s) until such time as all the PHI provided by CalOptima Health to the BA, or created or received by the Business Associate on behalf of CalOptima Health, is destroyed or returned to CalOptima Health as specified in the Service Agreement and outlined in the BAA.

6. Whenever a Service Agreement that included a BAA expires by its own terms or is terminated before the end of its term, the Contracting or Vendor Management Department, as applicable, must obtain written certification from the Business Associate that all PHI received from or created or received by the Business Associate has either been returned, destroyed, or otherwise accounted for in accordance with the terms of the Service Agreement.

7. The Business Associate shall comply with the disposition of PHI requirements as specified in the BAA Template section 15.

C. Regulatory Amendments to the BAA

1. CalOptima Health will promptly notify its Business Associates, in writing, of any Regulatory Change in accordance with applicable federal and/or state requirements. CalOptima Health will require its Business Associates to comply with the new Regulatory Change requirements within thirty (30) days of the effective date of the Regulatory Change, unless otherwise instructed by a CalOptima Health government regulator.

D. CalOptima Health's BAA will require that Business Associates comply with applicable laws that provide more protections to Member Medical Information.

1. CalOptima Health requires that businesses described in California Civil Code, Section 56.06 that maintain Member electronic Medical Information comply with the following requirements regarding Sensitive Services:

   a. Limit access privileges to information systems containing Medical Records related to Gender Affirming Care, abortion, abortion-related services, and contraception ("Restricted Information") only to persons authorized to access that specified information,

   b. Prevent disclosure, access, transfer, transmission, or processing (and provide the ability to automatically disable access) of Restricted Information by other persons and entities outside of California; and

   c. Segregate restricted information from the rest of the Member's records.

2. CalOptima Health will also require that contractors that maintain Member Medical Information do not cooperate with any inquiry or investigation by, or provide Medical Information to, any

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individual, agency, or department from another state or, to the extent permitted by federal law, to a federal law enforcement agency regarding Abortion Services, unless the request for Medical Information is authorized under California Civil Code, Section 56.110.

IV. ATTACHMENT(S)

A. Business Associate Disposition of Protected Health Information Form
B. Business Associate Retention of Protected Health Information Form
C. CalOptima Health Business Associate Agreement Template

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health PACE Program Agreement
C. Title 45, Code of Federal Regulations §160.103
D. Title 45, Code of Federal Regulations §164.502 (a)(1-4) & (e)(1-2)
E. Title 45, Code of Federal Regulations §164.504 (e)(1-2)
F. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
02/04/2022	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
12/20/2021	Special Meeting of the CalOptima Board of Directors
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	12/20/2021	HH.3022	Business Associate Agreements	Medi-Cal OneCare OneCare Connect PACE Administrative
Revised	12/31/2022	HH.3022	Business Associate Agreements	Medi-Cal OneCare PACE Administrative
Revised	09/01/2023	HH.3022	Business Associate Agreements	Medi-Cal OneCare PACE Administrative

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Action	Date	Policy	Policy Title	Program(s)
Revised	11/01/2023	HH.3022	Business Associate Agreements	Medi-Cal OneCare PACE Administrative
Revised	11/07/2024	HH.3022	Business Associate Agreements	Medi-Cal OneCare PACE Administrative

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IX. GLOSSARY

Term	Definition
Business Associate (BA)	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: 1. On behalf of such covered entity or of an organized health care arrangement (as defined in this section) in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or 2. Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of protected health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person. A covered entity may be a business associate of another covered entity. Business associate includes: 1. A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a covered entity and that requires access on a routine basis to such protected health information. 2. A person that offers a personal health record to one or more individuals on behalf of a covered entity. 3. A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the business associate.
Business Associate Agreement (BAA)	A covered entity's contract or other written arrangement with its business associate, which includes the elements specified at 45 CFR 164.504(e).

Term	Definition
Contract Owner	The one individual within CalOptima Health with ultimate responsibility for the relationship between CalOptima Health and the Delegated Entity. Contract Owner responsibilities include, but are not limited to, initial contact, procurement, negotiation of contract terms, compliance remediation, on-going entity relations, site closings, hours of operations, etc. The Contract Owner is the individual with responsibility for ensuring that the documentation regarding the relationship between CalOptima Health and the Delegated Entity is complete and accurate.
DHCS Contract	The written instrument between CalOptima Health and the Department of Health Care Services (DHCS) pursuant to which CalOptima Health is obligated to arrange and pay for the provision of Covered Services to Members in the Service Area.
Covered Entity	A health plan, a health care clearinghouse, or a health care provider who transmits any health information in electronic form in connection with a transaction covered by Title 45, Code of Federal Regulations, Part 160.
Disclosure	Has the meaning given such term in section 160.103 of Title 45, Code of Federal Regulations including the following: the release, transfer, provision of access to, or divulging in any other manner of information outside of the entity holding the information.
Electronic Protected Health Information (EPHI)	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. Individually identifiable health information that is transmitted by Electronic Media or maintained in Electronic Media
Gender Affirming Care	Medically necessary health care or gender affirming mental health care that respects the gender identity of the patient, as experienced and defined by the patient, and may include, but is not limited to: 1. Interventions to suppress the development of endogenous secondary sex characteristics; 2. Interventions to align the patient's appearance or physical body with the patient's gender identity; and 3. Interventions to alleviate symptoms of clinically significant distress resulting from gender dysphoria, as defined in the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition. Welfare and Institutions Code § 16010.2(b).
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, and as subsequently amended.

Term	Definition
Medical Information	Has the meaning in Civil Code § 56.05(j): Any individually identifiable information, in electronic or physical form, in possession of or derived from a provider of health care, health care service plan, pharmaceutical company, or contractor regarding a patient's medical history, mental health application information, Reproductive or Sexual Health Application Information, mental or physical condition, or treatment. For purposes of this definition, "Individually Identifiable" means that the Medical Information includes or contains any element of personal identifying information sufficient to allow identification of the individual, such as the patient's name, address, electronic mail address, telephone number, or social security number, or other information that, alone or in combination with other publicly available information, reveals the identity of the individual. For purposes of this definition, "Reproductive or Sexual Health Application Information" means information about an individual's reproductive health, menstrual cycle, fertility, pregnancy, pregnancy outcome, plans to conceive, or type of sexual activity collected by a reproductive or sexual health digital service, including, but not limited to, information from which one can infer someone's pregnancy status, menstrual cycle, fertility, hormone levels, birth control use, sexual activity, or gender identity. Civ. Code § 56.05(q).
Member	A beneficiary enrolled in a CalOptima Health program.
Payment	Has the meaning in Title 42 of the Code of Federal Regulations, Section 164.501, including: activities carried out by CalOptima Health including: 1. Determination of eligibility, risk adjustments based on Member health status and demographics, billing claims management, and collection activities; 2. Review of health care services regarding medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and 3. Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.
Protected Health Information (PHI)	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima Health or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member

Term	Definition
Sensitive Services	All health care services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence, and includes services described in Family Code, Sections 6924, 6925, 6926, 6927, 6928, 6929, and 6930, and Health and Safety Code, Sections 121020 and 124260, obtained by a patient at or above the minimum age specified for consenting to the service, in accordance with California Civil Code, Section 56.05(s).
Service Agreement	A service agreement is a written agreement whereby a Business Associate agrees to provide services to CalOptima Health, and the Business Associate creates, receives, maintains, uses or transmits Protected Health Information in order to provide those services.
Treatment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities undertaken on behalf of a Member including the provision, coordination, or management of health care and related services; the referral to, and consultation between, health care Providers; and coordination with third parties for services related to the management of the Member's health care benefits.
Use	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. The sharing, employment, application, utilization, examination, or analysis of the PHI within an entity that maintains such information.
Workforce	Has the meaning in 45 Code of Federal Regulations Section 160.103 Workforce means employees, volunteers, trainees, and other persons whose conduct, in the performance of work for a covered entity or business associate, is under the direct control of such covered entity or business associate, whether or not they are paid by the covered entity or business associate.

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Business Associate Disposition of Protected Health Information Form

On behalf of (Business Associate Name), I certify the following:

All PHI received from CalOptima Health has been returned or destroyed; return or destruction includes returning or destroying all PHI received from CalOptima Health or created or received by (Business Associate Name) in any form on behalf of CalOptima Health in accordance with the data destruction methods specified in Attachment A of the Business Associate Agreement.

(Business Associate Name) has destroyed all confidential information and PHI belonging to CalOptima Health as of the following date: _____

Furthermore, (Business Associate Name) has not downloaded, transferred, copied, duplicated, removed or otherwise taken without written authorization any such confidential information (including member health or other information) from any information systems or premise in violation of HIPAA and/or any other applicable state or federal confidentiality or privacy laws. Business Associate shall retain no copies of the PHI. This includes any PHI that is in the possession of the Business Associate and subcontractors or agents of the Business Associate.

(Business Associate Name) understands and acknowledges that this statement will be relied on by CalOptima Health for purposes of accountability to regulators.

(Business Associate Name) declares under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

_____
Business Associate Contract Owner/Designee (Signature)

_____
Business Associate Contract Owner/Designee (Print Name)

_____
Date

Please return completed form to CalOptima Health's Privacy Department at privacy@caloptima.org

Business Associate Retention of Protected Health Information Form

On behalf of (Business Associate Name), I certify the following:

In the event that (Business Associate Name) cannot return or destroy all PHI received from CalOptima Health or created or received by (Business Associate Name) in any form on behalf of CalOptima Health, Business Associate must specify the reason as to why return/destruction is not feasible below and include the status of the PHI. If such return or destruction is not feasible, (Business Associate Name) shall extend the protections of the contract and the BAA to the PHI and limit further uses and disclosures.

Reason:_____

_____

PHI Status:_____

_____

This includes any PHI that is in the possession of the Business Associate and subcontractors or agents of the Business Associate.

(Business Associate Name) understands and acknowledges that this statement will be relied on by CalOptima Health for purposes of accountability to regulators.

(Business Associate Name) declares under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

_____
Business Associate Contract
Owner/Designee (Signature)

_____
Business Associate Contract
Owner/Designee
(Print Name)

_____
Date

Please return completed form to CalOptima Health's Privacy Department at privacy@caloptima.org

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Business Associate Agreement

This Business Associate Agreement is entered into by and between the Orange County Health Authority, a California local public agency, doing business as CalOptima Health ("CalOptima Health"), and _____, a _____ ("Business Associate"), effective _____ ("Effective Date"). CalOptima Health and Business Associate are each a party to this Agreement and are collectively referred to as the "parties." Any extensions or renegotiations of this Agreement shall be reviewed by both parties and pursuant to CalOptima Health Policy HH.3022: Business Associate Agreements.

[*Alternative introduction for BAA as an exhibit*]

Business Associate Addendum

This Business Associate Addendum by and between CalOptima Health and Contractor, which for the purposes of this addendum shall be referred to as "**Business Associate**", is effective as of the Effective Date of the Agreement

RECITALS

WHEREAS, the parties have executed an agreement(s) whereby Business Associate provides services to CalOptima Health, and Business Associate creates, receives, maintains, uses, transmits protected health information ("PHI") in order to provide those services ("Services Agreement(s)");

WHEREAS, as a covered entity, CalOptima Health is subject to the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act ("HIPAA") of 1996, Public Law 104-191, and regulations promulgated thereunder, including the Standards for Privacy of Individually Identifiable Health Information at 45 Code of Federal Regulations (C.F.R.) Parts 160 and Subparts A and E of 45 C.F.R. Part 164 ("Privacy Regulations") and the Security Standards for Electronic Protected Health Information ("Security Regulations") at 45 C.F.R. Parts 160 and Subparts A and C of 45 C.F.R. Part 164, as amended by the Health Information Technology for Economic and Clinical Health Act ("HITECH Act") of 2009, Public Law 111-5, and regulations promulgated thereunder including the Breach Notification Regulations at Subpart D of 45 C.F.R. Part 164, and is subject to certain state privacy laws;

WHEREAS, as a business associate, Business Associate is subject to certain provisions of HIPAA, and regulations promulgated thereunder, as required by the HITECH Act and regulations promulgated thereunder;

WHEREAS, CalOptima Health and Business Associate are required to enter into a contract in order to mandate certain protections for the privacy and security of PHI;

WHEREAS, CalOptima Health's regulator(s) have adopted certain administrative, technical and physical safeguards deemed necessary and appropriate by it/them to safeguard regulators' PHI and have required that CalOptima Health incorporate such requirements in its business associate agreements with subcontractors that require access to the regulators' PHI;

NOW, THEREFORE, in consideration of the foregoing, and for other good and valuable consideration, the receipt and adequacy of which is hereby acknowledged, the parties agree as follows:

1. **Definitions**. Terms used, but not otherwise defined, in this Agreement shall have the same meaning as those terms in HIPAA, the HITECH Act, and regulations promulgated thereunder.

1.1. **Agreement** as used in this document means both this Business Associate Agreement and the Services Agreement to which this Business Associate Agreement applies, as specified in such Services Agreement.

1.2. **Breach** means, unless expressly excluded under 45 C.F.R. § 164.402, the acquisition, access, use, or disclosure of PHI in a manner not permitted under Subpart E of 45 C.F.R. Part 164 which compromises the security or privacy of the PHI and as more particularly defined under 45 C.F.R. § 164.402.

1.3. **Business associate** has the meaning given such term in 45 C.F.R. § 160.103.

1.4. **Confidential information** refers to information not otherwise defined as PHI in Section 1.15 below, but to which state and/or federal privacy and/or security protections apply.

1.5. **Data aggregation** has the meaning given such term in 45 C.F.R. § 164.501.

1.6. **Designated record set** has the meaning given such term in 45 C.F.R. § 164.501.

1.7. **Disclose** and **disclosure** mean the release, transfer, provision of access to, or divulging in any other manner of information outside the entity holding the information.

1.8. **Electronic health record** has the meaning given such term in 42 U.S.C. § 17921.

1.9. **Electronic media** means:

1.9.1. Electronic storage material on which data is or may be recorded electronically including, for example, devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; or

1.9.2. Transmission media used to exchange information already in electronic storage media. Transmission media include, for example, the internet, extranet or intranet, leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including of paper, via facsimile, and of voice, via telephone, are not considered to be transmissions via electronic media, because the information being exchanged did not exist in electronic form before the transmission.

1.10. **Electronic protected health information** ("ePHI") means individually identifiable health information that is transmitted by or maintained in electronic media.

1.11. **Health care operations** has the meaning given such term in 45 C.F.R. § 164.501.

1.12. **Individual** means the person who is the subject of PHI and shall include a person who qualifies as a personal representative in accordance with 45 C.F.R. § 164.502(g).

1.13. **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 C.F.R. § 160.103.

1.14. **Information system** means an interconnected set of information resources under the same direct management control that shares common functionality. A system normally includes hardware, software, information, data, applications, communications, and people.

1.15. **Protected health information** ("PHI"), as used in this Agreement and unless otherwise stated, refers to and includes both PHI as defined at 45 C.F.R. § 160.103 and personal information ("PI") as defined in the Information Practices Act at California Civil Code § 1798.3(a). PHI includes information in any form, including paper, oral, and electronic.

1.16. **Required by law** means a mandate contained in law that compels an entity to make a use or disclosure of PHI and that is enforceable in a court of law. Required by law 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; a civil or an authorized investigative demand; 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 benefits.

1.17. **Secretary** means the Secretary of the U.S. Department of Health and Human Services or the Secretary's designee.

1.18. **Security incident** means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

1.19. **Services** has the same meaning as in the Services Agreement(s).

1.20. **Unsecured protected health information** ("unsecured PHI") means PHI that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of technology or methodology specified by the Secretary in the guidance issued under 42 U.S.C. § 17932(h)(2).

1.21. **Use** and **uses** mean, with respect to individually identifiable health information, the sharing, employment, application, utilization, examination or analysis of such information within the entity that maintains such information.

2. CalOptima Health 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 PHI and/or confidential information protected by federal and/or state laws.

3. Business Associate is the business associate of CalOptima Health acting on CalOptima Health's behalf and provides services or arranges, performs or assists in the performance of functions or activities on behalf of CalOptima Health, 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.

4. **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 CalOptima Health, provided that such use or disclosure would not violate HIPAA, including the Privacy Regulations, if done by CalOptima Health.

4.1. **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, in writing, 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.

4.2. **Data Aggregation**. If authorized as part of the services provided to CalOptima Health under the Services Agreement, Business Associate may use PHI to provide data aggregation services relating to the health care operations of CalOptima Health.

5. **Prohibited Uses and Disclosures of PHI**

5.1. **Restrictions on Certain Disclosures to Health Plans**. 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 HIPAA and the HITECH Act, including 45 C.F.R. § 164.522(a). The term PHI, as used in this Section, only refers to PHI as defined in 45 C.F.R. § 160.103.

5. 2. **Prohibition on Sale of PHI; No Remuneration**. Business Associate shall not directly or indirectly receive remuneration in exchange for PHI, except with the prior written authorization of CalOptima Health and CalOptima Health's regulator(s), as applicable, and then, only as permitted by HIPAA and the HITECH Act. The term PHI, as used in this Section, only refers to PHI as defined in 45 C.F.R. § 160.103.

6. **Compliance with Other Applicable Law**

6.1. 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:

6.1.1. 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

6.1.2. To treat any violation of such additional and/or more protective standards as a breach or security incident, as appropriate, pursuant to Section 17 of this Agreement.

6.2 Examples of laws that provide additional and/or stricter privacy protections to certain types of PHI and/or confidential information, as defined in Section 1 of this Agreement, include, but are not limited to the Information Practices Act, California Civil Code §§ 1798-1798.78, Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, Welfare and Institutions Code § 5328, and California Health and Safety Code § 11845.5.

6.3 If Business Associate is a Qualified Service Organization ("QSO") as defined in 42 C.F.R. § 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 C.F.R. § 2.11.

7. **Additional Responsibilities of Business Associate**

7.1. **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.

7.2. **Safeguards and Security**

7.2.1. 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 C.F.R. Part 164 with respect to ePHI, to prevent use or disclosure of the information other than as provided for by this Agreement. Such safeguards shall be, at a minimum, at Federal Information Processing Standards (FIPS) Publication 199 protection levels. Business Associate shall implement reasonable and appropriate policies and procedures to comply with the standards, implementation specifications and other requirements of Subpart C of 45 C.F.R. Part 164, in compliance with 45 C.F.R. § 164.316. Business Associate shall maintain a comprehensive 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.

7.2.2. 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:

7.2.2.1. NIST SP 800-53 - National Institute of Standards and Technology Special Publication 800-53

7.2.2.2. FedRAMP - Federal Risk and Authorization Management Program

7.2.2.3. PCI - PCI Security Standards Council

7.2.2.4. ISO/ESC 27002 - International Organization for Standardization / International Electrotechnical Commission standard 27002

7.2.2.6. IRS PUB 1075 - Internal Revenue Service Publication 1075

7.2.2.7. HITRUST CSF - HITRUST Common Security Framework

7.2.3. 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. Business Associate shall maintain, at a minimum, the most current industry standards for transmission and storage of PHI and other confidential information, including, but not limited to, encryption of all workstations, laptops, and removable media devices containing PHI and data transmissions of PHI.

[*Alternate Provision for Section 7.2.3*: "Business Associate shall maintain, at a minimum, the most current industry standards for transmission and storage of PHI and other confidential information. Without limiting the foregoing, Business Associate shall maintain, at a minimum, the most current industry standards, for encryption of all workstations, laptops, and removable media devices containing PHI and data transmissions of PHI, unless Business Associate complies with applicable requirements of the Security Regulations, including 45 C.F.R. §§ 164.306 and 164.312."]

7.2.4. 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.

7.2.5. 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.

7.2.6. Business Associate shall identify the security official who is responsible for the development and implementation of the policies and procedures required by 45 C.F.R. Part 164, Subpart C.

7.3. **Minimum Necessary**. With respect to any permitted use, disclosure, or request of PHI under this Agreement, Business Associate shall make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of such use, disclosure, or request respectively, as specified in 45 C.F.R. § 164.502(b).

7.4. **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 through a written agreement to the same restrictions, conditions, and requirements that apply to Business Associate with respect to such PHI and/or confidential information.

8. **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.

9. **Access to PHI**. Except as otherwise provided in Section 9.1 below, Business Associate shall, to the extent CalOptima Health determines that any PHI constitutes a designated record set, make the PHI specified by CalOptima Health available to the individual(s) identified by CalOptima Health as being entitled to access and copy that PHI. Business Associate shall provide such access for inspection of that PHI within fifteen (15) calendar days after receipt of request from CalOptima Health. Business Associate shall also provide copies of that PHI ten (10) calendar days after receipt

of request from CalOptima Health. If Business Associate maintains an electronic health record with PHI, and an individual requests a copy of such information in electronic format, Business Associate shall make such information available in that format as required under the HITECH Act and 45 C.F.R. § 164.524(c)(2)(ii).

9.1. **Business Associate of CalOptima Health PACE**. This Section applies when Business Associate is a business associate of CalOptima Health in CalOptima Health's capacity as a health care provider through CalOptima Health Program of All-Inclusive Care for the Elderly ("CalOptima Health PACE"). Business Associate shall, to the extent CalOptima Health determines that any PHI constitutes a designated record set or patient records (as defined in California Health and Safety Code § 123105), make the PHI specified by CalOptima Health available to the individual(s) identified by CalOptima Health as being entitled to access and copy that PHI. To enable compliance with California Health & Safety Code § 123110 and 45 C.F.R. § 164.524, Business Associate shall provide such access for inspection of that PHI within three (3) working days after receipt of request from CalOptima Health. Business Associate shall also provide copies of that PHI ten (10) calendar days after receipt of request from CalOptima Health. If Business Associate maintains an electronic health record with PHI, and an individual requests a copy of such information in electronic format, Business Associate shall make such information available in that format as required under the HITECH Act and 45 C.F.R. § 164.524(c)(2)(ii).

10. **Amendment of PHI**. Business Associate shall, to the extent CalOptima Health determines that any PHI constitutes a designated record set, make PHI available for amendment and incorporate any amendments to PHI in accordance with 45 C.F.R. § 164.526 as requested by CalOptima Health in the time and manner designated by CalOptima Health.

11. **Accounting of Disclosures**. Business Associate shall document and make available to CalOptima Health or (at the direction of CalOptima Health) 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 HIPAA, the HITECH Act and implementing regulations. Unless directed by CalOptima Health to make available to an individual, Business Associate shall provide to CalOptima Health, within thirty (30) calendar days after receipt of request from CalOptima Health, information collected in accordance with this Section to permit CalOptima Health to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528. The term PHI, as used in this Section, only refers to PHI as defined in 45 C.F.R. § 160.103. Any accounting provided by Business Associate under this Section shall include:

11.1. The date of the disclosure;

11.2. The name, and address if known, of the entity or person who received the PHI;

11.3. A brief description of the PHI disclosed; and

11.4. A brief statement of the purpose of the disclosure.

For each disclosure that could require an accounting under this Section, Business Associate shall document the information enumerated above, and shall securely maintain the information for six (6) years from the date of the disclosure (but beginning no earlier than April 14, 2003).

12. **Compliance with HITECH Act**. Business Associate shall comply with the requirements of Title XIII, Subtitle D, of the HITECH Act, which are applicable to business associates, and shall comply with the regulations promulgated thereunder.

13. **Compliance with Obligations of CalOptima Health or DHCS**. To the extent Business Associate is to carry out an obligation of CalOptima Health or the California Department of Healthcare Services ("DHCS") under 45 C.F.R. Part 164, Subpart E, Business Associate shall comply with the requirements of such Subpart that apply to CalOptima Health or DHCS, as applicable, in the performance of such obligation.

14. **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 CalOptima Health available to CalOptima Health upon reasonable request, and to the DHCS and the Secretary for purposes of determining CalOptima Health's compliance with 45 C.F.R. Part 164, Subpart E. Business Associate also agrees to make its internal practices, books and records relating to the use and disclosure of PHI on behalf of CalOptima Health available to DHCS, CalOptima Health, and the Secretary for purposes of determining Business Associate's compliance with applicable requirements of HIPAA, the HITECH Act, and implementing regulations. Business Associate shall immediately notify CalOptima Health of any requests made by DHCS or the Secretary and provide CalOptima Health with copies of any documents produced in response to such request.

15. **Return or Destroy PHI on Termination; Survival**. At termination of this Agreement, if feasible, Business Associate shall return to CalOptima Health or, if agreed to by CalOptima Health, destroy all PHI and other confidential information received from, or created or received by Business Associate on behalf of, CalOptima Health that Business Associate or its agents or subcontractors still maintains in any form, and shall retain no copies of such information. If CalOptima Health elects destruction of PHI and/or other confidential information, Business Associate shall ensure such information is destroyed in accordance with the destruction methods specified in Sections 15.1 and 15.2 below, and shall certify in writing to CalOptima Health that such information has been destroyed accordingly. If return or destruction is not feasible, Business Associate shall notify CalOptima Health of the conditions that make the return or destruction infeasible. Subject to the approval of CalOptima Health's regulator(s) if necessary, if such return or destruction is not feasible, CalOptima Health shall determine the terms and conditions under which Business Associate may retain the PHI. Business Associate shall also 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.

    15.1 **Data Destruction**. Data destruction methods for CalOptima Health PHI or confidential information must conform to U.S. Department of Defense standards for data destruction 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 CalOptima Health and, if necessary, CalOptima Health's regulator(s).

    15.2 **Destruction of Hard Copy Confidential Data**. CalOptima Health PHI or confidential information in hard copy form must be disposed of through confidential means, such as crosscut shredding and pulverizing.

16. **Special Provision for SSA Data**. If Business Associate receives data from or on behalf of CalOptima Health 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 CalOptima Health, a list of all employees and agents and employees who have access to such data, including employees and agents of its agents, to CalOptima Health.

17. **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:

17.1. **Notice to CalOptima Health**

17.1.1. **Immediate Notice**. Business Associate shall notify CalOptima Health 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 CalOptima Health.

17.1.2. **24-Hour Notice**. Business Associate shall notify CalOptima Health within 24 hours by email (or by telephone if Business Associate is unable to email CalOptima Health) of the discovery of:

17.1.2.1. Unsecured PHI if the PHI is reasonably believed to have been accessed or acquired by an unauthorized person;

17.1.2.2. Any suspected security incident which risks unauthorized access to PHI and/or other confidential information;

17.1.2.3. Any intrusion or unauthorized access, use or disclosure of PHI in violation of this Agreement; or

17.1.2.4. Potential loss of confidential data affecting this Agreement.

17.1.3. Notice shall be provided to the CalOptima Health Privacy Officer ("CalOptima Health Contact") using the CalOptima Health Contact Information at Section 17.7 below. Such notification by Business Associate shall comply with CalOptima Health's form and content requirements for reporting privacy incident and shall include all information known at the time the incident is reported.

17.2. **Required Actions**. Upon discovery of a breach or suspected security incident, intrusion or unauthorized access, use or disclosure of PHI, Business Associate shall take:

17.2.1. Prompt action to mitigate any risks or damages involved with the security incident or breach;

17.2.2. Any action pertaining to such unauthorized disclosure required by applicable federal and state law; and

17.2.3. Any corrective actions required by CalOptima Health or CalOptima Health's regulator(s).

17.3. **Investigation**. Business Associate shall immediately investigate such security incident or confidential breach. Business Associate shall comply with CalOptima Health's additional form and content requirements for reporting such privacy incident.

17.3.1. Incident details including the date of the incident and when it was discovered;

17.3.2. The identification of each individual whose unsecured PHI has been, or is reasonably believed by Business Associate to have been accessed, acquired, used or disclosed during the breach;

17.3.3. The nature of the data elements involved, and the extent of the data involved in the breach;

17.3.4. A description of the unauthorized persons known or reasonably believed to have improperly used or disclosed PHI or confidential data;

17.3.5. A description of where the PHI or confidential data is believed to have been improperly transmitted, sent, or utilized;

17.3.6. A description of the probable causes of the improper use or disclosure;

17.3.7. Any other available information that the Business Associate is required to include in notification to the individual under 45 C.F.R. § 164.404(c);

17.3.8. Whether the PHI or confidential data that is the subject of the security incident, breach, or unauthorized use or disclosure of PHI or confidential data included unsecured PHI;

17.3.9. Whether a law enforcement official has requested a delay in notification of individuals of the security incident, breach, or unauthorized use or disclosure of PHI or confidential data because such notification would impede a criminal investigation or damage national security and whether such notice is in writing; and

17.3.10. Whether Section 13402 of the HITECH Act (codified at 42 U.S.C. § 17932), California Civil Code §§ 1798.29 or 1798.82, or any other federal or state laws requiring individual notifications of breaches are triggered.

17.4. **Complete Report**. Business Associate shall provide a complete written report of the investigation ("Final Report") to the CalOptima Health Contact within seven (7) working days of the discovery of the security incident or breach. Business Associate shall comply with CalOptima Health's additional form and content requirements for reporting of such privacy incident.

17.4.1. The Final Report shall provide a comprehensive discussion of the matters identified in Section 17.3 above and the following:

17.4.1.1. An assessment of all known factors relevant to a determination of whether a breach occurred under HIPAA and other applicable federal and state laws;

17.4.1.2. 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 and to reduce the harmful effects of the breach;

17.4.1.3. The potential impacts of the incident, such as potential misuse of data, identity theft, etc.; and

17.4.1.4. A corrective action plan describing how Business Associate will prevent reoccurrence of the incident in the future. Notwithstanding the foregoing, all corrective actions are subject to the approval of CalOptima Health and CalOptima Health's regulator(s), as applicable.

17.4.2. If CalOptima Health or CalOptima Health's regulator(s) requests additional information, Business Associate shall make reasonable efforts to provide CalOptima Health with such information. A supplemental written report may be used to submit revised or additional information after the Final Report is submitted.

17.4.3. CalOptima Health and CalOptima Health's regulator(s), as applicable, 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.

17.4.4. **New Submission Timeframe**. If Business Associate does not complete a Final Report within the seven (7) working day timeframe specified in Section 17.4 above, Business Associate shall request approval from CalOptima Health within the seven (7) working day timeframe of a new submission timeframe for the Final Report. Business Associate acknowledges that a new submission timeframe requires the approval of CalOptima Health and, if necessary, CalOptima Health's regulator(s).

17.5. **Notification of Individuals**. If the cause of a breach is attributable to Business Associate or its agents, then CalOptima Health or, as required by CalOptima Health, Business Associate shall notify individuals accordingly. The notifications shall comply with applicable federal and state law. All such notifications shall be coordinated with CalOptima Health. CalOptima Health and CalOptima Health regulator(s), as applicable, shall approve the time, manner and content of any such notifications. Business Associate acknowledges that such review and approval by CalOptima Health and CalOptima Health regulator(s), as applicable, must be obtained before the notifications are made.

17.6. **Responsibility for Reporting of Breaches to Entities Other than CalOptima Health**. If the cause of a breach of PHI is attributable to Business Associate or its subcontractors, Business Associate agrees that CalOptima Health shall make all required reporting of the breach as required by applicable federal and state law, including any required notifications to media outlets, the Secretary, and other government agency/regulator.

17.7. **CalOptima Health Contact Information**. To direct communications to CalOptima Health Privacy Officer, the Business Associate shall initiate contact as indicated here. CalOptima Health 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.

CalOptima Health Privacy Office

Privacy Officer
Office of Compliance
CalOptima Health
505 City Parkway West
Orange CA 92868

Email: privacy@caloptima.org

Telephone: (714) 246-8400 (ask the operator to connect to Privacy Officer)

18. **Responsibilities of CalOptima Health**

18.1 CalOptima Health 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.

18.2 **Notification of SSA Data**. CalOptima Health shall notify Business Associate if Business Associate receives data that is SSA data from or on behalf of CalOptima Health.

19. **Indemnification**. Business Associate will immediately indemnify and pay CalOptima Health for and hold it harmless from (i) any and all fees and expenses CalOptima Health incurs in investigating, responding to, and/or mitigating a breach of PHI or confidential information caused by Business Associate or its subcontractors or agents; (ii) any damages, attorneys' fees, costs, liabilities or other sums actually incurred by CalOptima Health due to a claim, lawsuit, or demand by a third party arising out of a breach of PHI or confidential information caused by Business Associate or its subcontractors or agents; and/or (iii) for fines, assessments and/or civil penalties assessed or imposed against CalOptima Health by any government agency/regulator based on a breach of PHI or confidential information caused by Business Associate or its subcontractors or agents. Such fees and expenses may include, without limitation, attorneys' fees and costs and costs for computer security consultants, credit reporting agency services, postal or other delivery charges, notifications of breach to individuals, and required reporting of breach. Acceptance by CalOptima Health of any insurance certificates and endorsements required under the Service Agreement(s) does not relieve Business Associate from liability under this indemnification provision. This provision shall apply to any damages or claims for damages whether or not such insurance policies shall have been determined to apply.

20. **Audits, Inspection and Enforcement**

20.1. From time to time, CalOptima Health or CalOptima Health's regulator(s) 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 CalOptima Health Privacy Officer in writing. Whether or how CalOptima Health or CalOptima Health's regulator(s) 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 CalOptima Health unless it is legally prohibited from doing so.

21. **Term and Termination**

[For Standalone BAA]

21.1. **Term.** The term of this Agreement shall be effective as of the Effective Date and shall terminate in either (i) accordance with this Section 21 or (ii) when all of the PHI provided by CalOptima Health to Business Associate, or created or received by Business Associate on behalf of CalOptima Health, is destroyed or returned to CalOptima Health in accordance with Section 15. CalOptima Health may terminate this BAA, without cause, on five (5) days' prior written notice to Business Associate.

[For BAA as an exhibit to an agreement]

21.1 **Term**. This exhibit is effective as of the Effective Date and shall terminate when (i) the Services Agreement terminates, (ii) in accordance with this Section 21, or (iii) when all of the PHI provided by CalOptima Health to Business Associate, or created or received by Business Associate on behalf of CalOptima Health, is destroyed or returned to CalOptima Health, or, if it is infeasible to return or destroy PHI, protections are extended to such information, in accordance with the termination provisions in Section 15.

21.2. **Termination for Cause**. Upon CalOptima Health's knowledge of a violation of this Agreement by Business Associate, CalOptima Health may in its discretion:

21.2.1. 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 CalOptima Health; or

21.2.2. Terminate this Agreement if Business Associate has violated a material term of this Agreement.

21.3. **Judicial or Administrative Proceedings**. CalOptima Health 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**. CalOptima Health 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 CalOptima Health or CalOptima Health's regulator(s) at no cost to CalOptima Health or CalOptima Health's regulator(s), as applicable, to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against CalOptima Health or CalOptima Health's regulator(s), their respective 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.

22.7. **Statutory or Regulatory Reference**. Any reference to statutory or regulatory language in this Agreement shall be to such language as in effect or as amended.

22.8. **Injunctive Relief**. Notwithstanding any rights or remedies provided in this Agreement, CalOptima Health retains all rights to seek injunctive relief to prevent or stop the unauthorized use or disclosure of PHI or confidential information by Business Associate or any agent, subcontractor, employee or third party that received PHI or confidential information.

22.9 **Monitoring.** As applicable, Business Associate shall comply with monitoring requirements of CalOptima Health's contracts with regulator(s) or any other monitoring requests by CalOptima Health's regulator(s).

EXECUTION

Subject to the execution of a Services Agreement or amendments thereto by Business Associate and CalOptima Health, this Business Associate Agreement shall become effective on the Effective Date.

In witness thereof, the parties have executed this Business Associate Agreement:

Business Associate	CalOptima Health
Print Name	Print Name
Signature	Signature
Title	Title
Date	Date

Policy:	HH.3024
Title:	**Confidentiality of Medical Information Act Compliance**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	*/s/*
Effective Date:	11/07/2024
Revised Date:	Not Applicable
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ PACE ☐ Administrative

I. PURPOSE

This policy is intended to ensure compliance with the California Confidentiality of Medical Information Act (CMIA).

II. POLICY

A. In addition to the requirements under the federal Health Insurance Portability Accountability Act (HIPAA) and its implementing regulations, CalOptima Health must protect the confidentiality of patient Medical Information in accordance with the CMIA. CalOptima Health may not share, sell, use for marketing, or otherwise use any Medical Information for any purpose not necessary to providing health care services to a Member or paying for those services unless an exception applies.

B. The CMIA allows CalOptima Health to disclose Medical Information only as authorized by state or federal law, or as otherwise expressly authorized by a Member.

C. The CMIA requires CalOptima Health to comply with Confidential Communications Requests from Members and prohibits CalOptima Health from requiring a Member covered under another Member's benefit plan or a minor who can consent to treatment (the non-primary Member) to obtain Authorization from the primary subscriber or another enrollee to obtain Sensitive Services if the individual has the right to consent to care. CalOptima Health may not condition enrollment or coverage on a Member waiving their rights under the CMIA.

D. The CMIA also requires that CalOptima Health ensure any entities that offer a Reproductive or Sexual Digital Service to CalOptima Health Members comply with the CMIA and that contractors that maintain electronic Medical Information segregate the information from the rest of the Member's record.

III. PROCEDURE

A. General Disclosures and Authorization: CalOptima Health will not disclose Medical Information unless the Member has provided a valid authorization for disclosure or as permitted or required by law, including:

1. CalOptima Health will disclose Medical Information without authorization as required by a court order, subpoena, or otherwise required by law.

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2. CalOptima Health may disclose Medical Information without authorization when necessary for treatment, payment, or health care operations purposes.

B. Communications Regarding Sensitive Services Provided to non-primary Members:

1. CalOptima Health may not disclose to the primary subscriber, or another enrollee, any Medical Information related to Sensitive Services received by a non-primary Member without express authorization from the non-primary Member.

2. CalOptima Health must direct all communications regarding Sensitive Services to the non-primary Member's designated alternate mailing address, email address, or telephonic number or, in the absence of such information, to the address or telephone on file in the name of the non-primary Member.

3. CalOptima Health may not require a non-primary Member to obtain authorization from the primary subscriber or another enrollee for the non-primary Member to obtain Sensitive Services if the non-primary Member has the right to consent to care.

4. For example, CalOptima Health must not require that a minor 12 years old or older obtain parental consent to obtain outpatient mental health treatment if in the opinion of the treating professional the minor is mature enough to participate intelligently in their care. In addition, the minor may request that CalOptima Health send Communications regarding those mental health or counseling services to a mailing address, email address, or telephone number specified by the minor Member.

C. Confidential Communications Requests: Members may submit Confidential Communications Requests to CalOptima Health as outlined in CalOptima Health's evidence of coverage and on CalOptima Health's website, and CalOptima Health shall process those requests as follows:

1. Privacy Department shall implement requests received electronically or telephonically within seven (7) calendar days of receipt or mail requests within 14 calendar days of receipt.

2. The Privacy Department will acknowledge receipt within two (2) business days. CalOptima Health shall also inform the Member within two (2) business days of the status of implementing the request if the Member asks CalOptima Health.

3. The [responsible department] will copy the Office of Compliance on any and all written communications with Members regarding Confidential Communication Requests.

4. To the extent readily producible, CalOptima Health will produce Confidential Communications in the form and format requested by the Member.

5. The Member's Confidential Communications Request shall remain in effect until revoked or replaced by the Member.

6. CalOptima Health will apply Confidential Communications Requests to all Communications that disclose Medical Information or Provider name and address information related to the Member's receipt of Sensitive Services.

D. Confidential Information Policy Requests: Members may request a written statement from CalOptima Health that describes how CalOptima Health maintains the confidentiality of Medical

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Information obtained by and in the possession of CalOptima Health. CalOptima Health shall respond to such requests with a statement that complies with the following:

1. Is in at least 12 point font type.

2. Describes how CalOptima Health protects the confidentiality of Member Medical Information and informs the Member that any disclosure of Medical Information beyond the provisions of the law is prohibited.

3. Describes the types of Medical Information that may be collected and the sources that may be used to collect the information, as well as the purposes for which CalOptima Health obtains Medical Information from other health care Providers.

4. Describes the circumstances under which Medical Information may be disclosed without prior authorization, in accordance with CalOptima Policies HH.3010: Protected Health Information Disclosures Permitted and Required by Law and HH.3015: Member Authorization for the Use and Disclosure of Protected Health Information.

5. Describes how Members may obtain access to Medical Information created by and in the possession of CalOptima Health, including copies of Medical Information. Members may request Confidential Communications in accordance with CalOptima Health Policy HH.3008: Member Right to Request Confidential Communications.

E. Reproductive or Sexual Health Digital Service: If CalOptima Health contracts with any entity that provides a Reproductive or Sexual Health Digital Service to CalOptima Health Members for the purpose of allowing Members to manage their information, or for the diagnosis, treatment, or management of medical conditions of Members, that entity is deemed a Provider subject to the CMIA. CalOptima Health shall ensure its contract with that entity requires the entity to comply with the CMIA.

1. For example, a software Provider that provides Members with an application for the Members to track their menstrual cycle is considered a Provider by the CMIA. CalOptima Health must ensure such a software Provider complies with the CMIA.

F. Abortion Services Information:

1. CalOptima Health shall not knowingly disclose, transmit, transfer, or grant access to Medical Information to an individual in another state that identifies or is related to an individual seeking, obtaining, providing, supporting, or aiding in the performance of an abortion that is lawful in California (Abortion Services), unless such access is:

   a. Properly authorized under Section III.A of this Policy and clearly states that Medical Information for Abortion Services may be disclosed;

   b. For payment, claims, and billing purposes;

   c. To persons reviewing competence or qualifications of health care professionals;

   d. To persons reviewing health care services with respect to necessity or services, quality of care, or justification of charges;

   e. To accrediting organizations; or

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f. For bona fide research purposes, as permitted under California Civil Code, Sections 56.10(c)(2)-(5), (7) and 56.110(a).

2. Notwithstanding Section III.F.1, CalOptima Health shall disclose electronic Medical Information related to Abortion Services:

a. At the request of a Member or their authorized representative under the Patient Access to Health Records Act;

b. In response to a California or federal court order to the extent clearly stated in the order, if all information about the Member's identity and records are protected from public scrutiny; or

c. Where required by federal law, but only to the extent expressly required.

G. Information Segregation and Investigations:

1. CalOptima Health shall ensure any contractor that maintains the electronic Medical Information of CalOptima Health Members complies with the following requirements regarding Sensitive Services:

a. Limits access privileges to information systems containing Medical Information related to Gender Affirming Care, abortion, abortion-related services, and contraception (Restricted Information) only to persons authorized to access that specified information;

b. Prevents disclosure, access, transfer, transmission, or processing (and provides the ability to automatically disable access) of Restricted Information by persons and entities outside of California; and

c. Segregates Restricted Information from the rest of the Member's records.

2. CalOptima Health and any of its contractors that maintain Restricted Information of CalOptima Health Members shall not cooperate with any inquiry or investigation by or provide Medical Information to any individual, agency, or department from another state regarding Abortion Services, unless the request for Restricted Information is authorized, as specified in Section III.F. above. This prohibition also applies to a federal law enforcement agency, to the extent allowed under federal law.

3. For example, if CalOptima Health's care management systems vendor hosts Member Restricted Information data, the care management system vendor must ensure that Restricted Information is segregated from the rest of the Member's record, the system provides access only to those individuals designated to have access to the Restricted Information, and Restricted Information is not accessible to persons or entities outside of California without proper Member authorization.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Policy HH.3000: Notice of Privacy Practices

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B. CalOptima Health Policy HH.3008: Member Right to Request Confidential Communications
C. CalOptima Health Policy HH.3010: Protected Health Information Disclosures Permitted and Required by Law
D. CalOptima Health Policy HH.3011: Use and Disclosure of Protected Health Information (PHI) for Treatment, Payment, and Health Care Operations
E. CalOptima Health Policy HH.3015: Member Authorization for the Use and Disclosure of Protected Health Information
F. CalOptima Health Policy HH.3022: Business Associate Agreements
G. California Civil Code §§ 56.06(e), 56.10, 56.107, 56.110, and 56.11
H. California Penal Code § 1543
I. 45 CFR §§ 164.502(a)(5)(iii)(A), (C); 164.509; and 164.512(d), (e), (f), (g)(1)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
TBD	Department of Health Care Services (DHCS)	TBD

VII. BOARD ACTION(S)

Date	Meeting
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	11/07/2024	HH.3024	Confidentiality of Medical Information Act Compliance	Medi-Cal OneCare PACE

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IX. GLOSSARY

Term	Definition
Authorization	Has the meaning given such term in 45 CFR Section 164.508 and other federal and state laws imposing more stringent Authorization requirements for the Use and Disclosure of Member PHI e.g. Welfare & Institution Code section 14100.2.
Authorized Representative (AR)	Any individual appointed in writing by a competent Member or Potential Member, to act in place or on behalf of the Member or Potential Member for purposes of assisting or representing the Member or Potential Member with Grievances and Appeals, State Fair Hearings, Independent Medical Reviews and in any other capacity, as specified by the Member or Potential Member.
Communications	For purposes of this policy and unless otherwise specified, communications subject to this policy include written, verbal, or electronic communications related to the receipt of Sensitive Services, including bills and attempts to collect payment; notices of adverse benefits determinations; explanation of benefits notices; CalOptima Health's request for additional information regarding a claim; a notice of a contested claim; the name and address of a provider, description of services provided, and any other information related to a visit; and any communication from CalOptima Health that contains Medical Information.
Confidential Communications Request	For purposes of this policy, this is a request by a Member that communications from CalOptima Health containing Medical Information ("Confidential Communications") be communicated to the Member at a specific mail address, email address, or telephone number, as designated by the Member. Civ. Code § 56.05(c). These requests also apply to communications that disclose a provider's name and address related to receipt of services by the Member requesting the confidential communication. Civ. Code § 56.107(b)(4).
Gender Affirming Care	Medically necessary health care or gender affirming mental health care that respects the gender identity of the patient, as experienced and defined by the patient, and may include, but is not limited to: 1. Interventions to suppress the development of endogenous secondary sex characteristics; 2. Interventions to align the patient's appearance or physical body with the patient's gender identity; and 3. Interventions to alleviate symptoms of clinically significant distress resulting from gender dysphoria, as defined in the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition. Welfare and Institutions Code § 16010.2(b).
Medical Information	Any individually identifiable information, in electronic or physical form, in possession of or derived from a provider of health care, health care service plan, pharmaceutical company, or contractor regarding a patient's medical history, mental health application information, Reproductive or Sexual Health Application Information, mental or physical condition, or treatment. "Individually Identifiable" means that the Medical Information includes or contains any element of personal identifying information sufficient to allow identification of the individual, such as the patient's name, address, electronic mail address, telephone number, or social security number, or other information that, alone or in combination with other publicly available information, reveals the identity of the individual. Civ. Code § 56.05(j).

Term	Definition
Member	A beneficiary enrolled in a CalOptima Health program.
Provider	Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
Reproductive or Sexual Health Application Information	Information about an individual's reproductive health, menstrual cycle, fertility, pregnancy, pregnancy outcome, plans to conceive, or type of sexual activity collected by a reproductive or sexual health digital service, including, but not limited to, information from which one can infer someone's pregnancy status, menstrual cycle, fertility, hormone levels, birth control use, sexual activity, or gender identity. Civ. Code § 56.05(q).
Sensitive Services	All health care services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence, and includes services described in Family Code, Sections 6924, 6925, 6926, 6927, 6928, 6929, and 6930, and Health and Safety Code, Sections 121020 and 124260, obtained by a patient at or above the minimum age specified for consenting to the service, in accordance with California Civil Code, Section 56.05(s).

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Policy:	HH.5000
Title:	**Provider Overpayment Investigation and Determination**
Department:	Office of Compliance
Section:	Fraud, Waste, and Abuse – Special Investigations Unit
CEO Approval:	*/s/*
Effective Date:	12/01/2016
Revised Date:	11/07/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ PACE ☐ Administrative

I. PURPOSE

This policy establishes an effective system for the review of suspect claims to detect and prevent Fraud, Waste, and Abuse (FWA) within a CalOptima Health program, in accordance with federal and state regulations, and to identify resulting Overpayments for recoupment.

II. POLICY

A. The CalOptima Health Special Investigations Unit (SIU) shall be responsible for identifying Overpayments for recoupment opportunities that may emerge in the course of an FWA investigation.

B. During the course of an investigation, the SIU team shall review claims, review Medical Records and other records, and/or conduct interviews or surveys to either verify if services were rendered, or if services were appropriately billed, as applicable.

C. Medical Records shall be established and maintained in accordance with CalOptima Health Policy GG.1603: Medical Records Maintenance.

~~C.~~D. CalOptima Health may receive complaints of suspected FWA from any of the following sources, including but not limited to:

1. Compliance and Ethics Hotline;
2. Internal audits;
3. Internal operational reviews;
4. External audits, including audits conducted by consultants and regulatory agencies;
5. FWA software runs;
6. Pharmacy Benefits Manager (PBM);
7. Compliance Committee;

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8. ~~Audit &~~Delegation Oversight Committee (~~AOC~~DOC);

9. Internal department referrals;

10. Claims auditors who review Provider claims through the claims review software system;

11. Internal and external claims and compliance audits; and

12. Any other source that identifies potential FWA.

III. PROCEDURE

A. Identification of Overpayments

1. CalOptima Health's SIU team shall investigate any identified Overpayments that are suspected to be the result of inappropriate and/or inaccurate billing activity.

2. CalOptima Health's SIU team shall utilize investigation software or internal data reports to identify suspicious billing patterns, or industry-identified FWA trends, to determine whether CalOptima Health disbursed an Overpayment to a Provider.

   a. Suspicious billing patterns or trends may include, but are not limited to, Providers who:

      i. Demonstrate a pattern of billing their claims with inappropriate or inaccurate modifiers;

      ii. Repeatedly submitting claims for procedures, items or units of services, that are excessive and/or not covered by Medi-Cal or Medicare;

      iii. Submit claims for particular procedure codes at a significantly higher frequency than other Providers within the same specialty.

      iv. Bill with inaccurate NPI(s);

      v. Bill a large proportion of high-level Evaluation and Management (E/M) Codes; or

      vi. Prescribe an unusual amount of Schedule II Medications in relation to their peers.

B. Investigation Protocol of Overpayments

1. FWA investigations may identify inappropriate and inaccurate activity through a variety of means, including but not limited to, inbound complaints, proactive data analysis, collaboration meetings with internal and external departments, and the Centers for Medicaid & Medicare Services (CMS) Health Plan Management System (HPMS) memoranda.

2. CalOptima Health's SIU investigation may include the following elements:

   a. Interviews with Members, Providers, and other witnesses;

   b. Data analysis, including but not limited to analysis of claims billing, payment trends, and procedure code combinations, etc.;

c. Review of Medical Records and other records by the SIU investigator, or, for complex reviews, a clinician, such as a Registered Nurse (RN), Licensed Vocational Nurse (LVN), Medical Doctor (MD), and Doctor of Pharmacy (Pharm. D); and

d. All relevant and pertinent data/information, as appropriate, that will aid in completing the investigation to closure.

3. The SIU shall obtain Medical Records and other records from the Provider if it is necessary to determine if an Overpayment occurred. The SIU may utilize a copy service, as needed, to obtain Medical Records from a Provider.

   a. The SIU shall make three (3) attempts to obtain Medical Records and other records from a Provider.

   b. The number of records requested may vary depending on the nature of the investigation.

   c. Records shall be submitted to the SIU within the timeframes outlined below:

      i. Initial request – records must be returned within fifteen (15) business days.

      ii. Second request – records must be returned within five (5) business days.

      iii. Final warning – records must be received the next business day.

      iv. An extension may be granted upon written request and at the discretion of the SIU management.

   d. Failure to provide records after the final warning has been issued in writing or past the approved extension deadline will result in CalOptima Health initiating an Overpayment request due to the Provider's not being able to corroborate services rendered.

   e. Providers must adhere to the requirements for the Medical Record and other record request set forth in the demand letter issued by the Office of Compliance.

4. CalOptima Health's SIU shall consult with qualified personnel in reviewing the Medical Records and other records. If CalOptima Health's SIU investigation yields findings, and if an Overpayment is determined to be an appropriate administrative action that is based on potential FWA, inappropriate, and/or inaccurate billing, SIU shall proceed with Overpayment recoupment activities. SIU shall provide guidance to CalOptima Health Claims Administration Department, including drafting the content of Overpayment letters.

C. Documentation

1. If SIU identifies an Overpayment as a result of an investigation, an "Overpayment Spreadsheet" shall be provided by CalOptima Health SIU team in detail with each determination to the Claims Administration Department.

2. The "Overpayment Spreadsheet" shall include the minimum necessary information to adequately review, investigate, and determine if claims were overpaid. The "Overpayment Spreadsheet" may include the following details, as applicable:

   a. Tax ID;

b. Billing Provider NPI;

c. Rendering Provider NPI;

~~c.~~d. Member name;

~~d.~~e. Unique Member identification (ID) number;

~~e.~~f. Claim number;

~~f.~~g. HCPCS/CPT Code;

~~g.~~h. ICD-9 and/or ICD-10 codes;

~~h.~~i. Revenue codes;

~~i.~~j. Place of service;

~~j.~~k. Modifier;

~~k.~~l. Date(s) of service;

~~l.~~m. Number of services billed;

~~m.~~n. Number of units allowed;

~~n.~~o. Billed amount;

~~o.~~p. Allowed amount;

~~p.~~q. Paid amount;

~~q.~~r. Overpayment amount; and

~~r.~~s. Overpayment recovery reason.

D. Resolution

1. If CalOptima Health's SIU investigation has identified an Overpayment, and does not contain a component of FWA, the Overpayment shall be referred to CalOptima Health Claims Administration Department for Overpayment set up, collection, and recoupment, as outlined in CalOptima Health Policy FF.2001: Claims Processing for Covered Services for which CalOptima Health is Financially Responsible.

2. The SIU shall notify the Department of Health Care Services (DHCS) and/or the CMS of Overpayment determinations, in accordance with CalOptima Health Policy HH.1107: Fraud, Waste, and Abuse Investigation and Reporting and as required by law and state and federal regulations, but no later than ten (10) business days to the DHCS Contract Manager and DHCS Audits and Investigations Unit, and thirty (30) calendar days to the CMS, after the date CalOptima Health identified the Overpayment.

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3. If the claim(s) review determines that the billing was improperly paid and if the payment was determined to be based on inappropriate and/or inaccurate billing activity, and it contains a component of FWA, CalOptima Health's SIU shall:

   a. Document the rationale for assessing the Overpayment;

   b. Initiate recoupment process of the Overpayment through appropriate channels, including coordination with the CalOptima Health Claims Administration Department;

   c. Send the Provider the required demand letter, signed by SIU management;

   d. Continue collection activity, as necessary, and assist respective department(s) as needed with investigation in coordination with the CalOptima Health Claims Administration Department, such as prepayment reviews;

   e. Notify the DHCS and/or the CMS of Overpayment determinations, in accordance with CalOptima Health Policy HH.1107: Fraud, Waste, and Abuse Investigation and Reporting and as required by law and state and federal regulations, but no later than ten (10) business days to the DHCS Contract Manager and DHCS Audits and Investigations Unit, and thirty (30) calendar days to CMS, after the date CalOptima Health identified the Overpayment.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Health PACE Program Agreement
D. CalOptima Health Policy FF.2001: Claims Processing for Covered Services for which CalOptima is Financially Responsible
E. CalOptima Health Policy HH.1107: Fraud, Waste, and Abuse Investigation and Reporting
F. CalOptima Health Policy GG.1603: Medical Records Maintenance
~~F.~~G. CMS Guidance for Reporting Medicare Advantage Organization and/or Sponsor Identified Overpayments for CMS
~~G.~~H. Department of Health Care Services (DHCS) All Plan Letter (APL) 15-026: Actions Required following Notice of a Credible Allegation of Fraud
~~H.~~I. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-011: Treatment of Recoveries Made by the Managed Care Health Plan of Overpayments to Providers (Supersedes APL 17-003)
~~I.~~J. California Health and Safety Code §1371
~~J.~~K. Social Security Act, §1128J(d)
~~K.~~L. Title 22, California Code of Regulations (C.C.R.), §§51045, 51047, 51458.1
~~L.~~M. Title 28, California Code of Regulations (C.C.R.), §1300.71
~~M.~~N. Title 42, Code of Federal Regulations (C.F.R.), §§405.980, 405.982, 405.984, 405.986, 405.978, 405.990, 422.326 and 423.360
~~N.~~O. Title 42, Code of Federal Regulations (C.F.R.), §§411.404, 411.406, 411.408
~~O.~~P. Title 45, Code of Federal Regulations (C.F.R.), §79
~~P.~~Q. Welfare and Institutions Code, 14172, 14172.5, 14173, 14176, 14177

VI. REGULATORY AGENCY APPROVAL(S)

Date	Meeting	Response
09/01/2023	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
12/01/2022	Regular Meeting of the CalOptima Health Board of Directors
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	12/01/2016	HH.5000~~A~~	Provider Overpayment Investigation and Determination	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.5000~~A~~	Provider Overpayment Investigation and Determination	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.5000~~A~~	Provider Overpayment Investigation and Determination	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.5000~~A~~	Provider Overpayment Investigation and Determination	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.5000~~A~~	Provider Overpayment Investigation and Determination	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.5000~~A~~	Provider Overpayment Investigation and Determination	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	HH.5000	Provider Overpayment Investigation and Determination	Medi-Cal OneCare PACE
Revised	07/01/2023	HH.5000	Provider Overpayment Investigation and Determination	Medi-Cal OneCare PACE
Revised	11/07/2024	~~HH.~~5000	Provider Overpayment Investigation and Determination	Medi-Cal OneCare PACE

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IX. GLOSSARY

Term	Definition
Abuse	~~Actions that may, directly or indirectly,~~Medi-Cal: Practices that are inconsistent with sound fiscal and business practices or medical standards, and result in an unnecessary ~~costs~~cost to ~~a CalOptima Health Program, improper payment, payment~~the Medi-Cal program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards ~~of~~for health care~~, or services that are medically~~. It also includes Member practices that result in unnecessary~~. Abuse involves payment for items or services when there is no legal entitlement~~ cost to ~~that payment and~~ the Medi-Cal program. OneCare: A Provider ~~has not knowingly and/~~practice that is inconsistent with sound fiscal, business, or ~~intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from Fraud, because the distinction between "Fraud"~~medical practice, and ~~"Abuse" depends on specific facts~~ results in an unnecessary cost to CalOptima Health and ~~circumstances, intent~~the OneCare program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to CalOptima Health and ~~prior knowledge~~the OneCare program. A Provider practice that is inconsistent with sound fiscal, business, or medical practice, and ~~available evidence, among other factors~~results in an unnecessary cost to CalOptima Health and the Medi-Cal program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to CalOptima Health and the Medi-Cal program.
~~Audit &~~Delegation Oversight Committee (~~AOC~~DOC)	A subcommittee of the Compliance Committee chaired by the Director(s) of ~~Audit &~~Delegation Oversight to oversee CalOptima Health's delegated functions. ~~-~~The composition of the ~~AOC~~DOC includes representatives from CalOptima Health's departments as provided for in CalOptima Health Policy HH.4001: ~~Audit &~~Delegation Oversight Committee.
Fraud	Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or Fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. § 1347.)
Medical Record	Medi-Cal: ~~Any single, complete~~The record ~~kept or required to be kept by any Provider that documents all the~~of a Member's medical ~~services received by the Member,~~information including~~,~~ but not limited to, ~~inpatient, outpatient~~medical history, care or treatments received, test results, diagnoses, and ~~emergency care, referral requests, authorizations, or other documentation as indicated by CalOptima Health policy.~~ prescribed medications. OneCare: A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal

Term	Definition
	documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal. PACE: Written documentary evidence of treatments rendered to plan Members.
Overpayment	For purposes of this policy, a payment disbursed in excess amounts properly payable under Medicare and Medi-Cal statutes and regulations.
Provider	Medi-Cal: Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so. ~~Medi-Cal: A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, or other person or institution that furnishes Covered Services.~~ OneCare: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B.
Schedule II Medication	Narcotic substances with a high potential for Abuse which may lead to severe psychological or physical dependence.
Waste	~~Overutilization~~Medi-Cal: The overutilization or inappropriate utilization of services and misuse of resources. OneCare: The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Health Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources~~.~~, overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare Program.

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Policy:	HH.5000
Title:	**Provider Overpayment Investigation and Determination**
Department:	Office of Compliance
Section:	Fraud, Waste, and Abuse – Special Investigations Unit
CEO Approval:	*/s/*
Effective Date:	12/01/2016
Revised Date:	11/07/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ PACE ☐ Administrative

I. PURPOSE

This policy establishes an effective system for the review of suspect claims to detect and prevent Fraud, Waste, and Abuse (FWA) within a CalOptima Health program, in accordance with federal and state regulations, and to identify resulting Overpayments for recoupment.

II. POLICY

A. The CalOptima Health Special Investigations Unit (SIU) shall be responsible for identifying Overpayments for recoupment opportunities that may emerge in the course of an FWA investigation.

B. During the course of an investigation, the SIU team shall review claims, review Medical Records and other records, and/or conduct interviews or surveys to either verify if services were rendered, or if services were appropriately billed, as applicable.

C. Medical Records shall be established and maintained in accordance with CalOptima Health Policy GG.1603: Medical Records Maintenance.

D. CalOptima Health may receive complaints of suspected FWA from any of the following sources, including but not limited to:

1. Compliance and Ethics Hotline;
2. Internal audits;
3. Internal operational reviews;
4. External audits, including audits conducted by consultants and regulatory agencies;
5. FWA software runs;
6. Pharmacy Benefits Manager (PBM);
7. Compliance Committee;

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8. Delegation Oversight Committee (DOC);

9. Internal department referrals;

10. Claims auditors who review Provider claims through the claims review software system;

11. Internal and external claims and compliance audits; and

12. Any other source that identifies potential FWA.

III. PROCEDURE

A. Identification of Overpayments

1. CalOptima Health's SIU team shall investigate any identified Overpayments that are suspected to be the result of inappropriate and/or inaccurate billing activity.

2. CalOptima Health's SIU team shall utilize investigation software or internal data reports to identify suspicious billing patterns, or industry-identified FWA trends, to determine whether CalOptima Health disbursed an Overpayment to a Provider.

   a. Suspicious billing patterns or trends may include, but are not limited to, Providers who:

      i. Demonstrate a pattern of billing their claims with inappropriate or inaccurate modifiers;

      ii. Repeatedly submitting claims for procedures, items or units of services, that are excessive and/or not covered by Medi-Cal or Medicare;

      iii. Submit claims for particular procedure codes at a significantly higher frequency than other Providers within the same specialty.

      iv. Bill with inaccurate NPI(s);

      v. Bill a large proportion of high-level Evaluation and Management (E/M) Codes; or

      vi. Prescribe an unusual amount of Schedule II Medications in relation to their peers.

B. Investigation Protocol of Overpayments

1. FWA investigations may identify inappropriate and inaccurate activity through a variety of means, including but not limited to, inbound complaints, proactive data analysis, collaboration meetings with internal and external departments, and the Centers for Medicaid & Medicare Services (CMS) Health Plan Management System (HPMS) memoranda.

2. CalOptima Health's SIU investigation may include the following elements:

   a. Interviews with Members, Providers, and other witnesses;

   b. Data analysis, including but not limited to analysis of claims billing, payment trends, and procedure code combinations, etc.;

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c. Review of Medical Records and other records by the SIU investigator, or, for complex reviews, a clinician, such as a Registered Nurse (RN), Licensed Vocational Nurse (LVN), Medical Doctor (MD), and Doctor of Pharmacy (Pharm. D); and

d. All relevant and pertinent data/information, as appropriate, that will aid in completing the investigation to closure.

3. The SIU shall obtain Medical Records and other records from the Provider if it is necessary to determine if an Overpayment occurred. The SIU may utilize a copy service, as needed, to obtain Medical Records from a Provider.

   a. The SIU shall make three (3) attempts to obtain Medical Records and other records from a Provider.

   b. The number of records requested may vary depending on the nature of the investigation.

   c. Records shall be submitted to the SIU within the timeframes outlined below:

      i. Initial request – records must be returned within fifteen (15) business days.

      ii. Second request – records must be returned within five (5) business days.

      iii. Final warning – records must be received the next business day.

      iv. An extension may be granted upon written request and at the discretion of the SIU management.

   d. Failure to provide records after the final warning has been issued in writing or past the approved extension deadline will result in CalOptima Health initiating an Overpayment request due to the Provider's not being able to corroborate services rendered.

   e. Providers must adhere to the requirements for the Medical Record and other record request set forth in the demand letter issued by the Office of Compliance.

4. CalOptima Health's SIU shall consult with qualified personnel in reviewing the Medical Records and other records. If CalOptima Health's SIU investigation yields findings, and if an Overpayment is determined to be an appropriate administrative action that is based on potential FWA, inappropriate, and/or inaccurate billing, SIU shall proceed with Overpayment recoupment activities. SIU shall provide guidance to CalOptima Health Claims Administration Department, including drafting the content of Overpayment letters.

C. Documentation

1. If SIU identifies an Overpayment as a result of an investigation, an "Overpayment Spreadsheet" shall be provided by CalOptima Health SIU team in detail with each determination to the Claims Administration Department.

2. The "Overpayment Spreadsheet" shall include the minimum necessary information to adequately review, investigate, and determine if claims were overpaid. The "Overpayment Spreadsheet" may include the following details, as applicable:

   a. Tax ID;

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b. Billing Provider NPI;

c. Rendering Provider NPI;

d. Member name;

e. Unique Member identification (ID) number;

f. Claim number;

g. HCPCS/CPT Code;

h. ICD-9 and/or ICD-10 codes;

i. Revenue codes;

j. Place of service;

k. Modifier;

l. Date(s) of service;

m. Number of services billed;

n. Number of units allowed;

o. Billed amount;

p. Allowed amount;

q. Paid amount;

r. Overpayment amount; and

s. Overpayment recovery reason.

D. Resolution

1. If CalOptima Health's SIU investigation has identified an Overpayment, and does not contain a component of FWA, the Overpayment shall be referred to CalOptima Health Claims Administration Department for Overpayment set up, collection, and recoupment, as outlined in CalOptima Health Policy FF.2001: Claims Processing for Covered Services for which CalOptima Health is Financially Responsible.

2. The SIU shall notify the Department of Health Care Services (DHCS) and/or the CMS of Overpayment determinations, in accordance with CalOptima Health Policy HH.1107: Fraud, Waste, and Abuse Investigation and Reporting and as required by law and state and federal regulations, but no later than ten (10) business days to the DHCS Contract Manager and DHCS Audits and Investigations Unit, and thirty (30) calendar days to the CMS, after the date CalOptima Health identified the Overpayment.

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3. If the claim(s) review determines that the billing was improperly paid and if the payment was determined to be based on inappropriate and/or inaccurate billing activity, and it contains a component of FWA, CalOptima Health's SIU shall:

   a. Document the rationale for assessing the Overpayment;

   b. Initiate recoupment process of the Overpayment through appropriate channels, including coordination with the CalOptima Health Claims Administration Department;

   c. Send the Provider the required demand letter, signed by SIU management;

   d. Continue collection activity, as necessary, and assist respective department(s) as needed with investigation in coordination with the CalOptima Health Claims Administration Department, such as prepayment reviews;

   e. Notify the DHCS and/or the CMS of Overpayment determinations, in accordance with CalOptima Health Policy HH.1107: Fraud, Waste, and Abuse Investigation and Reporting and as required by law and state and federal regulations, but no later than ten (10) business days to the DHCS Contract Manager and DHCS Audits and Investigations Unit, and thirty (30) calendar days to CMS, after the date CalOptima Health identified the Overpayment.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Health PACE Program Agreement
D. CalOptima Health Policy FF.2001: Claims Processing for Covered Services for which CalOptima is Financially Responsible
E. CalOptima Health Policy GG.1603: Medical Records Maintenance
F. CalOptima Health Policy HH.1107: Fraud, Waste, and Abuse Investigation and Reporting
G. CMS Guidance for Reporting Medicare Advantage Organization and/or Sponsor Identified Overpayments for CMS
H. Department of Health Care Services (DHCS) All Plan Letter (APL) 15-026: Actions Required following Notice of a Credible Allegation of Fraud
I. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-011: Treatment of Recoveries Made by the Managed Care Health Plan of Overpayments to Providers (Supersedes APL 17-003)
J. California Health and Safety Code §1371
K. Social Security Act, §1128J(d)
L. Title 22, California Code of Regulations (C.C.R.), §§51045, 51047, 51458.1
M. Title 28, California Code of Regulations (C.C.R.), §1300.71
N. Title 42, Code of Federal Regulations (C.F.R.), §§405.980, 405.982, 405.984, 405.986, 405.978, 405.990, 422.326 and 423.360
O. Title 42, Code of Federal Regulations (C.F.R.), §§411.404, 411.406, 411.408
P. Title 45, Code of Federal Regulations (C.F.R.), §79
Q. Welfare and Institutions Code, 14172, 14172.5, 14173, 14176, 14177

VI. REGULATORY AGENCY APPROVAL(S)

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Date	Meeting	Response
09/01/2023	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
12/01/2022	Regular Meeting of the CalOptima Health Board of Directors
11/07/2024	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	12/01/2016	HH.5000	Provider Overpayment Investigation and Determination	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.5000	Provider Overpayment Investigation and Determination	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.5000	Provider Overpayment Investigation and Determination	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.5000	Provider Overpayment Investigation and Determination	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.5000	Provider Overpayment Investigation and Determination	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.5000	Provider Overpayment Investigation and Determination	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	HH.5000	Provider Overpayment Investigation and Determination	Medi-Cal OneCare PACE
Revised	07/01/2023	HH.5000	Provider Overpayment Investigation and Determination	Medi-Cal OneCare PACE
Revised	11/07/2024	HH.5000	Provider Overpayment Investigation and Determination	Medi-Cal OneCare PACE

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IX. GLOSSARY

Term	Definition
Abuse	Medi-Cal: Practices that are inconsistent with sound fiscal and business practices or medical standards, and result in an unnecessary cost to the Medi-Cal program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to the Medi-Cal program. OneCare: A Provider practice that is inconsistent with sound fiscal, business, or medical practice, and results in an unnecessary cost to CalOptima Health and the OneCare program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to CalOptima Health and the OneCare program. A Provider practice that is inconsistent with sound fiscal, business, or medical practice, and results in an unnecessary cost to CalOptima Health and the Medi-Cal program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to CalOptima Health and the Medi-Cal program.
Delegation Oversight Committee (DOC)	A subcommittee of the Compliance Committee chaired by the Director(s) of Delegation Oversight to oversee CalOptima Health's delegated functions. The composition of the DOC includes representatives from CalOptima Health's departments as provided for in CalOptima Health Policy HH.4001: Delegation Oversight Committee.
Fraud	Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or Fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. § 1347.)
Medical Record	Medi-Cal: The record of a Member's medical information including but not limited to, medical history, care or treatments received, test results, diagnoses, and prescribed medications. OneCare: A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal. PACE: Written documentary evidence of treatments rendered to plan Members.
Overpayment	For purposes of this policy, a payment disbursed in excess amounts properly payable under Medicare and Medi-Cal statutes and regulations.

Term	Definition
Provider	Medi-Cal: Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so. OneCare: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B.
Schedule II Medication	Narcotic substances with a high potential for Abuse which may lead to severe psychological or physical dependence.
Waste	Medi-Cal: The overutilization or inappropriate utilization of services and misuse of resources. OneCare: The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Health Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources, overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare Program.

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CalOptima Health Board Action Agenda Referral

Action To Be Taken November 7, 2024
Regular Meeting of the CalOptima Health Board of Directors

Report Item

15. Authorize the Chief Executive Officer to Use Reserve Funds to Make Payments to Primary Care Practices Participating in the Equity and Practice Transformation Payment Program Prior to Receipt of Funds Included in the State of California Fiscal Year 2024-25 Budget

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 923-8834
Michael Gomez, Executive Director, Network Operations, (714) 347-3292

Recommended Actions

1. Authorize the Chief Executive Officer, or designee, to make directed payments to Medi-Cal primary care practices participating in the Equity and Practice Transformation Payment Program; and
2. Authorize expenditures of $228,080.80 from existing reserves to fund the initial directed payments prior to the receipt of funds included in the State of California Fiscal Year 2024-25 budget.

Background and Discussion

CalOptima Health was one of 19 managed care plans (MCPs) approved by the Department of Health Care Services (DHCS) to participate in the statewide Equity and Practice Transformation (EPT) Payment Program. The original program was slated to span five years and was funded by the State of California at $700 million. In the final State Fiscal Year 2024-25 budget, DHCS restructured the program to three years and reduced the overall funding to $140 million. The revised total funding available for the EPT provider directed payment component is $97 million statewide. The maximum potential EPT provider directed payments to CalOptima Health primary care practices participating in the EPT Payment Program was reduced from $21 million to $5.7 million.

The EPT Provider Directed Payment Program focuses on improving access for Medi-Cal enrollees to advance equity, reduce disparities, and investing in building the foundation of patient-centered population health models that align with future value-based payments. There are three components in the EPT Payment Program: (1) Medi-Cal MCP initial provider planning incentive payments; (2) EPT provider directed payments; and (3) the statewide learning collaborative. This recommended action only pertains to the EPT provider directed payment component.

As a requirement of participation in the EPT Provider Directed Payment Program, the primary care practice must implement processes that support the three-year program requirements, submit reports on their progress in achieving their milestones, submit an annual assessment, and report their progress in sharing and integrating data from external sources to produce a key performance indicator report.

DHCS selected the participating primary care practices on December 11, 2023, with an effective date of January 1, 2024. DHCS selected 18 provider practices in Orange County and 15 of those practices are contracted with CalOptima Health as their MCP for this program.

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CalOptima Health will administer the EPT provider directed payment component for the 15 primary care practices by making directed payments in the amounts approved by DHCS.

The first provider directed payment was expected to go to EPT Payment Program participating providers in September 2024. However, DHCS notified CalOptima Health that the payment will be delayed, and as of this writing, DHCS has committed to distributing the payment to CalOptima Health in March 2025.

All 15 providers attributed to CalOptima Health met the requirements of the EPT Provider Directed Payment Program and are entitled to the DHCS-approved payment. The total payout to CalOptima Health EPT providers is $228,080.80 for the 2024 reporting period. The payment they will receive is based on the payment data file released by DHCS in July 2024, included as Attachment 2.

Fiscal Impact

The aggregate amount payable for the initial EPT provider directed payment is $228,080.80. Upon receipt of DHCS funding in March 2025, staff will return these funds to reserves. Staff anticipates DHCS EPT Payment Program funding will be sufficient to fully cover the directed payments to participating primary care practices, with no additional fiscal impact to CalOptima Health's budget.

Rationale for Recommendation

CalOptima Health believes it is in the best interest of its EPT providers and its members for the participating primary care practices to receive the directed payments in advance of the March 2025 DHCS payment to CalOptima Health. Many of the EPT primary care practices have already incurred start-up costs for the implementation of this program, including hiring additional staff. As a committed partner to the participating EPT providers, CalOptima Health would like to support their continued efforts for this critical work.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Entities Covered by the Recommended Action
2. DHCS EPT Practice-Payments for CalOptima Health July 2024

/s/ Michael Hunn *11/01/2024*
Authorized Signature **Date**

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Camino Health Center	30300 Camino Capistrano	San Juan Capistrano	CA	92675
Celebrating Life Community Health Center	27800 Medical Center Road, Suite 109/110	Mission Viejo	CA	92691
Families Together of Orange County	9918 Katella Ave., Suites A-C	Anaheim	CA	92804
Korean Community Services, Inc. Dba: KCS	7212 Orangethorpe Ave., Suite 9-A	Buena Park	CA	90621
North Orange County Reg Health Foundation dba Family Health Matters	1182 N Euclid St	Anaheim	CA	92801
Saint Youstina	809 S Main St., Suite A	Santa Ana	CA	92701
Serve the People Community Health Center	1206 E 17th St., Suite 101	Santa Ana	CA	92701
S A Medical Center Inc. dba: San Antonio Medical Center	610 W 17th	Santa Ana	CA	92706
Latino Health Services Medical Group dba Clinica Medica Familiar De Santa Ana	517 N Main Street	Santa Ana	CA	92701
Mohan Kumaratne, MD, Inc	17692 Beach Blvd., Suite 200	Huntington Beach	CA	92647
Dr. M. Forghani, S. Corp dba: Mehrdad Forghani-Arani, Do	1515 N Broadway	Santa Ana	CA	92706
Cedars Family Medicine Inc.	18021 Sky Park Circle . Suite G	Irvine	CA	92614
Children's Hospital of Orange County (CHOC Children's)	Children's Hospital of Orange County 1201 W La Veta Avenue Attn: Primary Care Administration	Orange	CA	92868
Sangeeta Patel dba Docs For Kids	13372 Newport Ave., Suite B	Tustin	CA	92780
CHOICE Health Network	408 S Beach Blvd., Suite 111	Anaheim	CA	92804

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Name of Practice	Provider Reported NPIs	Assigned Lives	EPT Sponsor MCP	County	Revised Potential Practice Payment	Payment Per (phmCAT) Milestone (n = 25)
S A Medical Center Inc. dba: San Antonio Medical Center	1548277767, 1952498867	1,000	CalOptima	Orange County	$ 250,000.00	$ 10,000.00
Sangeeta Patel (dba) Docs For Kids	1386682177	1,200	CalOptima	Orange County	$ 250,000.00	$ 10,000.00
Saint Youstina	1740822360	2,050	CalOptima	Orange County	$ 291,000.00	$ 11,640.00
Latino Health Services Medical Group dba Clinica Medica Familiar De Santa Ana	1790701514	2,150	CalOptima	Orange County	$ 293,000.00	$ 11,720.00
Mohan Kumaratne, MD, Inc	1104881523	2,800	CalOptima	Orange County	$ 306,000.00	$ 12,240.00
Serve the People, Inc. dba Serve the People Community Health Center	1770803462	4,009	CalOptima	Orange County	$ 330,180.00	$ 13,207.20
Dr. M. Forghani, S. Corp dba: Mehrdad Forghani-Arani, Do	1912176264, 1457373342, 1891497517, 1235742420	4,500	CalOptima	Orange County	$ 340,000.00	$ 13,600.00
North Orange County Regional Health Foundation dba Family Health Matters	1194974402	4,907	CalOptima	Orange County	$ 348,140.00	$ 13,925.60
Korean Community Services, Inc. dba KCS	1821689324	5,016	CalOptima	Orange County	$ 350,320.00	$ 14,012.80
Cedars Family Medicine Inc.	1215297463	5,063	CalOptima	Orange County	$ 351,260.00	$ 14,050.40
Families Together of Orange County	1194122457, 1548813041, 1144969809	5,600	CalOptima	Orange County	$ 362,000.00	$ 14,480.00
CHOICE Health Network	1952073157, 1306296835, 1376735340	5,954	CalOptima	Los Angeles County; Orange County	$ 369,080.00	$ 14,763.20
Celebrating Life Community Health Center	1386273100, 1578221537, 1013630128, 1558068098, 1841913951	10,107	CalOptima	Orange County	$ 452,140.00	$ 18,085.60
Camino Health Center	1538549449, 1366560393, 1194274811	15,912	CalOptima	Orange County	$ 568,240.00	$ 22,729.60
Children's Hospital of Orange County (CHOC Childrens)	1427121375, 1265569008, 1679600852, 1568599769	29,533	CalOptima	Orange County	$ 840,660.00	$ 33,626.40
Totals:					**$ 5,702,020.00**	**$ 228,080.80**

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Continued to a Future Meeting

CalOptima Health Board Action Agenda Referral

Action To Be Taken November 7, 2024
Regular Meeting of the CalOptima Health Board of Directors

Report Item

16. Authorize the Chief Executive Officer to Execute Contract Amendments with Collective Medical Technologies, Inc., a PointClickCare company, and Safety Net Connect, Inc. to Improve Information Exchange for Members and Providers Across Care Settings

Contacts

Richard Pitts, D.O., Ph.D., Chief Medical Officer, (714) 246-8491
Kelly Giardina, Executive Director, Clinical Operations, (714) 745-0125

Recommended Actions

1. Make an exception to CalOptima Health Policy GA.5002: Purchasing Policy and authorize the Chief Executive Officer to execute a contract amendment with Collective Medical Technologies, Inc., a PointClickCare company, to expand the scope of work to include new products for the Medicare line of business, update payments terms, and extend the contract term for an additional three-year term beginning November 30, 2025, with two one-year extension options, each exercisable at CalOptima Health's discretion.

2. Make an exception to CalOptima Health Policy GA.5002: Purchasing Policy and authorize the Chief Executive Officer to execute a contract amendment with Safety Net Connect, Inc., to extend the contract for a three-year term beginning December 17, 2025, with two one-year extension options, each exercisable at CalOptima Health's discretion under the same terms and conditions.

Background

Collective Medical Technologies, Inc., a PointClickCare company (Collective Medical Technologies) is one of CalOptima Health's hospital data exchange services, providing real-time or near real-time information and alerts on members' emergency department (ED) visits, hospital admissions, transitions of care, and referrals to community-based organizations. Collective Medical Technologies acute-care encounter data allows CalOptima Health to meet regulatory requirements for transition of care services by ensuring timely admission, discharge, and transfer (ADT) notifications from acute care facilities, EDs, and skilled nursing facilities (SNFs), as required in the Department of Health Care Services (DHCS) 2024 Population Health Management Policy Guide.

Safety Net Connect, Inc. (SNC) provides CalOptima Health with hospital data exchange services and a service portal (CalOptima Connect) to support CalOptima Health's CalAIM program. Community Supports and Enhanced Care Management (ECM) providers leverage the system to manage service referrals, authorizations, and provider invoice billing for the CalAIM program. As CalAIM continues to evolve with additional service offerings, SNC has added critical new components and provided enhancements to its system to support the changes needed to enable providers to serve CalOptima Health's members. This CalAIM service portal data currently integrates with Jiva, CalOptima Health's clinical documentation platform for utilization, authorization, automation and care plan completion.

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In November 2020, CalOptima Health executed contracts with Collective Medical Technologies and SNC after completion of a formal competitive procurement process for the most comprehensive information exchange solution. The Collective Medical Technologies initial contract effective date was November 30, 2020, with an end date of November 29, 2025. The SNC initial contract effective date was December 17, 2020, with an end date of December 16, 2025.

Although there are similarities in the services that Collective Medical Technologies and SNC provide, the unique and extensive programmatic design for each vendor delivers separate solutions to providers at the point of service.

Discussion

Collective Medical Technologies Contract Amendment

Shortly after signing the contract, Collective Medical Technologies was acquired by PointClickCare Technologies, Inc. (PointClickCare). Staff was informed that new products were available to CalOptima Health that were not previously available at the time of the initial contract.

PointClickCare expanded the post-acute data set that was combined with Collective Medical Technologies' full-continuum network, giving CalOptima Health and delegated health networks real-time access to clinical information during a member's inpatient episode. This expanded access to data has significantly improved care coordination, member follow-ups, and clinical outcomes by sharing vital and timely information from CalOptima Health's contracted and non-contracted hospitals. This integrated and seamless data sharing allows for enhanced collaboration and care delivery between health plans and providers.

CalOptima Health Policy GA.5002: Purchasing outlines the processes for the procurement of goods and services essential to the operations of CalOptima Health. Competitive procurement is the required purchasing method unless competition is not feasible due to an emergency, restricted availability of goods or services, or other circumstances that would justify waiving the competitive requirements or the acquisition qualifies for another exception under the policy. Staff recommends that the CalOptima Health Board of Directors (Board) authorize an exception to CalOptima Health Policy GA.5002: Purchasing to expand the scope of work to include new products for the Medicare line of business, update payment terms, and extend the contract term with the existing vendor without competitive procurement.

Staff recommends expanding the scope of work effective November 30, 2024, to include three new services that will strengthen current data integration with hospitals, SNFs, and clinical teams coordinating care within the OneCare program. These services will enhance current OneCare data sharing and care coordination as follows:

- PACMan for Health Plans - Connects hospitals and health systems/managed care plans with post-acute partners (*e.g.*, SNFs, Long-Term Acute Care) through real-time insights.

- Quality & Coding Management (QCM) - Provides visibility into member care needs and coding gaps to help improve collaboration and timely intervention and optimize quality and performance metrics (*e.g.,* Centers for Medicare & Medicaid Services Star Ratings).

- QCM with Transition of Care - Queries Collective Medical Technologies' network hospitals and returns acute discharge information from continuity-of-care documents. This information can then be utilized by attributed providers and health systems/managed care plans for more coordinated care delivery.

Effective November 30, 2025, the new contract will update payment terms to include Consumer Price Index for All Urban Consumers (CPI-U) increases. CPI-U is a measure of inflation that tracks the average change in prices paid for services consumed by urban households. Incorporating a CPI-U increase will address the effects of inflation during the contract period.

Staff recommends that the Board authorize an exception to CalOptima Health Policy GA.5002: Purchasing to allow CalOptima Health to renew its existing contract with Collective Medical Technologies beginning November 30, 2025, for an additional three-year term with two additional one-year extension options, each exercisable at CalOptima Health's discretion, without competitive bidding.

Collective Medical Technologies is an industry-leading healthcare software provider with a robust network and exceptional coverage of Orange County-based hospitals and SNFs. This service enables CalOptima Health's contracted and non-contracted facilities to provide timely notification of ADT, ensuring members receive the necessary care. CalOptima Health is currently unaware of other vendors with comparable SNF and ADT volume. Although there are companies offering similar services, they are not centered in Orange County. When the solicitation for proposals was completed in November 2020, two proposals were found to be suitable, Collective Medical Technologies and SNC, and CalOptima awarded both companies contracts. Replicating the network and the procurement process would require a significant investment of time, money, and resources; delay clinical operations; and may result in regulatory non-compliance. Staff estimates it would take up to two years to select a new contractor and develop a comparable network.

Attachment 2 provides a summary of the new product services, including additional features, events of interest, and types of scheduled reports, that will be included in the expanded statement of work. Attachment 3 provides additional details on the new products' subscription fee and program configurations.

SNC Contract Amendment

Staff recommends that the Board authorize an exception to CalOptima Health Policy GA.5002: Purchasing to allow CalOptima Health to extend its existing contract, under the same terms and conditions, with SNC beginning December 17, 2025, for an additional three-year term with two additional one-year extension options, each exercisable at CalOptima Health's discretion, without competitive bidding.

SNC has demonstrated agility and partnership with CalOptima Health to create CalOptima Connect. CalOptima Connect is an integrated referral and authorization module that connects Community Supports providers to clinical inpatient information for real-time coordination of care. The initial speed to build allowed for the launch of 14 Community Supports programs, two ancillary programs (Supplemental Housing Assistance and Community Health Workers), and all nine ECM Populations of Focus. SNC has been agile in creating additional program enhancements in their system to support each initiative and address changes from DHCS.

Replicating and building access to a new CalAIM provider network would require significant expenses, delays, and potential regulatory non-compliance. The extensive configuration needed to connect the data exchange between SNC and CalOptima Health technology platforms would result in unmanageable and non-compliant delays to payment and clinical operations.

It is important to maintain consistency and streamlined protocols for CalAIM providers to continue to operationalize the DHCS's vision for ECM and integrated Community Supports.

Fiscal Impact

Collective Medical Technologies, a PointClickCare company Contract Amendment

The estimated annual net fiscal impact to expand the scope of work to include new products for the Medicare line of business is $54,000, or $31,500 for the seven-month period of November 30, 2024, through June 30, 2025 in the current fiscal year. Funding for the new products will be funded within the Medical Management budget approved in the CalOptima Health FY 2024-25 Operating Budget on June 6, 2024.

Effective November 30, 2025, the estimated annual net fiscal impact to account for the new products for the Medicare line of business and the CPI-U increases is approximately $370,000. The total annual cost for the Collective Medical Technologies contract is approximately $1.5 million. Staff will include operating expenses for the period beginning July 1, 2025, and after in future operating budgets.

SNC Contract Amendment

The total annual cost for SNC contract is approximately $1.6 million. Staff will include operating expenses for the period beginning December 17, 2025, and after in future operating budgets.

Rationale for Recommendation

Approving the contract extensions with Collective Medical Technologies will ensure continued access to hospital and SNF ADT data exchange services, enabling real-time transmission of members' ADT data for clinical decision-making, data sharing, and regulatory compliance. In addition, funding new product services for Medicare members will enhance member activity visibility and care management support.

Approving the contract extension with SNC will ensure continued access to CalOptima Health's Community Supports providers to support the CalAIM program. The collaboration and data sharing on the CalOptima Connect portal hosted by SNC enables CalOptima Health's providers to continue their outreach to the vulnerable homeless population.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Entities Covered by this Recommended Action
2. Product Services Summary

/s/ Michael Hunn *11/01/2024*
Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Collective Medical Technologies, a PointClickCare company	4760 S. Highland Dr. Suite 217	Holladay	UT	84117
Safety Net Connect	101 Academy Way Suite 100	Irvine	CA	92617

Attachment 1 – New Product Services Summary

	PACMan for Health Plans (SNF)	**Quality & Coding Management (QCM)**	***QCM with Transition of Care (TRC)**
Feature Pages (Portal)	Patient overview Cohorts Scheduled Reports Notifications Manage Facility (e.g., manage users)	Patient overview Cohorts Scheduled Reports Notifications Manage Facility (e.g., manage users)	CMT will query Collective Medical network hospitals and return acute discharge information from Continuity of Care Documents (CCDs) which can then be delivered to attributed providers and Subscribers. <u>Delivery to Subscriber:</u> • CCD feature in Subscriber portal • Share Acute Discharge Summary Key Components • Monthly report outlining various encounter elements <u>Delivery to Attributed Care Provider:</u> • CMT will collaborate with Subscriber to make acute CCDs available to attributed care providers within 48 hours from the date of discharge through Collective Medical Portal or Direct Secure Email **TRC product service is only available if the QCM product service is purchased – cannot be a stand-alone product service*
Additional Features (Portal)	Patient Search Patient Demographic Tags Care Team Encounter Information Care Insights Security & Safety Events Customer Community (Help) EMR data for case management including demographics, functional independence, patient clinical information including temperature, heart rate, blood pressure, respiratory rate, oxygen saturation, blood glucose, pain, weight, diagnoses, and active medications.	Patient Search Patient Demographic Tags Care Team Encounter Information Care Insights Security & Safety Events Customer Community (Help)	
Events of Interest (Criteria)	SNF Admissions SNF Discharges ED Encounter Post SNF Discharge 30 days IP Admission Post SNF Discharge 30 days Tag/Flag Criteria	Acute Care Encounters Categorized Encounters Tag/Flag Criteria	
Scheduled Reports (Can be delivered daily, weekly, or monthly)	• Patient Activity (Census Reports) – all patient SNF encounters in specific timeframe • Criteria (Cohort) Resorts – patient who met specific criteria in a timeframe • Flag Reports – patient lists related to specific Flags sourced • New Member Utilization Reports – historical utilization for new health plans members	• Criteria (Cohort) Resorts – patient who met specific criteria in a timeframe • Flag Reports – patient lists related to specific Flags sourced • New Member Utilization Reports – historical utilization for new health plans members	

CalOptima Health Board Action Agenda Referral

Action To Be Taken November 7, 2024
Regular Meeting of the CalOptima Health Board of Directors

Report Item

17. Approve Actions Related to the CalAIM Incentive Payment Program for Justice-Involved Services Learning Collaborative Selected Recipients

Contacts

Kelly Bruno Nelson, Executive Director, Medi-Cal and CalAIM, (657) 550-4741
Yunkyung Kim, Chief Operating Officer, (714) 923-8834

Recommended Actions

1. Approve CalOptima Health staff's recommendations to administer grant agreements and award payments totaling $1,000,000 from the CalAIM Incentive Payment Program, Program Year 1, to the selected grant recipients (listed in Attachment 1) for the Justice-Involved Services Learning Collaborative program.

Background

The State of California is transforming Medi-Cal by offering new and improved CalAIM services to ensure Californians get the care they need to lead healthier lives. The CalAIM Incentive Payment Program (IPP) supports the implementation and expansion of Enhanced Care Management (ECM), Community Supports, and other CalAIM initiatives by providing incentives to Medi-Cal managed care plans. CalOptima Health's total funding from the California Department of Health Care Services (DHCS) for CalAIM IPP, Program Year 1, was nearly $45 million in aggregate. As of May 2024, the remaining balance available for new initiatives is approximately $5 million.

As CalOptima Health continues to implement CalAIM benefits and monitor progress with IPP measurement submissions, staff has identified areas for improvement. One such area is the roll-out of the Justice-Involved (JI) in-reach services. These services involve CalOptima Health-contracted ECM providers entering Orange County's Correctional Facilities to coordinate a community re-entry care plan that will assist people leaving incarceration in connecting to the physical and behavioral health services they need prior to release. These services require intensive coordination and collaboration between CalOptima Health, its contracted ECM providers, and multiple Orange County agencies, including, but not limited to, Orange County Sherriff Department, the Health Care Agency, and the Social Services Agency. The JI in-reach services, which will be available for up to 90 days prior to release, are new to the state and will launch in Orange County no sooner than January 2025.

In August 2024, the CalOptima Health Board of Directors (Board) approved the release of a notice of funding opportunity (NOFO) to solicit applications from up to five entities in an amount of up to $200,000 per entity for ECM provider capacity building through the JI Services Learning Collaborative program. Through the JI Services Learning Collaborative program, the selected organizations will meet with CalOptima Health staff regularly to streamline implementation, share lessons learned, and develop a JI Best Practices Guide. The JI Services Learning Collaborative program will ensure that CalOptima Health and its partners can pave the way for additional providers to join in serving this vulnerable

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population, ensuring those leaving the carceral system receive the comprehensive care and support they deserve.

Discussion

The JI Services NOFO was released on August 12, 2024, via the distribution list for entities providing or on the path to providing CalOptima Health ECM services for the JI population. CalOptima Health staff conducted a bidders' conference for eligible applicants with a presentation describing the grant application process, applicant eligibility criteria, and responded to questions about the process and the portal. The portal was open for applications from August 12 through September 13, 2024. In total, CalOptima Health received and reviewed six completed proposals.

An internal committee of evaluators from CalOptima Health reviewed and scored the submitted proposals based on the review criteria in Attachment 2. Evaluators scored all applications on these criteria using a scoring rubric, and their scores were averaged to give each application a final score as presented in Attachment 3. These scores were ranked, and the top five scorers are being recommended for grant funding, pursuant to the August 1, 2024, Board action. In their proposals, the recommended organizations demonstrated the ability to partner with local jails, conduct in-reach services to individuals identified as for Medi-Cal post-release, continue servicing individuals upon release with the provision of ECM and other support services, and actively participate in the JI Learning Collaborative.

With Board approval, staff would like to proceed with prompt development and execution of grant agreements with the organizations listed in Attachment 1. Staff will provide oversight of the grant pursuant to CalOptima Health Policy AA.1400p: Grants Management and will return to the Board to provide updates on the status of these grants at future meetings.

Fiscal Impact

The recommended action has no additional fiscal impact. A previous Board action on August 1, 2024, authorized up to $1 million from CalAIM IPP, Program Year 1 unallocated funds for ECM provider capacity building. CalOptima Health reserves the right to recoup funds for lack of demonstrated effort or for not meeting grant requirements.

Rationale for Recommendation

To ensure the success of in-reach services for CalOptima Heath's JI members, launching the JI Services Learning Collaborative is essential as it will facilitate the much-needed coordination among all stakeholders, allowing CalOptima Health to address and overcome existing barriers effectively and develop an experience-based set of best practices.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Entities Covered by this Recommended Action
2. Notice of Funding Opportunity Review Criteria
3. Applicant Scores, Award Recommendations and Amounts

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Board Actions

Board Meeting Dates	Action	Term	Not to Exceed Amount
December 20, 2021	Consider Approval of Program Year 1 CalAIM Performance Incentive Payment Methodology for All Health Networks, Except AltaMed Health Services Corporation, Arta Western California, Inc., Monarch Health Plan, Inc., and Talbert Medical Group, P.C.	-	$45,000,000 (in aggregate)
August 1, 2024	Authorize CalOptima Health staff to conduct a notice of funding opportunity (NOFO) process related to the Justice-Involved (JI) Learning Collaborative, administer grant agreements, and release award payments to up to five selected entities in an amount of up to $200,000 per grantee (as of December 1, 2024). Approve allocation of up to $1 million in Incentive Payment Program (IPP) funds for Program Year (PY) 1 for the Delivery System Infrastructure IPP priority area to provide capacity building support to enhanced care management providers for the JI population of focus.	-	$1,000,000

/s/ Michael Hunn *11/01/2024*
Authorized Signature **Date**

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Attachment to the November 7, 2024 Board of Directors Meeting – Agenda Item 17

CONTRACTED/ IMPACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
HealthRIGHT360	1563 Mission St.	San Francisco	CA	94103
Korean Community Services	451 W. Lincoln Ave.	Anaheim	CA	92805
Mariposa Women and Family Center	1845 W Orangewood Ave.	Orange	CA	92868
Mindful Living Center California LLC	900 Pacific Coast Hwy, Ste. 105	Huntington Beach	CA	92648
Project Kinship	2215 N. Broadway, #2	Santa Ana	CA	92706

ATTACHMENT 2. PROPOSAL RATING CRITERIA:

Evaluation Criteria	**Points Available**	**Description**
Outreach Scope	15	Applicant ability to reach a number of jails, correctional institutions; ability to reach a variety of areas in OC; variety of threshold languages available.
Program Description	10	Program description is clear and concise; clear rationale for the strategies they are employing and connection to how those activities will produce the outcomes they propose.
Program Implementation	15	Objectives that meet or exceed minimum service requirement; implementation plan clearly demonstrates how activities will result in accomplishing proposed metrics; staffing proposed will be able to accomplish said objectives.
Regional Knowledge and Community Experience	15	How will they incorporate voice of lived experience, do they mention critical partnerships, are they based in Orange County or have strong connections to the region.
Organizational Readiness	10	Timeline is feasible and start-up time needed is minimal.
Skills and Experience	15	Past experience conducting working with this population.
Applicant Capacity	10	Number of dedicated staff; strength of organizational financial position, strong board of directors, diversity of funding sources so not heavily reliant on this grant; consider status of other grants from CalOptima Health.
Evaluation Plan	10	Do they have built-in systems and experience doing this kind of evaluation and reflection.
Total	100	

Attachment to the November 7, 2024 Board of Directors Meeting – Agenda Item 17

SCORES OF JUSTICE-INVOLVED SERVICES LEARNING COLLABORATIVE NOFO APPLICANTS

	JI NOFO Applicants	**Score out of 100**	**Award Amount**	**Funding Recommendation**
1	Korean Community Services	89.8	$200,000	Fund
2	HealthRIGHT360	79.5	$200,000	Fund
3	Project Kinship	77.3	$200,000	Fund
4	Mariposa Women and Family Center	75.5	$200,000	Fund
5	Mindful Living Center California LLC	74.0	$200,000	Fund
	Subtotal of proposed funding		$1,000,000	
6	Olive Crest	69.8	$200,000	Do Not Fund

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CalOptima Health Board Action Agenda Referral

Action To Be Taken November 7, 2024
Regular Meeting of the CalOptima Health Board of Directors

Report Item

18. Approve Modifications to the CalOptima Health Mental Health (Non-Applied Behavior Analysis) Provider Pay-for-Value Program

Contacts

Richard Pitts, D.O., Ph.D., Chief Medical Officer, (714) 246-8491
Carmen Katsarov, LPCC, CCM, Executive Director Behavioral Health Integration, (714) 796-6168

Recommended Actions

Approve the modifications to the Mental Health (non-Applied Behavior Analysis) Provider Pay-for-Value Program measures.

Background

On May 2, 2024, the Behavioral Health Integration leadership recommended implementing the Mental Health (non-Applied Behavior Analysis) Provider Pay-for-Value Program (Program) for mental health providers contracted directly with CalOptima Health. The Board of Directors approved the Program for measurement periods starting January 1, 2025, through December 31, 2026, for mental health providers contracted directly with CalOptima Health. The initial intent of the Program was to use industry standards aligned with federal and state requirements and guidance (*e.g.*, Department of Health Care Services (DHCS), Managed Care Accountability Set (MCAS), Centers for Medicare and Medicaid Services (CMS) Star measurement sets).

Discussion

Initially, the mental health (non-ABA) providers were to be measured according to the 10 quality measures listed below:

#	Quality Measures
1	Follow-Up After ED Visit for Mental Illness—30 days
2	Follow-Up After ED Visit for Substance Use—30 days
3	Depression Screening and Follow-Up for Adolescents and Adults
4	Depression Remission or Response for Adolescents and Adults
5	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications
6	Follow-Up Care for Children Prescribed ADHD Medication: Continuation and Maintenance Phase
7	Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase
8	Metabolic Monitoring for Children and Adolescents on Antipsychotics
9	Antidepressant Medication Management: Acute Phase Treatment
10	Antidepressant Medication Management: Continuation Phase Treatment

During an internal reevaluation of the Program before the intended go-live of January 2025, CalOptima Health had to revise the Program measures to align to the unique providers' current capabilities related to providing supplemental data submissions to show evidence of how the measures have been met. The updated measures listed in the table below will continue to align with the combination of standards,

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including some HEDIS quality measures, Department of Managed Health Care (DMHC) timely access standards, and clinical industry best practices. Each provider's score that meets or exceeds the target will earn 100% of the incentive allocation for that measure. This Program is a CalOptima Health proprietary designed program.

	Category	Program Measures
1	Quality Process	Timely Follow-up After BH/SUD ED visit
2	Quality Process	Follow–up After Initial Visits
3	Quality Process	Effective Ongoing Care
4	Capacity/Growth	Capacity/Panel Growth
5	Care Effectiveness	Quality Monitoring of Essential Labs and Diagnostics
6	Care Effectiveness	Clinical Measurement of Care
7	Care Experience	Care Experience (Member satisfaction)

Substance Use Disorder (SUD) / Emergency Department (ED)

Program Methodology

The data collection will be captured by various methods such as claims/encounter data, provider attestation forms, and digital surveys. The measurement review will be performed semi-annually.

The providers will be able to earn up to a 10% additional payment on claims during the payout period by achieving any or all the Program elements in the measurement period. The payout to providers will follow prospective payment methodology.

Measurement Period	Payout Period
Jan – Jun 2025	Jan – Jun 2026
July – Dec 2025	Jul – Dec 2026
Jan – Jun 2026	Jan – Jun 2027
July – Dec 2026	Jul – Dec 2027

To be eligible for this Program, the behavioral health providers must maintain a contract with CalOptima Health throughout the measurement period, still be contracted with CalOptima health, and be in good standing, as determined by the Audit and Oversight Department. CalOptima Health will have sole discretion to modify measurements and targets to drive maximum quality performance and will provide regular reports to the CalOptima Health Quality Assurance Committee.

Fiscal Impact

Staff estimates that the annual fiscal impact for each payout period for the Program will be no more than 10% of the paid claims or approximately $4.2 million on an annual basis. The estimated payments for the proposed payout periods will be included beginning with the Fiscal Year 2025-26 and will also be incorporated in future operating budgets.

Rationale for Recommendation

The Program will improve the quality of care for CalOptima Health members.

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Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Previous Board Action dated May 2, 2024, Approve CalOptima Health Mental Health (non-Applied Behavior Analysis) Provider Pay-for-Value Program

/s/ Michael Hunn *11/01/2024*
Authorized Signature **Date**

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CalOptima Health Board Action Agenda Referral

Action To Be Taken May 2, 2024
Regular Meeting of the CalOptima Health Board of Directors

Report Item

18. Approve CalOptima Health Mental Health (non-Applied Behavior Analysis) Provider Pay-for-Value Program

Contacts

Carmen Katsarov, LPCC, CCM, Executive Director Behavioral Health Integration, (714) 796-6168
Richard Pitts, D.O., Ph.D., Chief Medical Officer, (714) 246-8491

Recommended Action

1. Approve the CalOptima Health Mental Health (non-Applied Behavior Analysis) Provider Pay-for-Value Program with measurement periods starting January 1, 2025, through December 31, 2026.

Background

CalOptima Health's existing Medi-Cal Pay-for-Value (P4V) Program has aligned and incentivized performance on all Healthcare Effectiveness Data and Information Set (HEDIS®) measures included in the Department of Health Care Services (DHCS) Managed Care Accountability Set (MCAS) measures required to achieve a minimum performance level (MPL) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) member satisfaction measures. The OneCare P4V Program utilizes Centers for Medicare & Medicaid Services (CMS) Star HEDIS and CAHPS measures and focuses on the most significant improvement opportunity.

Discussion

The Behavioral Health Integration leadership recommends implementing the Mental Health (non-Applied Behavior Analysis (ABA)) Provider P4V Program for mental health providers contracted directly with CalOptima Health. CalOptima Health's members have established trusted relationships with their physicians and mental health providers, which can help drive quality measures and member care coordination. The program will use industry standard measures aligned with federal and state requirements and guidance (*e.g.,* DHCS MCAS, CMS Star measurement sets) and applicable Department of Managed Health Care standards. The following provides more detail on the components of the Mental Health (non-ABA) Provider P4V Program.

Quality Measures

The mental health (non-ABA) providers will be measured according to the following 10 quality measures. Each provider's score that meets or exceeds the target will earn 100% of the incentive allocation for that measure.

#	Quality Measures	Measure Acronym	Measure Steward	Weight %
1	Follow-Up After ED Visit for Mental Illness—30 days	FUM	NCQA	2.0
2	Follow-Up After ED Visit for Substance Use—30 days	FUA	NCQA	2.0
3	Depression Screening and Follow-Up for Adolescents and Adults	DSF-E	NCQA	.75

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#	Quality Measures	Measure Acronym	Measure Steward	Weight %
4	Depression Remission or Response for Adolescents and Adults	DRR-E	NCQA	.75
5	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications	SSD	NCQA	.75
6	Follow-Up Care for Children Prescribed ADHD Medication: Continuation and Maintenance Phase	ADD-E C&M	NCQA	.75
7	Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase	ADD-E Init	NCQA	.75
8	Metabolic Monitoring for Children and Adolescents on Antipsychotics	APM-E	NCQA	.75
9	Antidepressant Medication Management: Acute Phase Treatment	AMM-Acute	NCQA	.75
10	Antidepressant Medication Management: Continuation Phase Treatment	AMM-Cont	NCQA	.75
Total				**10**

Program Methodology

The quality measures will be compared to the DHCS Minimum Performance Levels (MPL) at the 50th percentile and Medicare measures will be compared to the National Committee for Quality Assurance (NCQA) Medicare National Percentile Benchmarks. The performance compared to benchmarks will earn incentives based on to following:

Performance Benchmark	Percent of Incentive Earned per Measure
50th percentile	50%
75th percentile	75%
90th percentile	100%

Program Measurement Period and Payout

The incentive budget is allocated based on the percentage of paid claims. Providers will be able to earn up to 10% of the paid claims during each measurement period based on their performance against the quality measures:

	Measurement Period	Incentive Payment Timeframe*
Baseline	January – December 2024	NA
Year 1	January – December 2025	Quarter 4 2026
Year 2	January – December 2026	Quarter 4 2027

*Incentive Payment Timeframe will be affected by HEDIS reporting timeframes and claims lag

Measurement Process and Incentive Payments

To qualify for incentive payments, mental health (non-ABA) providers must be contracted with CalOptima Health during the entire measurement period, be currently contracted, and in good standing with CalOptima Health, as determined by the Audit and Oversight Department. CalOptima Health staff

will calculate the rating score for the mental health (non-ABA) providers. The provider's performance score will be derived from the most recently audited plan-level HEDIS results. Providers can monitor their performance and progress through scorecards distributed by CalOptima Health. The distribution of the performance incentive payment will be based on each measure's rate final calculation and validation.

Fiscal Impact

Staff estimates that the annual fiscal impact for each measurement year for the Mental Health (non-ABA) Provider P4V Program will be no more than 10% of the paid claims during each measurement period or approximately $3.1 million.

Management will include 100% of pool funding for the measurement year (MY) 2025 Mental Health (non-ABA) Provider P4V Program initiatives in the Fiscal Year 2024-25 Operating Budget. The estimated payout for MY 2026 will be included in future operating budgets.

Rationale for Recommendation

The Mental Health (non-ABA) Provider P4V Program will improve the quality of care for our CalOptima Health members.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

None

/s/ Michael Hunn *04/26/2024*
Authorized Signature **Date**