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

DECEMBER 1, 2022
2:00 P.M.

505 CITY PARKWAY WEST, SUITE 108
ORANGE, CALIFORNIA 92868

BOARD OF DIRECTORS

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

Supervisor Katrina Foley, Alternate

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

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

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

The Board Meeting Agenda and supporting materials are available for review at CalOptima 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.

To ensure public safety and compliance with emergency declarations and orders related to the COVID-19 pandemic, individuals are encouraged not to attend the meeting in person. As an alternative, members of the public may:
Participate via Zoom Webinar at:
https://us06web.zoom.us/webinar/register/WN_6_r9t6BHQWyQGQG6-SX_5g
and Join the Meeting.
Webinar ID: 857 6840 3773
Passcode: 927208-- Webinar instructions are provided below.

CALL TO ORDER
Pledge of Allegiance
Establish Quorum

PRESENTATIONS/INTRODUCTIONS

MANAGEMENT REPORTS
1. Chief Executive Officer Report

2. Digital Transformation Update

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

CONSENT CALENDAR
3. Minutes
   a. Approve Minutes of the November 3, 2022 Regular Meeting of the CalOptima Health Board of Directors
   b. Receive and File Minutes of the September 15, 2022 Regular Meeting of the CalOptima Health Board of Directors' Finance and Audit Committee

4. Adopt Board Resolution No. 22-1201-01, Authorizing Remote Teleconference Meetings for the CalOptima Health Board of Directors and its Advisory Committees in Accordance with California Government Code section 54953, subdivision (e)

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

6. Approve CalOptima Health's Calendar Year 2023 OneCare Member Health Rewards and Incentives

7. Authorize an Amendment to the Kaiser Foundation Health Plan Inc. Medi-Cal Health Maintenance Organization Contract for Health Care Services

8. Authorize Contract Amendment Related to CalOptima Health's Key Operational System Vendors for Office Ally Inc., Change Healthcare Technologies LLC, and Health Management Systems, Inc.

9. Approve New CalOptima Health Claims Administration Policy FF.1014p

10. Approve Updates to CalOptima Health Policy EE.1106: Health Network and CalOptima Health Community Network Minimum and Maximum Member Enrollment

11. Approve Modification to CalOptima Health Policy AA.1223: Participation in Community Events with External Entities

12. Approve CalOptima Health Board of Directors' Member Advisory Committee, Provider Advisory Committee, and Whole-Child Model Family Advisory Committee Policies and Procedures

13. Adopt Resolution No. 22-1201-02 Approving and Adopting Updated and New CalOptima Health Human Resources Policies

14. Adopt Resolution No. 22-1201-04 Approving Updated CalOptima Health Policy GA.8012

15. Adopt Resolution No. 22-1201-05 Approving and Adopting Updated CalOptima Health Policy GA.8058: Salary Schedule and Authorize the Chief Executive Officer to Implement Changes to Executive Level Job Titles

16. Adopt Resolution No. 22-1201-06 to Amend CalOptima Health's Conflict of Interest Code

17. Adopt Resolution Approving Revised CalOptima Health 2023 Compliance Plan and Approval of Revised Office of Compliance Policies and Procedures

18. Approve Modifications to CalOptima Health Policy GA.3400 Annual Investments

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

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

REPORTS/DISCUSSION ITEMS

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

22. Approve Actions Related to the National Alliance for Mental Illness Orange County Peer Support Program

23. Approve CalOptima Health's Measurement Year 2023 Medi-Cal and OneCare Quality Pay for Value Programs

24. Approve CalOptima Health's Five-Year Hospital Quality Program Beginning Measurement Year 2023

25. Approve Actions Related to the Medi-Cal Annual Wellness Visit Initiative

26. Authorize Actions Related to Improving Member Quality and Experience of Care Through Better Access to Skilled Nursing Facilities

27. Authorize In-Home Care Pilot Program with the University of California Irvine Family Health Center

28. Authorize Actions Related to the CalOptima Health Comprehensive Community Cancer Screening and Support Program for Medi-Cal Members

ADVISORY COMMITTEE UPDATES

29. OneCare Connect Member Advisory Committee Update

30. Whole-Child Model Family Advisory Committee Update

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 December 1, 2022 at 2:00 p.m. (PST)

To **Register** in advance for this webinar:
https://us06web.zoom.us/webinar/register/WN_6_r9t6BHQWyQGQG6-SX_5g

To **Join** from a PC, Mac, iPad, iPhone or Android device:
Please click this URL to join.
https://us06web.zoom.us/s/85768403773?pwd=cll5ckExM01qaEM4a1BYVVRtK29QZz09

Passcode: **927208**

Or One tap mobile:
+16694449171,,85768403773#,,,,*927208# US
+13462487799,,85768403773#,,,,*927208# US (Houston)

Or join by phone:
Dial(for higher quality, dial a number based on your current location):
US: +1 669 444 9171 or +1 346 248 7799 or +1 719 359 4580 or +1 720 707 2699 or +1 253 205 0468 or +1 253 215 8782 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 or +1 301 715 8592 or +1 305 224 1968 or +1 309 205 3325

Webinar ID: **857 6840 3773**
Passcode: **927208**
International numbers available: **https://us06web.zoom.us/u/kctPNtP3zg**

CalOptima Health

MEMORANDUM

DATE:	November 22, 2022
TO:	CalOptima Health Board of Directors
FROM:	Michael Hunn, Chief Executive Officer
SUBJECT:	CEO Report — December 1, 2022, Board of Directors Meeting
COPY:	Sharon Dwiers, Clerk of the Board; Member Advisory Committee; Provider Advisory Committee; OneCare Connect Member Advisory Committee; and Whole-Child Model Family Advisory Committee

a. CalOptima Health Wins OCBC Award

CalOptima Health was honored at the Orange County Business Council's (OCBC) 12th Annual "Turning Red Tape Into Red Carpet Awards." These awards honor outstanding local agencies, leaders, programs and public-private partnerships that cut through red tape. CalOptima Health was nominated for two awards in the public-private partnership category and won for partnering with the Orange County Health Care Agency and private organizations on the Be Well OC Orange Campus.

b. Member Health Needs Assessment RFP Released

CalOptima Health has released a request for proposal (RFP) for the services of a community research consultant with knowledge of multicultural populations and strategies for improved program engagement to conduct a comprehensive Member Health Needs Assessment (MHNA). The 2023 MHNA will be an expanded version of the original assessment completed in 2017–18. Given the inequities revealed through the COVID-19 pandemic, the assessment will result in a final report that includes recommendations about how to address the needs of members and newly identified populations, barriers to care, gaps in services and health disparities.

c. Public Health Emergency Now Extends Into April

The Federal COVID-19 Public Health Emergency (PHE) is now expected to continue through at least April 11, 2023. The current PHE designation — which has been continuously renewed in maximum 90-day increments — lasts through January 11, but the U.S. Department of Health & Human Services (HHS) did not provide the guaranteed 60-day termination notice by November 11. Therefore, it is expected to be renewed for an additional 90 days. In the meantime, Medicare telehealth services, Medicaid (Medi-Cal) coverage protections and several state supports will continue.

d. Strategy Session Develops Federal Priorities

CalOptima Health's federal lobbyists recently visited for a strategy session with me, Chief of Staff Veronica Carpenter, COO Yunkyung Kim and Government Affairs Manager Donovan Higbee. As we

prepare for a new Congress in January, this helped develop the federal legislative and regulatory priorities that will guide our advocacy efforts over the next two years. Major policy areas discussed include social determinants of health, behavioral health, provider rates and Program of All-Inclusive Care for the Elderly (PACE) regulations. We also discussed ways to enhance our relationships with Congressional offices and key federal agencies as well as position ourselves as a leader in the national Medicaid and Medicare space. In early December, we will hold a strategy session with our state lobbyists as we work to finalize our 2023–24 Legislative Platform by early 2023.

e. CalOptima Health Advocates Removing PACE Barriers for Unhoused

With the assistance of U.S. Rep. Lou Correa, CalOptima Health recently delivered a letter to U.S. Secretary of Health & Human Services (HHS) Xavier Becerra regarding current barriers to PACE enrollment. Specifically, Centers for Medicare & Medicaid (CMS) regulations prevent PACE organizations from enrolling older adults who are not considered stably housed — a population that would arguably benefit most from PACE's coordinated model of care. Rectifying this barrier would expand our ability to provide PACE services to those residing in a recuperative care facility, such as through our proposed Community Living Center and PACE Center in Tustin. The letter requests Sec. Becerra's assistance in clarifying or updating this current CMS policy in coordination with the California Department of Health Care Services (DHCS), which reviews PACE enrollment applications.

f. CalOptima Health Gathers Preliminary Midterm Election Results

On November 8, midterm general elections were held for several federal, state, county, local and judicial offices. At the federal level, Democrats will maintain a majority in the U.S. Senate, and Republicans have gained control of the U.S. House of Representatives. At the state level, Gov. Gavin Newsom has been re-elected governor of California, and Democrats will maintain supermajorities in both the State Senate and State Assembly. However, winners have still not been declared in several individual races as more ballots are tabulated over the next few weeks. After results are certified by December 16, I will share the final election outcomes for Orange County's representatives.

g. Senator Newman Tours PACE Center

On October 31, State Senator Josh Newman and I toured the CalOptima Health PACE Center along with COO Yunkyung Kim, PACE Director Monica Macias and Government Affairs Manager Donovan Higbee. Sen. Newman expressed a keen interest in all the clinical and day center services and asked several questions about expanding PACE in Orange County. Staff continues to raise awareness about the PACE program with our elected officials and plans to schedule additional tours soon.

h. Respiratory Syncytial Virus (RSV) Declared a Local Health Emergency

Due to record numbers of pediatric hospitalizations and daily emergency room visits for RSV, local public health officials issued a health emergency on October 31. The County Health Officer and Orange County Health Care Agency (HCA) medical directors strongly encourage the community to follow preventive measures such as staying home when sick, covering coughs and sneezes, washing hands frequently and masking up in large group settings. CalOptima Health shared this information on social media and in email newsletters to community stakeholders and providers. Chief Medical Officer Richard Pitts, D.O., Ph.D., was interviewed by KFI News about the rising RSV cases.

i. Medi-Cal Member Wins National Scholarship

The Association for Community Affiliated Plans (ACAP) has named CalOptima Health member Marina Esquivel Cisneros as the winner of its National Scholarship Contest. ACAP established the scholarship in 2011 to provide crucial, timely financial assistance to an enrollee of an ACAP health plan seeking higher education to pursue a career in health care or social services. Marina will receive $5,000 toward tuition and educational expenses in pursuit of a nursing degree. In her essay, Marina details her interest in pursuing a career in health care based on her dedication to serving the community and the caring example of nurses who served her grandmother.

j. InfoSeries on Equity Shared With Community Partners

On November 15, CalOptima Health hosted a virtual InfoSeries presentation for community partners and stakeholders titled "Equity for a Healthy Orange County." As the pandemic exposed deep health disparities evident in different vaccination and mortality rates based on ethnicity, the InfoSeries gave attendees an opportunity to learn about community-based initiatives supporting equity. Presenters included Hieu Nguyen, Director of Population Health and Equity, Orange County Health Care Agency; Mario Ortega, Chief Executive Officer, Abrazar Inc.; and Katie Balderas, Director of Population Health, CalOptima Heath.

k. Continuing Medical Education (CME) Webinar Held on Childhood Lead Poisoning

Ninety providers attended CalOptima Health's CME webinar on preventing childhood lead poisoning. Our Population Health Management (Quality Initiatives) team planned the course to increase provider awareness about the importance of lead screenings and support the regulatory requirements for testing. Lead poisoning is one of the most common and preventable environmental conditions in California children, and blood lead screenings are the only way to identify if a child has been exposed. The course was led by Jean Woo, M.D., Public Health Medical Officer at the Childhood Lead Poisoning Prevention Branch at the California Department of Public Health.

l. CalOptima Health Featured in Media Coverage

- On October 27, Payers and Providers covered CalOptima Health's NCQA rating of 4, listing us among the top health plans in California.
- On November 1, Chief Medical Officer Richard Pitts, D.O., Ph.D., was interviewed by KFI News about the rising RSV cases in Orange County.
- On November 3, BusinessWire.com and Yahoo.com published articles on CalOptima Health's texting campaign for CalFresh that won an mPulse Activate award.

CalOptima Health

Fast Facts
As of October 2022

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

Membership Data* (as of October 31, 2022)

Total CalOptima Health Membership

937,584

Program	Members
Medi-Cal	919,992
OneCare Connect	14,198
OneCare (HMO D-SNP)	2,964
Program of All-Inclusive Care for the Elderly (PACE)	430

*Based on unaudited financial report and includes prior period adjustment

Operating Budget (for four months ended October 31, 2022)

	YTD Actual	YTD Budget	Difference
Revenues	$1,415,869,993	$1,329,510,548	$86,359,445
Medical Expenses	$1,340,186,038	$1,244,967,734	($95,218,304)
Administrative Expenses	$57,727,398	$69,105,803	$11,378,405
Operating Margin	$17,956,557	$15,437,011	$2,519,546
Medical Loss Ratio (MLR)	94.7%	93.6%	1.0%
Administrative Loss Ratio (ALR)	4.1%	5.2%	1.1%

Reserve Summary (as of October 31, 2022)

	Amount (in millions)
Board Designated Reserves	$562.7*
Capital Assets (Net of depreciation)	$67.9
Resources Committed by the Board	$364.7
Resources Unallocated/Unassigned	$444.4*
Total Net Assets	$1,439.7

Total of Board designated reserves and unallocated resources can support approximately 98 days of CalOptima Health's current operational cash needs.

Total Annual Budgeted Revenue **$4 Billion**

CalOptima Health Fast Facts

As of October 2022

Personnel Summary (as of October 29, 2022, pay period)

	Filled	Open	Vacancy %
Staff	1,328.4	158.5	10.7%
Manager	95.0	15.0	13.6%
Director	46.0	15.5	25.2%
Executive Director	10.0	1.0	9.1%
Chief	9.0	1.0	10.0%
Total FTE Count	1,488.4	191.0	11.4%

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

Provider Network Data (as of October 31, 2022)

	Number of Providers
Primary Care Providers	1,497
Specialists	9,184
Pharmacies	569
Acute and Rehab Hospitals	45
Community Health Centers	34
Long-Term Care Facilities	99

Treatment Authorizations (as of September 31, 2022)

	Mandated	Average Time to Decision	Average Time to Decision (Previous Month)
Inpatient Concurrent Urgent	72 hours	24.58 hours	26.6 hours
Prior Authorization – Urgent	72 hours	12.33 hours	12.4 hours
Prior Authorization – Routine	5 days	1.31 days	1.34 days

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

Member Demographics (as of October 31, 2022)

Member Age	
0 to 5	9%
6 to 18	25%
19 to 44	34%
45 to 64	20%
65 +	12%

Language Preference	
English	58%
Spanish	27%
Vietnamese	10%
Other	2%
Korean	1%
Farsi	1%
Chinese	<1%
Arabic	<1%

Medi-Cal Aid Category	
Temporary Assistance for Needy Families	40%
Expansion	37%
Optional Targeted Low-Income Children	8%
Seniors	9%
People With Disabilities	5%
Long-Term Care	<1%
Other	<1%

CalOptima Health

Digital Transformation
Key Performance Indicators (KPIs)

Board of Directors Meeting

December 1, 2022

Wael Younan, Chief Information 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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Digital Transformation KPIs (Jan 2022–Present)

Member and Provider Portals
Active Subscriptions and Enrollments

Members	Total Member Portal users enrolled	38k ↑ 99k
	Unique logins to Member Portal	28k ↑ 64k
	New user enrollment to Member Portal in Q3	7K
Providers	Total Provider Portal users enrolled	6k ↑ 15k
	Unique logins to Provider Portal	11k ↑ 23k
	New user enrollment to Provider Portal in Q3	2k

Annual Transactions in Support of our Members

Real-time eligibility files processed daily	1.4m
Claims transmitted	5.6m
Encounters transmitted	4.3M
Admission, Discharge, Transfer (ADT's)	6.9m

Pharmacy Orders

- Reduced faxing by 75% through portal submissions
- 80% reduction in time to complete pharmacy submissions

Security

- Completion of 30 ITS Security projects by 12/31

Infrastructure

- Cloud Migration begins for Applications and Hardware in December 2022

Application Development

- Planning for redetermination, intelligent texting and CalOptima mobile application

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CalOptima Health

Digital Transformation KPIs (Cont.)

Cost-Saving Opportunities

Retired CalOptima Link portal *(reduced monthly expense)*	**$150K**
Q1 – SecurePrint Deployment *(reduced ongoing printing costs)*	**$80K**
Q2 – InTune Implementation, Crowdstrike Deployment *(eliminating legacy products)*	**$135K**
Q3 – Lumen Renegotiation, Cisco Umbrella, RSA, MiFi, GoTo Meeting *(retirements)*	**$452K**

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CalOptima Health

Digital Transformation Projects

Projects In Progress or Approved

Burgess Reimbursement System	$1,506,000
Robotic Process Automation	$1,500,000
Customer Relationship Management	$925,000
Web Traffic Analytic Solution	$150,000
FWA Data Analytics/Detection Solution	$950,000
Encounter Data Management System	$3,500,000
Data Protection and Recovery Solution	$450,000
Cybersecurity Asset Management	$400,000
Cloud Migration Strategy	$340,000
Enterprise Resource Planning System	$1,312,000
Web Content Management Platform	$600,000
Care Management System	$3,500.000
TOTAL	**$15,133,000**

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Digital Transformation Strategy Spending

Capital Assets	$1,942,129
Salary, Wages, Benefits	$218,935
Other Expenses	$110,252
TOTAL	**$2,271,316**

Total Projected Spend:
(estimated, pending contract completion)

$17,404,316

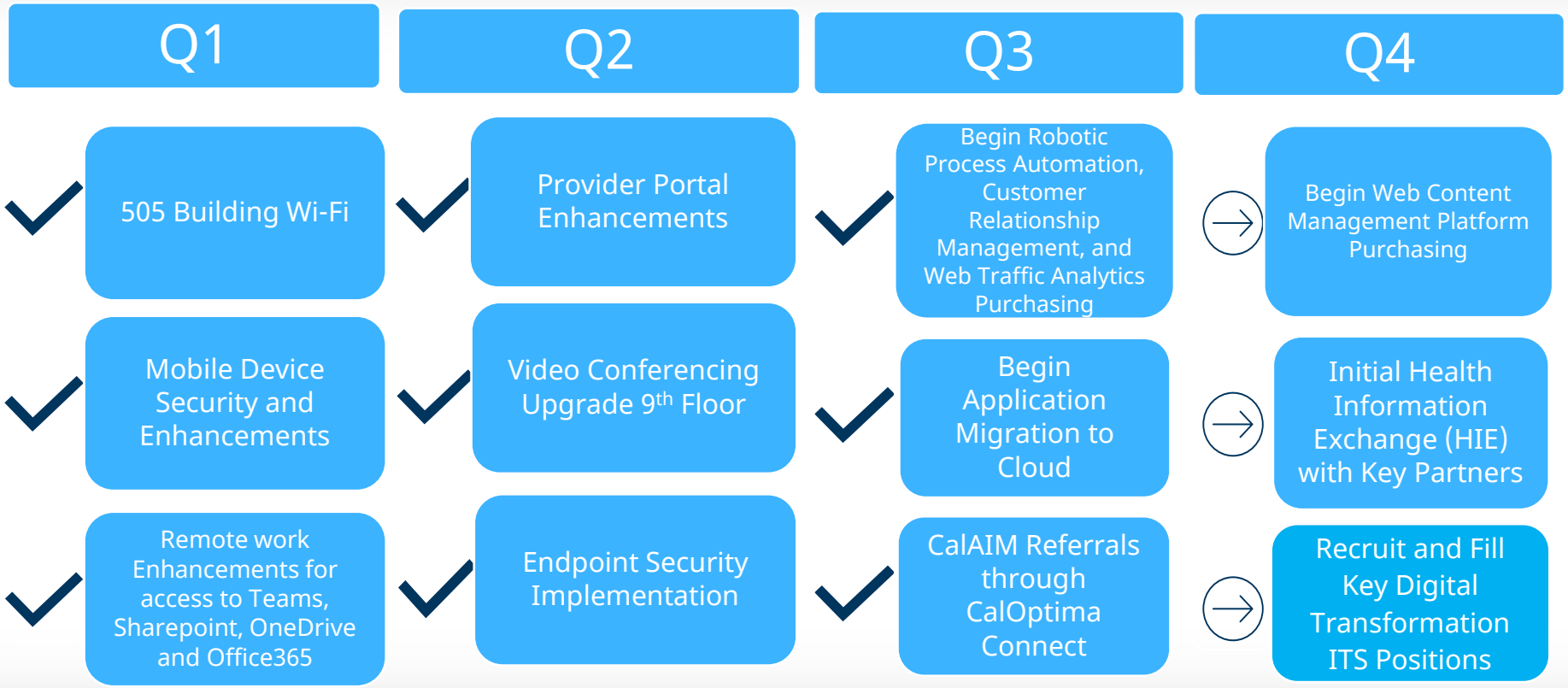
CalOptima Health

Digital Transformation

✓ Complete

→ In Process

2022 Key Planned Milestones



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Q4 & Q1 Project Kickoffs

- Web Content Management/Digital Experience Platform (November)
  - Enhanced member and provider website and functions
- Cybersecurity Asset Management Solution (Q4)
  - Implementing a solution to track, manage, and maintain all devices that reside within the CalOptima network.
- Data Classification/Access Governance Solution (Q4)
  - Solution to assess data categorization for security and organization-wide retention
- Data Protection/Recovery Solution (Q1-2023)
  - Implement a modern solution that improves the continuity of business operations and provide protection against threats

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MINUTES
REGULAR MEETING
OF THE
CALOPTIMA HEALTH BOARD OF DIRECTORS

November 3, 2022

A Regular Meeting of the CalOptima Health Board of Directors (Board) was held on November 3, 2022, at CalOptima, 505 City Parkway West, Orange, California. The meeting was held via teleconference (Zoom) in light of the COVID-19 public health emergency and Assembly Bill (AB) 361 (Chaptered September 16, 2021), which allows for temporary relaxation of certain Brown Act requirements related to teleconferenced meetings. Vice Chair Clayton Corwin called the meeting to order at 2:03 p.m., and Director Trieu Tran led the Pledge of Allegiance.

ROLL CALL

Members Present: Clayton Corwin, Vice Chair; Isabel Becerra; Supervisor Doug Chaffee (at 2:05 p.m.); Clayton Chau, M.D. (non-voting); Blair Contratto; José Mayorga M.D.; Scott Schoeffel; Nancy Shivers; Trieu Tran, M.D.

(All Board Members participated remotely except Vice Chair Corwin, Director Contratto, and Director Tran, who participated in person)

Members Absent: Supervisor Andrew Do, Chairman

Others Present: 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

PRESENTATIONS/INTRODUCTIONS

None

MANAGEMENT REPORTS

1. Chief Executive Officer Report

Yunkyung Kim, Chief Operating Officer, presented the Chief Executive Officer (CEO) Report in Michael Hunn's absence. In light of the new local public health emergency, regarding the latest respiratory syncytial virus that mainly affects children, also known as RSV, Ms. Kim asked Chief Medical Officer Richard Pitts, D.O. Ph.D., to provide a quick overview of what CalOptima Health is seeing.

Dr. Pitts thanked the County Health Officer, Dr. Regina Chinsio-Kwong, and CHOC Children's Health Chief Medical Officer, Dr. Michael Weiss, for their assistance in providing additional details on the RSV virus. Dr. Pitts explained that the children's hospitals are quickly becoming at or over capacity. He noted that this virus is extremely serious for obligate nose breathers, for children that only breathe through their noses, which can cause them to not feed as they cannot breathe and feed at the same time and are more likely to become dehydrated. Dr. Pitts also noted that RSV can also affect the elderly.

Dr. Clayton Chau added that an emergency health order was put in place ahead of the children's hospitals becoming at or over capacity and adds additional resources should they be needed.

Back to Agenda

Director Mayorga noted that at the UC Irvine Health Clinics, he is seeing the impacts of this RSV amongst children, including hospitalization, but said it is also affecting quite a few children that are not ending up in the hospital. He added that there have been a lot of challenges over the last several years due to the COVID-19 pandemic, but it is important to continue to educate the public at large on the basic fundamentals for keeping everyone healthy, especially as the community moves into the flu season. Director Mayorga commended the Health Care Agency and Dr. Chinsio-Kwong for the proactive approach to ensuring that the county is prepared in order to serve the entire community.

Director Becerra echoed Director Mayorga's comments and again reminded the public that the community is facing multiple viruses. She also thanked Dr. Chow and Dr. Chinsio-Kwong for their proactive approach to keep the county safe.

Dr. Chow added that it is not so much the need for beds or space, but for staffing to be able to care for those people who get sick.

Ms. Kim reviewed several items from the CEO Report.

CalFresh Program

Ms. Kim reported that that there were two updates regarding the CalFresh Program. For the first update, last month, CalOptima Health partnered with Northgate Markets to announce the increased CalFresh benefit amount, which is $281.00 for an individual and $939.00 for a family of four. In addition, Northgate Market offers an incentive program called Más Fresco for CalFresh members providing an additional $100.00 a month when they purchase fresh fruits and vegetables at Northgate Markets. Ms. Kim noted that this event received wide media coverage from NBC, CBS, KTLA, as well as the Orange County Register and Los Angeles Daily News.

For the second update, Ms. Kim shared that CalOptima Health received the mPulse Activate 2022 Award for Most Improved Consumer Experience resulting from a successful member texting campaign. The campaign was a multilingual, two-way SMS texting program that addressed language barriers around food security. The program educated members on the availability and benefits of the CalFresh program. To date, CalOptima Health has sent out more than 410,000 texts to its members.

Fast Facts as of September 2022

Ms. Kim reviewed data from CalOptima Health's Fast Facts as of September 2022.

CalOptima Health has over 939,000 members as of September 30, 2022, which is a 13,000-member increase from the end of August 2022. Ms. Kim added that since the beginning of the calendar year CalOptima Health has added over 62,000 new members. She noted that this increased membership highlights for CalOptima Health and the community that there are 939,000 individuals who have very few resources and it reminds CalOptima Health of what an honor it is to serve such a large portion of the community.

Financially, CalOptima Health is on target. At the end of the first quarter, CalOptima Health is on track to meet its year end goal of 0.9% operating margin. Ms. Kim noted that CalOptima Health did receive from the state and distributed to its hospital partners $135 million dollars in directed payments, which

accounts for the majority of the variance that is reflected in the Fast Facts. CalOptima Health's administrative loss ratio (ALR) remains under 4%, which is the lowest in the state for a Medicaid health plan. Ms. Kim also reviewed the CalOptima Health personnel data by staff level as recommended by the Board. She noted that there were 203 open positions at the end of October, and 1,500 employees. There are currently two executive positions open, the Executive Director of Quality and the Chief Equity Officer position.

Ms. Kim ended the CEO Report by sharing a short message received from a CalOptima Health member. She noted that CalOptima Health receives many messages from its members throughout the month, but this one stood out. CalOptima Health has a team that works with its members who need organ transplants, and Dr. Richard Lopez is the Medical Director in charge of transplants. Dr. Lopez reviews every single potential organ transplant case, and CalOptima Health has a team of case managers and personal care coordinators who work with members who have a catastrophic illness. The team works with the members through the procedure of the organ transplant, and through the lifelong recovery and healing for those members. One CalOptima Health member took the time to send a card to Andrea Cerda, Personal Care Coordinator, that read in part, "you made me believe angels do exist among humans." Ms. Kim added that health plans are rarely called angels, so CalOptima Health staff and its organ transplant team are living its mission and providing members with hope, empathy, compassion, and dignity.

Director Contratto complimented staff on an incredible report, noting that it is a great way to tell the CalOptima Health story. She also noted that staff jumped right over the treatment authorizations statistics, which many months ago, were backlogged and in violation of CalOptima Health's agreements. Director Contratto added that it is worth noting that now CalOptima Health is exceeding every single target for on-time treatment authorizations, which is amazing work. She shared that it is rewarding to sit on the Board of Directors and see the transformation and thanked staff for the commendable work being done.

PUBLIC COMMENTS

There were no requests for public comment.

CONSENT CALENDAR

2. Minutes

a. Approve Minutes of the October 6, 2022 Regular Meeting of the CalOptima Health Board of Directors
b. Receive and File Minutes of the August 24, 2021 Regular Meeting of the CalOptima Health Board of Directors' Whole-Child Model Family Advisory Committee; the August 11, 2022 Regular Meeting of the CalOptima Health Board of Directors' Joint Member Advisory Committee and Provider Advisory Committee; and the September 20, 2022 Regular Meeting of the CalOptima Health Board of Directors' Whole-Child Model Family Advisory Committee

3. Adopt Board Resolution No. 22-1103-01, Authorizing Remote Teleconference Meetings for the CalOptima Health Board of Directors and its Advisory Committees in Accordance with California Government Code section 54953, subdivision (e)

Back to Agenda

4. Authorize and Direct Execution of Amendment 01 to the Agreement with the California Department of Health Care Services for the CalOptima Health Program of All-Inclusive Care for the Elderly

5. Approve Modifications to CalOptima Health's Coronavirus (COVID-19) Member Vaccination Incentive Program

6. Receive and File:

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

Action: ***On motion of Director Contratto, seconded and carried, the Board of Directors approved the Consent Calendar, as presented. (Motion carried 8-0-0; Chairman Do absent)***

REPORTS/DISCUSSION ITEMS

7. Approve Actions Related to the Street Medicine Pilot Program

Director Becerra did not participate in this item due to her role as Chief Executive Officer of the Coalition of Orange County Community Health Centers.

Kelly Bruno-Nelson, Executive Director, CalAIM, introduced the item noting that the CalOptima Health Street Medicine Program is a critical piece of its larger, comprehensive approach to caring for its members living on the street and assisting them in their journey home. Ms. Bruno-Nelson added that this overall approach pairs three integrated key components: first, is outreach and engagement; second, coordinated medical care that meets members where they are; and third, comprehensive care, coordination, and community supports. These integrated components will address acute health concerns and deploy integral preventative care.

Ms. Bruno-Nelson responded to questions from the Board. After which, the Board took the following action:

Action: ***On motion of Director Tran, seconded and carried, the Board of Directors authorized the Chief Executive Officer to negotiate and execute contracts for the Street Medicine Pilot Program with awarded Medi-Cal providers. (Motion carried 7-0-0; Director Becerra recused and Chairman Do absent)***

8. Approve Actions Related to the CalOptima Health Member Health Needs Assessment 2023

Ms. Kim introduced the item noting that the last CalOptima Health Member Health Needs Assessment (MHNA) was completed in 2018 and at that time CalOptima Health was a health plan of 800,000 members and received input from more 6,000-member, provider, and community stakeholders. With the increase in membership, CalOptima Health is proposing to increase the survey size to at least 10% of its membership. Ms. Kim noted that the CalOptima Health 2023 MHNA will inform programs, services and operations and serve as the foundation for CalOptima Health's annual assessment of the social

determinates of health as set forth in the vision adopted by this Board earlier this year.

Action: ***On motion of Director Contratto, seconded and carried, the Board of Directors: 1.) Approved the scope of work (SOW) for the CalOptima Health 2023 Member Health Needs Assessment (MHNA) and release a request for proposal; and 2.) Authorized unbudgeted expenditures and appropriate funds in an amount up to $1 million from existing reserves for the CalOptima Health 2023 MHNA. (Motion carried 8-0-0; Chairman Do absent)***

9. Approve Extension of Ancillary Services Contract with Disposable Incontinence Supplies and Non-Medical Transportation Vendors

Action: ***On motion of Director Tran, seconded and carried, the Board of Directors approved extension of Medi-Cal, OneCare, and PACE fee-for service ancillary services contracts with disposable incontinence supplies and non-medical transportation vendors, for a period of one year – January 1, 2023, through December 31, 2023. (Motion carried 8-0-0; Chairman Do absent)***

10. Approve Actions Related to the Procurement of an Enterprise Resource Planning System

Action: ***On motion of Director Contratto, seconded and carried, the Board of Directors: 1.) Approved the scope of work (SOW) for the Enterprise Resource Planning (ERP) system; and 2.) Authorized the Chief Executive Officer to release the ERP system request for proposal (RFP) with the approved SOW and to negotiate and contract with the selected vendor. (Motion carried 8-0-0; Chairman Do absent)***

11. Approve Actions Related to the Procurement of a Web Content Management and Digital Experience Platform Solution

Action: ***On motion of Director Tran, seconded and carried, the Board of Directors:1.) Approved the scope of work (SOW) for the Web Content Management and Digital Experience Platform Solution; and 2.) Authorized the Chief Executive Officer to release the request for proposal (RFP), select a vendor, and negotiate and execute a contract with the selected vendor. (Motion carried 8-0-0; Chairman Do absent)***

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

Director Schoeffel thanked Vice Chair Corwin for conducting a smooth meeting in the absence of Chairman Do.

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ADJOURNMENT

Hearing no further business, Vice Chair Corwin adjourned the meeting at 2:54 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: December 1, 2022

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MINUTES

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

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

September 15, 2022

A Regular Meeting of the CalOptima Health Board of Directors' Finance and Audit Committee (FAC) was held on September 15, 2022, at CalOptima Health, 505 City Parkway West, Orange, California. The meeting was held via teleconference (Zoom-Webinar) in light of the COVID-19 public health emergency and of Assembly Bill (AB) 361 (Chaptered September 16, 2021), which allows for temporary relaxation of certain Brown Act requirements related to teleconferenced meetings

Chair Isabel Becerra called the meeting to order at 3:01 p.m., and Director Schoeffel led the Pledge of Allegiance.

ROLL CALL

Members Present: Isabel Becerra, Chair; Blair Contratto; Scott Schoeffel (all members participated remotely)

Members Absent: Clayton Corwin

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

MANAGEMENT REPORTS

1. Chief Financial Officer Report

Nancy Huang, Chief Financial Officer, started off the meeting noting that she had two items to update the FAC members on during her Chief Financial Officer Report. The first update was on the procurement of an enterprise resource planning system. Ms. Huang noted that the cost was included in the fiscal year (FY) 2022-23 Budget and the new system will consolidate four different system programs CalOptima Health is currently using. Staff will bring an action to the November Board, with a scope of work for issuing a request for proposal for consideration. The second update was regarding new requirements from the Department of Health Care Services (DHCS) for medical loss ratio (MLR) under the new California Advancing and Innovating Medi-Cal (CalAIM) program. Ms. Huang noted that under CalAIM, CalOptima Health is required to report MLR for its individual health networks. Staff is currently working with the health networks to meet this new requirement.

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INVESTMENT ADVISORY COMMITTEE UPDATE

2. Treasurer's Report

Ms. Huang presented the Treasurer's Report for the period of April 1, 2022, through June 30, 2022. The portfolio totaled approximately $2.4 billion as of June 30, 2022. Of this amount, $1.8 billion was in CalOptima Health's operating account, and $573 million was included in CalOptima's Board-designated reserves. Meketa Investment Group Inc. (Meketa), CalOptima Health's investment advisor, completed an independent review of the monthly investment reports. Meketa reported that all investments were compliant with Government Code section 53600 *et seq*. and with CalOptima Health's Board-approved Annual Investment Policy during that period.

Ms. Huang also noted that as suggested at the May FAC meeting, the Meketa written report also included a summary at the top of the report.

PUBLIC COMMENTS

There were no requests for public comment.

CONSENT CALENDAR

3. Approve the Minutes of the May 19, 2022, Special Meeting of the CalOptima Health Board of Directors' Finance and Audit Committee and Receive and File Minutes of the April 25, 2022 Regular Meeting of the CalOptima Health Board of Directors' Investment Advisory Committee

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

REPORT

4. Recommend that the Board of Directors Accept and Receive and File Fiscal Year 2021-22 CalOptima Health Audited Financial Statements

Ms. Huang introduced Moss Adams, LLP (Moss Adams) to provide further details on the audit results and was happy to inform the FAC that there were no significant issues noted during the audit.

Stacy Stelzriede of Moss-Adams, CalOptima Health's independent financial auditor, presented the draft audit of the consolidated financial statements for the fiscal year ending June 30, 2022. An overview of the areas of audit emphasis was presented, including capitation revenue and receivables, cash and investments, medical claims liability, and required communications. Ms. Stelzriede reported that Moss Adams will be issuing an unmodified opinion indicating that the FY 2021-22 financial statements fairly state the financial condition of CalOptima Health in all material respects. Ms. Stelzriede introduced Aparna Venkateswaran who provided additional detail on the audit.

Action: ***On motion of Director Schoeffel, seconded and carried, the Committee recommended that the CalOptima Health Board of Directors accept and receive and file the Fiscal Year (FY) 2021-22 CalOptima Health consolidated audited financial statements as submitted by independent auditors Moss-Adams, LLP (Moss-Adams). (Motion carried 3-0-0; Director Corwin absent)***

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5. Recommend Reappointments to the CalOptima Health Board of Directors' Investment Advisory Committee

Action: ***On motion of Director Contratto, seconded and carried, the Committee recommended that the Board of Directors reappoint the following individuals to the Board of Directors' Investment Advisory Committee (IAC) for two (2)-year terms beginning October 6, 2022: 1.) Colleen Clark; 2.) David Hutchison; and 3.) David Young. (Motion carried 3-0-0; Director Corwin absent)***

6. Recommend that the Board of Directors Approve Actions Related to the Procurement of an Encounter Data Management System

Action: ***On motion of Director Schoeffel, seconded and carried, the Committee recommended that the Board of Directors: 1.) Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to execute the contract with Edifecs for an Encounter Data Management System for a three (3)-year period, with the option of two (2) additional one-year extensions, each exercisable at CalOptima Health's sole discretion; and 2.) Authorize unbudgeted expenditures and appropriate funds in an amount of up to $2.15 million from the Digital Transformation and Workplace Modernization Reserve to fund the contract for Year 1. (Motion carried 3-0-0; Director Corwin absent)***

7. Recommend that the Board of Directors Authorize Employee and Retiree Group Health Insurance and Wellness Benefits for Calendar Year 2023

Director Schoeffel did not participate in Agenda Item 7 due to potential conflicts of interest. Action on Agenda Item 7 was continued to a future meeting.

Brigette Hoey, Chief Human Resources Officer, provided details to the FAC on Agenda Item 7 as an informational item. The FAC did not take any action.

Director Contratto asked if the broker provided a comparison to show how CalOptima Health's health benefit package compares against similar organizations. Ms. Hoey responded that the broker did not provide those details and indicated that staff will request that information going forward. Director Contratto also noted that in the details of this item it appears that CalOptima Health pays for health benefits for retirees. Ms. Hoey responded that yes, currently CalOptima Health pays for health benefits for approximately 40 retirees per the policies set in place at the time. New employees do not have that benefit. CalOptima Health discontinued that benefit in 2004.

The following items were accepted as presented.

8. July 2022 Financial Summary

9. CalOptima Information Technology Services Security Update

10. Quarterly Operating and Capital Budget Update

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11. Quarterly Reports to the Finance and Audit Committee
    a. Shared Risk Pool Performance
    b. Whole-Child Model Financial Report
    c. Enhanced Care Management Financial Report
    d. Reinsurance Report
    e. Health Network Financial Report
    f. Contingency Contract Report

COMMITTEE MEMBER COMMENTS

Director Contratto reiterated her desire to have a one-page document that can be reviewed at the FAC meetings and at the Board of Directors meetings that easily shows the financial health of CalOptima Health.

Ms. Huang responded that Mr. Hunn, Chief Executive Officer, is sharing a preview of this one-page financial document with the Board members at their briefings, and the goal is to start sharing this information at the October Board meeting and going forward.

Hearing no further business, FAC Chair Becerra adjourned the meeting at 3:46 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: November 17, 2022

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 1, 2022
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

4. Adopt Board Resolution No. 22-1201-01, Authorizing Remote Teleconference Meetings for the CalOptima Health Board of Directors and its Advisory Committees in Accordance with California Government Code section 54953, subdivision (e)

Contact

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

Recommended Action

Adopt Board Resolution No. 22-1201-01, authorizing remote teleconference meetings for the CalOptima Health Board of Directors and its advisory committees in accordance with Government Code section 54953, subdivision (e).

Background

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

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

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

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

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

Discussion

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

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

Given the continued active declaration of emergency arising from the COVID-19 pandemic, there is an ongoing need for holding teleconference meetings for the CalOptima Health Board of Directors and its advisory committees. In addition, the County of Orange Health Officer issued "Orders and Strong Recommendations," updated as of September 23, 2022, to strongly recommend preventative measures such as wearing masks in all public spaces and businesses, and engaging in social distancing for vulnerable populations. For CalOptima Health to continue the teleconference meetings, the required findings are set forth in the attached Resolution No. 22-1201-01.

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

- Allow the public to access the meeting and require that the agenda provide an opportunity for the public to directly address the legislative body pursuant to the Brown Act's other teleconferencing provisions.
- In each instance when CalOptima Health provides notice of the teleconferenced meeting or post its agenda, give notice for how the public can access the meeting and provide public comment.
- Identify and include in the agenda an opportunity for all persons to attend via a call-in or an internet-based service option.
- Conduct teleconference meetings in a manner that protects the statutory and constitutional rights of the public.
- In the event of service disruption that either prevents CalOptima Health from broadcasting the meeting to the public using the call-in or internet-based service option or a disruption within CalOptima Health's control that prevents the public from submitting public comments, stop the meeting until public access is restored.

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- Not require comments be submitted in advance and provide the opportunity to comment in real time.
- Provide adequate time for public comment, either by establishing a timed public comment period or by allowing a reasonable amount of time to comment, including the time that may be required for an individual to register to log in to the teleconference to provide public comment.

Fiscal Impact

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

Rationale for Recommendation

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

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Board Resolution No. 22-1201-01, Authorizing Remote Teleconference Meetings for the CalOptima Board of Directors and its Advisory Committees in Accordance with Government Code section 54953, subdivision (e)
2. March 4, 2020, Proclamation of a State of Emergency
3. September 23, 2022, Orange County Health Officer's Orders and Strong Recommendations
4. Government Code section 54953, as amended by AB 361

/s/ Michael Hunn *11/23/2022*
Authorized Signature **Date**

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RESOLUTION NO. 22-1201-01

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

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

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

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

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

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

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

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

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

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

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

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

WHEREAS, on September 23, 2022, the County of Orange Health Officer issued a revised "Orders and Strong Recommendations," which includes strong recommendations for preventative measures, such as wearing masks in all public spaces and businesses, and engaging in social distancing for vulnerable populations;

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

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

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

NOW, THEREFORE, BE IT RESOLVED:

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

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

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

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

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APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a. CalOptima Health, this 1st day of December 2022.

AYES: _____

NOES: _____

ABSENT: _____

ABSTAIN: _____

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

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

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EXECUTIVE DEPARTMENT
STATE OF CALIFORNIA

PROCLAMATION OF A STATE OF EMERGENCY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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IT IS HEREBY ORDERED THAT:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

GAVIN NEWSOM
Governor of California

ATTEST:

ALEX PADILLA
Secretary of State

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REGINA CHINSIO-KWONG, DO
COUNTY HEALTH OFFICER/
CHIEF MEDICAL OFFICER

MATTHEW ZAHN, MD
DEPUTY COUNTY HEALTH OFFICER, PUBLIC HEALTH SERVICES/
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COUNTY OF ORANGE HEALTH OFFICER'S ORDERS AND STRONG RECOMMENDATIONS
(Revised September 23, 2022)

In light of recent updated COVID-19 State Public Health Officer Orders on masking guidance, vaccine requirements and testing recommendations, the following Orders and Strong Recommendations shall revise and replace the prior Orders and Strong Recommendations of the County Health Officer that were issued on September 16, 2022. The Orders and Strong Recommendations issued on September 16, 2022, are no longer in effect as of September 23, 2022.

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

ORDERS

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

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

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

1. Persons who are symptom-free but test positive for COVID-19.
If you do not have any COVID-19 symptoms (as defined below in this Order) but test positive for

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

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

Exceptions.

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

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

2. Persons who have COVID-19 symptoms.

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

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

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

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

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

Exception:

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

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

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

3. Additional Considerations for Self-Isolation.

- A person who is self-isolated may not leave his or her place of isolation except to receive necessary medical care.
- If a more specific and individualized isolation order is issued by the County Health Officer for any county resident, the resident shall follow the specific order instead of the order herein.
- People who are severely ill with COVID-19 might need to stay in self-isolation longer than 5 days and up to 20 days after symptoms first appeared. People with weakened immune systems should talk to their healthcare provider for more information.
- Rebound: Regardless of whether an individual has been treated with an antiviral agent, risk of transmission during COVID-rebound can be managed by following CDC's guidance on isolation (https://www.cdc.gov/coronavirus/2019-ncov/your-health/quarantine-isolation.html). An individual with rebound may end re-isolation after 5 full days of isolation with resolution of their fever for 24 hours without the use of fever-reducing medication and if symptoms are improving. The individual should wear a mask for a total of 10 days after rebound symptoms started.
    - More information can be found at https://www.cdph.ca.gov/Programs/OPA/Pages/CAHAN/CAHAN-Paxlovid-Recurrence-06-07-22.aspx.

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

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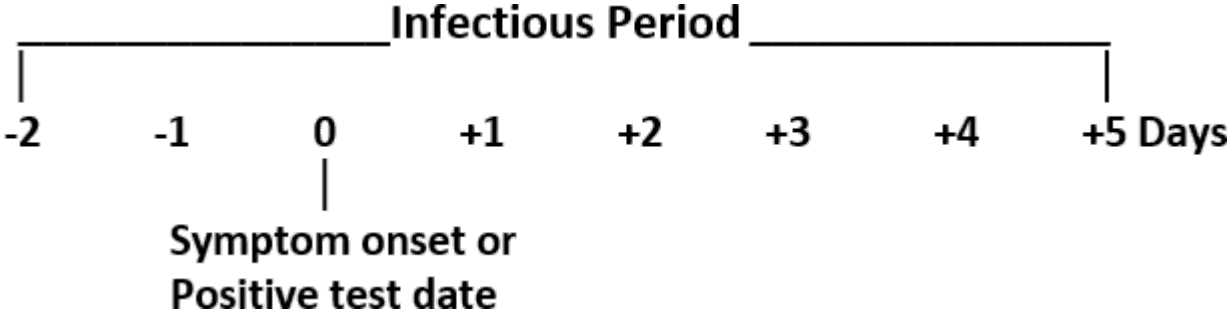

NOTE: In workplaces, employers and employees are subject to the Isolation and quarantine requirements as stated in the CalOSHA COVID-19 Emergency Temporary Standards (ETS) as modified by the Governor's Executive Order N-5-22 or in some workplaces the Cal/OSHA Aerosol transmissible Diseases (ATD) Standard.

Information about CalOSHA COVID-19 Emergency Temporary Standards (ETS) can be found at https://www.dir.ca.gov/dosh/coronavirus.

Definition.

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

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

II. Face-Coverings/Masks:

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

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

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NOTE: For Correctional Facilities and Detention centers, when utilizing COVID-19 Community levels to determine masking requirements, an outbreak in these settings is defined as three suspected, probable, or confirmed COVID-19 cases within a 14-day period among residents and/or staff.

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

Exemptions to masks requirements.

The following individuals are exempt from this mask order:

- Persons younger than two years old.
- Persons with a medical condition, mental health condition, or disability that prevents wearing a mask. This includes persons with a medical condition for whom wearing a mask could obstruct breathing or who are unconscious, incapacitated, or otherwise unable to remove a mask without assistance.
- Persons who are hearing impaired, or communicating with a person who is hearing impaired, where the ability to see the mouth is essential for communication.
- Persons for whom wearing a mask would create a risk to the person related to their work, as determined by local, state, or federal regulators or workplace safety guidelines.
- Additional exceptions to masking requirements in high-risk settings can be found at https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Face-Coverings-QA.aspx.

In workplaces, employers and employees are subject to either the CalOSHA COVID-19 Emergency Temporary Standards (ETS) or the Cal/OSHA Aerosol Transmissible Diseases (ATD) Standard and should consult those regulations for additional applicable requirements.

III. COVID-19 Vaccine Requirement Order

- Health Care Workers COVID-19 Vaccine Requirement Order:

  To help prevent transmission of COVID-19, all workers who provide services or work in facilities described below shall comply with the COVID-19 vaccination and booster dose requirements as

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set forth in the September 13, 2022, State Health Officer Order. A copy of the State Health Officer Order is attached herein as Attachment "**B**" and can be found at the following link:

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

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

The word, "worker," as used in this Order shall have the same meaning as defined in the State Health Officer's Order, dated September 13, 2022.

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

  To prevent the further spread of COVID-19 in local correctional facilities and detention centers, all individuals identified in the State Health Officer Order, effective September 13, 2022, shall comply with the State Health Officer's Order with regards to obtaining COVID-19 vaccination and booster doses. A copy of the State Health Officer Order is attached herein as Attachment "**C**" and can be found at the following link:

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

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

To help prevent transmission of COVID-19, all individuals specified below shall comply with the COVID-19 vaccination and booster dose requirements as set forth in the September 13, 2022, State Health Officer Order. A copy of the State Health Officer Order is attached herein as Attachment "**D**" and can be found at the following link:

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

Individuals covered by this order include:

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

IV. Seasonal Flu Vaccination Order:

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Seasonal Flu Vaccination for Certain County Residents.

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

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

STRONG RECOMMENDATIONS

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

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

- If you are known to be exposed to COVID-19 (regardless of vaccination status, prior disease, or occupation), it is strongly recommended to follow CDPH Quarantine guidance found at https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Guidance-on-Isolation-and-Quarantine-for-COVID-19-Contact-Tracing.aspx.
- **K-12 Schools and Child Care**
  - Schools/school districts are advised to follow CDPH COVID-19 Public Health Guidance for K-12 Schools in California, 2022-2023 School Year found

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at: https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/K-12-Guidance-2022-23-School-Year.aspx

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

- **Workplaces**

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

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

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

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

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

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

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

GENERAL PROVISIONS

1. The Orders and Strong Recommendations, above, shall not supersede any conflicting or more restrictive orders issued by the State of California or federal government. If any portion of this document or the application thereof to any person or circumstance is held to be invalid, the

remainder of the document, including the application of such part or provision to other persons or circumstances, shall not be affected and shall continue in full force and effect. To this end, the provisions of the orders and strong recommendations are severable.

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

REASONS FOR THE ORDERS AND STRONG RECOMMENDATIONS

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

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

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

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

5. As of September 23, 2022, the County has reported a total of 664,185 recorded confirmed COVID-19 cases and 7,432 of COVID-19 related deaths.

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

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

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

9. The Orders and the Strong Recommendations contained in this document are based on the following facts, in addition to the facts stated under the foregoing paragraphs: (i) Safe and effective FDA authorized COVID-19 vaccines have been widely available, but certain populations have been slow to getting vaccinated or boosted (ii) the current consensus among public health officials for slowing down the transmission of and avoiding contracting COVID-19 is for at-risk persons to complete a COVID-19 vaccination series and receive a booster if eligible, wear well-fitted mask in indoor settings when around others outside of their household, practice distancing, frequently wash

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hands with soap (iii) some individuals who contract COVID-19 have no symptoms or have only mild symptoms and so are unaware that they carry the virus and are transmitting it to others; (iv) current evidence shows that the novel coronavirus can survive on surfaces and can be indirectly transmitted between individuals; (v) older adults and individuals with medical conditions are at higher risk of severe illness; (vi) sustained COVID-19 community transmission continues to occur; (vii) the age, condition, and health of a portion of Orange County's residents place them at risk for serious health complications, including hospitalization and death, from COVID-19; (viii) younger and otherwise healthy people are also at risk for serious negative health outcomes and for transmitting the novel coronavirus to others.

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

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

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

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

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

IT IS SO ORDERED:

Date: September 23, 2022

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Regina Chinsio-Kwong, DD

County Health Officer

County of Orange

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GOVERNMENT CODE - GOV

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(B) Any of the following circumstances exist:

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

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

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

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

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

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CalOptima Health Board Action Agenda Referral

Action To Be Taken December 1, 2022
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

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

Contacts

John Tanner, Chief Compliance Officer, (657) 235-6997
Nancy Huang, Chief Financial Officer, (657) 235-6935

Recommended Actions

Authorize and direct the Chairman of the Board of Directors to execute an Amendment to the Secondary Agreement between the California Department of Health Care Services and CalOptima Health related to state-only funded Medi-Cal services (State Supported Services) for calendar year 2023.

Background

As a County Organized Health System, CalOptima Health contracts with the Department of Health Care Services (DHCS) to provide health care services to Medi-Cal beneficiaries in Orange County. In December 2016, CalOptima Health entered into a new four (4) year agreement with the DHCS for the Secondary Agreement. Amendments to this agreement are summarized in the attached appendix (Attachment 1), including Amendment 12, which extends the Secondary Agreement to December 31, 2022. Additionally, staff received authority during the May 2022 Board of Directors meeting to extend the Secondary Agreement to December 31, 2023. The Secondary Agreement contains among other terms and conditions, the payment rates CalOptima Health receives from DHCS to provide health care services.

Discussion

On October 17, 2022, DHCS provided managed care plans (MCPs) with a draft version of the Calendar Year (CY) 2023 Secondary Contract Amendment (Attachment 2) and advised that DHCS must execute this contract amendment by the end of CY 2022. The amendment covers existing State Supported Services in the current Secondary Agreement and will include covered services for members with unsatisfactory immigration status (UIS). The Secondary Agreement will continue to cover family planning services that do not receive federal funds (also referred to as Hyde services) and their payment rates, as well as cover services and capitation payment rates for MCP members with UIS. DHCS has provided a matrix (Attachment 3) detailing which provisions and paragraphs have been carried over from the current Secondary Agreement, and which have been created to address the inclusion of the UIS population. CalOptima Health staff has expanded upon this matrix to include additional detail regarding contract requirements.

The agreement amendment contains notable language changes, and it is worth noting that DHCS has generally implemented the requirements of the CY 2023 agreement amendment through the issuance of sub-regulatory guidance to the MCPs. Simultaneously, DHCS has been working with CMS to formalize the requirements in DHCS' agreement with MCPs, including CalOptima Health. DHCS' implementation of these requirements via sub-regulatory guidance prior to the

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formal inclusion of the requirements in MCP agreements is largely due to the lengthy CMS review process.

This agreement does not contain rate changes or otherwise set new rates. Staff received draft CY 2023 rates from the DHCS in September 2022 and will request authority from the Board of Directors upon receipt of the final CY 2023 rates. DHCS has only shared boilerplate agreement amendments with CalOptima Health at this time and therefore certain provisions of the boilerplate will be absent in the MCP-specific amendments that are ultimately provided for signature, as appropriate. If the final agreement amendments are not consistent with staff's understanding as presented in this document, or if it includes substantive and unexpected language changes, staff will return to the Board of Directors for subsequent consideration.

Fiscal Impact

The recommended action has no additional fiscal impact. A previous Board of Directors action on May 5, 2022, authorized the extension of the termination date for the secondary agreement to December 31, 2023. The Fiscal Year 2022-23 Operating Budget enrollment forecasts included projections for the defined UIS populations.

Rationale for Recommendation

CalOptima Health's execution of the CY 2023 contract amendment to its Secondary Agreement with DHCS is necessary for the continued operation of CalOptima Health's Medi-Cal program.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Appendix summary of amendments to Primary and Secondary Agreements with DHCS
2. New State-Only Contract CY 2023 Medi-Cal MCP Review 10-13-22
3. Additional CY 2023 Secondary Contract Amendment Detail

/s/ Michael Hunn *11/23/2022*
Authorized Signature **Date**

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APPENDIX TO AGENDA ITEM 5

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

Amendments to Primary Agreement	Board Approval
A-01 provided language changes related to Indian Health Services, home and community-based services, and addition of aid codes effective January 1, 2009.	October 26, 2009
A-02 provided rate changes that reflected implementation of the gross premiums tax authorized by AB 1422 (2009) for the period January 1, 2009, through June 30, 2009.	October 26, 2009
A-03 provided revised capitation rates for the period July 1, 2009, through June 30, 2010; and rate increases to reflect the gross premiums tax authorized by AB 1422 (2009) for the period July 1, 2009, through June 30, 2010.	January 7, 2010
A-04 included the necessary contract language to conform to AB X3 (2009), to eliminate nine (9) Medi-Cal optional benefits.	July 8, 2010
A-05 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, including rate increases to reflect the gross premium tax authorized by AB 1422 (2009), the hospital quality assurance fee (QAF) authorized by AB 1653 (2010), and adjustments for maximum allowable cost pharmacy pricing.	November 4, 2010
A-06 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, for funding for legislatively mandated rate adjustments to Long Term Care facilities effective August 1, 2010; and rate increases to reflect the gross premiums tax on the adjusted revenues for the period July 1, 2010, through June 30, 2011.	September 1, 2011
A-07 included a rate adjustment that reflected the extension of the supplemental funding to hospitals authorized in AB 1653 (2010), as well as an Intergovernmental Transfer (IGT) program for Non-Designated Public Hospitals (NDPHs) and Designated Public Hospitals (DPHs).	November 3, 2011
A-08 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine.	March 3, 2011
A-09 included contract language and supplemental capitation rates related to the addition of the Community Based Adult Services (CBAS) benefit in managed care plans.	June 7, 2012

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A-10 included contract language and capitation rates related to the transition of Healthy Families Program (HFP) subscribers into CalOptima's Medi-Cal program	December 6, 2012
A-11 provided capitation rates related to the transition of HFP subscribers into CalOptima's Medi-Cal program.	April 4, 2013
A-12 provided capitation rates for the period July 1, 2011 to June 30, 2012.	April 4, 2013
A-13 provided capitation rates for the period July 1, 2012 to June 30, 2013	June 6, 2013
A-14 extended the Primary Agreement until December 31, 2014	June 6, 2013
A-15 included contract language related to the mandatory enrollment of seniors and persons with disabilities, requirements related to the Balanced Budget Amendment of 1997 (BBA) and Health Insurance Portability and Accountability Act (HIPAA) Omnibus Rule	October 3, 2013
A-16 provided revised capitation rates for the period July 1, 2012, through June 30, 2013 and revised capitation rates for the period January 1, 2013, through June 30, 2014 for Phases 1, 2 and 3 transition of Healthy Families Program (HFP) children to the Medi-Cal program	November 7, 2013
A-17 included contract language related to implementation of the Affordable Care Act, expansion of Medi-Cal, the integration of the managed care mental health and substance use benefits and revised capitation rates for the period July 1, 2013 through June 30, 2014.	December 5, 2013
A-18 provided revised capitation rates for the period July 1, 2013, through June 30, 2014.	June 5, 2014
A-19 extended the Primary Agreement until December 31, 2015 and included language that incorporates provisions related to **Medicare Improvements for Patients and Providers Act** (MIPPA)-compliant contracts and eligibility criteria for Dual Eligible Special Needs Plans (D-SNPs)	August 7, 2014
A-20 provided revised capitation rates for the period July 1, 2012, through June 30, 2013, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine and Optional Targeted Low-Income Child Members	September 4, 2014
A-21 provided revised 2013-2014 capitation rates.	November 7, 2013
A-22 revised capitation rates for Fiscal Year (FY) 2013-14 and added an aid code to implement Express Lane/CalFresh Eligibility	November 6, 2014
A-23 revised ACA 1202 rates for January – June 2014, established base capitation rates for FY 2014-2015, added an aid code related to the OTLIC and AIM programs, and contained language revisions related to supplemental payments for coverage of Hepatitis C medications.	December 4, 2014
A-24 revises capitation rates to include SB 239 Hospital Quality Assurance Fees for the period January 1, 2014 to June 30, 2014.	May 7, 2015
A-25 extends the contract term to December 31, 2016. DHCS is obtaining a continuation of the services identified in the original agreement.	May 7, 2015

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A-26 adjusts the 2013-2014 Intergovernmental Transfer (IGT) rates.	May 7, 2015
A-27 adjusts 2013-2014 capitation rates for Optional Expansion and SB 239.	May 7, 2015
A-28 incorporates language requirements and supplemental payments for BHT into primary agreement.	October 2, 2014
A-29 added optional expansion rates for January- June 2015; also added updates to MLR language.	April 2, 2015
A-30 incorporates language regarding Provider Preventable Conditions (PPC), determination of rates, and adjustments to 2014-2015 capitation rates with respect to Intergovernmental Transfer (IGT) Rate Range and Hospital Quality Assurance Fee (QAF).	December 1, 2016
A-31 extends the Primary Agreement with DHCS to December 31, 2020.	December 1, 2016
A-32 incorporates base rates for July 2015 to June 2016 with Behavioral Health Treatment (BHT) and Hepatitis–C supplemental payments, and Partial Dual/Medi-Cal only rates, and added aid codes 4U, and 2P–2U as covered aid codes.	February 2, 2017
A-33 incorporates base rates for July 2016 to June 2017.	February 2, 2017
A-34 incorporates revised Adult Optional Expansion rates for January 2015 to June 2015. These rates were revised to include the impact of the Hospital Quality Assurance Fee (HQAF) required by Senate Bill (SB) 239.	June 1, 2017
A–35 incorporates Managed Long–Term Services and Supports (MLTSS) into CalOptima's Primary Agreement with the DHCS.	March 6, 2014 February 2, 2017
A–36 incorporates revised base rates for July 2015 to June 2016.	December 7, 2017
A–37 incorporates revised base rates for July 2016 to June 2017.	February 7, 2019
A–38 incorporates full dual rates for Calendar Year (CY) 2015	August 1, 2019
A–39 incorporates full dual rates for Calendar Year (CY) 2016	August 1, 2019
A-40 incorporates Final Rule contract language.	June 1, 2017 February 6, 2020
A-41 incorporates base rates for July 2017 to June 2018, Transportation, American Indian Health Program, Mental Health Parity, CCI updates and Adult Expansion Risk Corridor language for SFY 2017-18.	December 7, 2017 June 7, 2018 February 6, 2020
A-42 incorporated revised base rates for July 2017 to June 2018, directed payments language and mental health parity documentation requirements.	August 1, 2019
A–43 incorporates revises Hospital Quality Assurance Fee (HQAF) rates for January 1, 2017 to June 30, 2017.	August 1, 2019
A-44 incorporates full dual rates for Calendar Year (CY) 2017.	August 1, 2019
A–45 incorporates the new requirements of the 2018 Final Rule Amendment, Behavioral Health Treatment (BHT) and State Fiscal Year (SFY) 2018 – 19 capitation rates	June 7, 2018 August 1, 2019 August 6, 2020
A-46 incorporates full dual rates for Calendar Year (CY) 2018.	August 1, 2019
A-47 incorporates full dual rates for Calendar Year (CY) 2019.	October 1, 2020

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A-48 incorporates new Bridge Period, Health Homes Program (HHP) and Whole Child Model (WCM) language and adds 2019 – 2020 capitation rates	June 7, 2018 October 1, 2020 February 4, 2021
A-49 extends the Primary Agreement with DHCS to December 31, 2021	November 5, 2020
A-50 incorporates full dual rates for Calendar Year (CY) 2020.	February 4, 2021
A-51 incorporates full dual rates for Calendar Year (CY) 2021.	February 4, 2021
A-52 incorporates Calendar Year (CY) 2021 base amendment contract language.	October 7, 2021
A-53 incorporates Calendar Year (CY) 2021 fall amendment contract language.	October 7, 2021
A-54 extends the Primary Agreement with DHCS to December 31, 2022.	October 7, 2021
A-55 incorporates full dual rates for Calendar Year (CY) 2022.	March 3, 2022
A-57 incorporates Calendar Year (CY) 2022 risk mitigation language.	March 3, 2022
A-58 incorporates the COVID Vaccination Incentive Program.	March 3, 2022
A-62 extends the Primary Agreement with DHCS to December 31, 2023.	May 5, 2022

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

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

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A-07 extends the Secondary Agreement with the DHCS to December 31, 2020.	December 1, 2016
A–08 incorporates Adult & Family/Optional Targeted Low–Income Child and Adult Expansion rates for July 2016 to June 2017 and July 2017 to June 2018.	December 6, 2018
A-10 extends the Secondary Agreement with DHCS to December 31, 2021	November 5, 2020
A-12 extends the Secondary Agreement with DHCS to December 31, 2022.	October 7, 2021

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

Amendments to Agreement 16-93274	Board Approval
A-01 extends the Agreement 16-93274 with DHCS to December 31, 2018.	August 3, 2017
A–02 extends the Agreement 16–93274 with DHCS to December 31, 2019	June 7, 2018
A–03 extends the Agreement 16–93274 with DHCS to December 31, 2020	May 2, 2019
A–04 extends the Agreement 16–93274 with DHCS to December 31, 2021	June 4, 2020
A–05 extends the Agreement 16–93274 with DHCS to December 31, 2023.	June 3, 2021

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

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

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EXHIBIT A
Scope of Work

1. Service Overview

This is a companion to Contractor's Medi-Cal Managed Care Health Plan Contract [**Contract #**], hereafter referred to as the "Primary Contract", to cover specific Medi-Cal State-Supported Services to Contractor's Members enrolled under Contractor's Primary Contract.

A. All Covered Services as defined in Contractor's Primary Contract will be provided to Unsatisfactory Immigration Status (UIS) Members in the same manner and subject to the same requirements as described in the Primary Contract, except as described in this Contract.

B. Private Services described in Exhibit A, Provision 4, Paragraph A must be provided in the same manner as described in the Primary Contract under Exhibit A, Attachment 9, Access and Availability.

C. Contractor must provide services and interact with UIS Members on an equal basis as with Members covered under the Primary Contract. Contractor, including but not limited to Contractor's Network Providers and Subcontractors, are required to cover and provide services to UIS Members in a manner that is indistinguishable from the rest of Contractor's Members covered under the Primary Contract.

2. Service Location

The Service Area covered under this Contract between Department of Health Care Services (DHCS) and Contractor is the same as specified in the Primary Contract.

3. Project Representatives

A. The Contract representatives during the term of this Contract will be:

Department of Health Care Services	**[Health Plan Name]**
Managed Care Operations Division	**[Health Plan dba Name, if different]**
Attention: Chief, Procurement and	Attention: Government Relations
Contract Development Branch	Director
Telephone: (916) 449-5000	Telephone: (831) 430-5603
Fax: (916) 449-5090	Fax: (831) 430-5852

B. Direct all inquiries to:

Department of Health Care Services	**[Health Plan Name]**
Managed Care Operations Division	**[Health Plan dba Name, if different]**
Attention: Contracting Officer	Attention: Executive Director
1501 Capitol Avenue, Suite 71.4001	1600 Green Hills Road
Mail Stop 4408	Scotts Valley, CA 95066-9998
P.O. Box 997413	
Sacramento, CA 95899-7413	
Telephone: (916) 449-5000	Telephone: (831) 430-5520
Fax: (916) 449-5090	Fax: (831) 430-5856

C. Either party may make changes to the information above by giving written notice to the other party. Said changes shall not require an amendment to this Contract.

4. All State-Supported Services to be Performed

A. Contractor agrees to provide, or arrange to provide, to eligible Members enrolled under either this Contract or the Primary Contract, the following Private Services:

1) Current Procedural Terminology Codes*: 59840 through 59857

2) CMS Common Procedure Coding System Codes*: X1516, X1518, X7724, X7726, Z0336

B. The codes identified above in Provision 4, Paragraph A are subject to change upon the Department of Health Care Services (DHCS) implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) electronic transaction and code sets provisions. Such changes shall not require an amendment to this Contract.

C. Contractor agrees to provide, or arrange to provide, to UIS Members enrolled under this Contract all Covered Services specified in the Primary Contract, except as set forth in Exhibit A, Provision 5 of this Contract.

5. Primary Contract Covered Services Excluded from This Contract

The following services are covered, and will remain covered, in the Primary Contract and are therefore excluded from this Contract:

A. The provision of pregnancy-related services for UIS Members as described in Exhibit A, Attachment 10, Provision 7, of the Primary Contract.

EXHIBIT A
Scope of Work

B. The provision of Emergency Services for UIS Members as described in Exhibit A, Attachment 8, Provision 13, and defined in Exhibit E, Attachment 1, of the Primary Contract.

EXHIBIT B
Budget Detail and Payment Provisions

1. Overview

Unless otherwise provided for herein, Contractor and DHCS agree to be bound by all applicable terms and conditions of Exhibit B of the Primary Contract between Contractor and DHCS, in accordance with Exhibit E, Provision 1, of this Contract.

2. Capitation Rates

A. DHCS shall remit to Contractor a Capitation Payment for each month that a Member appears on the approved list of Members supplied to Contractor by DHCS. Capitation Payments shall be made in accordance with the schedule of Capitation Payment rates set forth below.

For period January 1, 2023 through December 31, 2023:

	[County]
Aid Group	**Rate**
PS Adult & Family/OTLIC (Under 19)	
PS Adult Expansion	
PS Adult & Family/OTLIC (19 & Older)	
UIS Adult & Family/OTLIC (Under 19)	
UIS Adult & Family/OTLIC (19 & Over)	
UIS SPD	
UIS SPD Dual	
UIS BCCTP	
UIS LTC Non-Dual	
UIS LTC Dual	
UIS Adult Expansion	
UIS WCM	

B. Aid Codes within each Aid Group for this time period are set forth in the Primary Contract for Members enrolled under the Primary Contract. For the purposes of this Contract, UIS Members are additionally defined in Exhibit E, Provision 10.

C. The amount shall be calculated based on the enrollment of Members identified in the approved list for the month of eligibility of each month at the rate specified for each Service Area included under this Contract.

D. The actuarial basis for the computation of the Capitation Payment rates shall be set forth in DHCS' rate certification(s), including any amendment(s) or revision(s), for the applicable Rating Period. Said rate certification(s) are hereby

EXHIBIT B
Budget Detail and Payment Provisions

incorporated by reference and made a part of this Contract by this reference as if attached hereto in full.

EXHIBIT E
Additional Provisions

1. Additional Incorporated Exhibits

A. Unless otherwise provided for herein, Contractor and DHCS agree to be bound by all applicable terms and conditions of the Primary Contract between Contractor and DHCS, including all applicable amendments to the Primary Contract as of the effective date of this Contract, all applicable subsequent amendments to the Primary Contract, and all applicable Exhibits and Attachments to the Primary Contract, all of which are hereby incorporated by reference as if fully set forth herein, except for the following Exhibits and Provisions from the Primary Contract, which shall be excluded from this Contract:

1) Exhibit B, Provision 3, Capitation Rates;

2) Exhibit B, Provision 11, Paragraph B regarding disallowance of Federal Financial Participation (FFP);

3) Exhibit B, Provision 13, Adult Expansion Risk Corridor;

4) Exhibit B, Provision 14, Supplemental Payments;

5) Exhibit B, Provision 20, State Programs Receiving Federal Financial Participation;

6) Exhibit D(F);

7) Exhibit E, Attachment 2, Provision 3, Amendment Process;

8) Any Primary Contract provision deemed not applicable by DHCS to the performance of this Contract; and

9) Any Primary Contract provision otherwise provided for in this Contract.

B. In the event of a conflict between the provisions of this Contract and the Primary Contract, the provisions of this Contract shall prevail.

2. Governing Law

In addition to Exhibit C, Provision 14, Governing Law, Contractor also agrees to the following:

A. If it is necessary to interpret this Contract, all applicable laws may be used as aids in interpreting the Contract. However, the parties agree that any such applicable laws shall not be interpreted to create contractual obligations upon DHCS or Contractor, unless such applicable laws are expressly incorporated

into this Contract in some section other than this provision, Governing Law. Except for Exhibit E, Attachment 2, Provision 15, Sanctions, the parties agree that any remedies for DHCS' or Contractor's non-compliance with laws not expressly incorporated into this Contract, or any covenants judicially implied to be part of this Contract, shall not include money damages, but may include equitable remedies such as injunctive relief or specific performance. This Contract is the product of mutual negotiation, and if any ambiguities should arise in the interpretation of this Contract, both parties shall be deemed authors of this Contract.

B. Any provision of this Contract that is in conflict with current or future applicable federal or State laws or regulations is hereby amended to conform to the provisions of those laws and regulations. Such amendment of the Contract shall be effective on the effective date of the statutes or regulations 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.

C. Such amendment shall constitute grounds for termination of this Contract in accordance with the procedures and provisions of Exhibit E, Attachment 2, Provision 13, Paragraph C, Termination – Contractor in the Primary Contract. The parties shall be bound by the terms of the amendment until the effective date of the termination.

3. Entire Agreement

This written Contract and any amendments shall constitute the entire agreement between the parties. No oral representations shall be binding on either party unless such representations are reduced to writing and made an amendment to the Contract.

4. Amendment Process

Should either party, during the life of this Contract, desire a change in this Contract, that change shall be proposed in writing to the other party. The other party shall acknowledge receipt of the proposal within 10 days of receipt of the proposal. The party proposing any such change shall have the right to withdraw the proposal any time prior to acceptance or rejection by the other party. Any proposal shall set forth an explanation of the reason and basis for the proposed change and the text of the desired amendment to this Contract that would provide for the change. If the proposal is accepted, this Contract shall be amended to provide for the change mutually agreed to by the parties on the condition that the amendment is approved by the State Department of Finance, if necessary.

5. Notices

EXHIBIT E
Additional Provisions

All notices to be given under this Contract will be in writing and will be deemed to have been given when mailed to DHCS or the Contractor:

Department of Health Care Services
Managed Care Operations Division
Attn: Contracting Officer
MS 4408
P.O. Box 997413
Sacramento, CA 95899-7413

[Plan Name]
Attn: Executive Director

Address
City, CA Zip Code

6. Term

The Contract will become effective January 1, 2023, and will continue in full force and effect through the term of the Primary Contract, subject to the provisions of Exhibit B, Provision 1, Budget Contingency Clause, of the Primary Contract.

7. Non-Cancellation

Except as set forth in Exhibit E, Provision 8 below, this Contract will thereafter continue in full force and effect through the end date specified in the Primary Contract, subject to Exhibit B, Provision 1, of the Primary Contract.

8. Termination for Cause and Other Terminations

Contractor agrees to the termination provisions in the Primary Contract, which are incorporated into this Contract.

9. Administrative Duties/Responsibilities

Contractor shall maintain the organizational and administrative capabilities to carry out its duties and responsibilities under this Contract in the same manner as required by the Primary Contract.

10. Definitions

As used in this Contract, unless otherwise expressly provided or the context otherwise requires, the definitions of terms in the Primary Contract will govern the construction of this Contract.

A. **Primary Contract** means Contract Number **XX-XXXXX**, including all applicable amendments, Exhibits, and/or Attachments to that Contract as of and subsequent to the effective date of this Contract. Termination of the Primary Contract shall be deemed a termination of this Contract.

EXHIBIT E
Additional Provisions

B. **Private Services (PS)** means Current Procedural Terminology Codes 59840 through 59857 and CMS Common Procedure Coding System Codes X1516, X1518, X7724, X7726, and Z0336.

C. **State-Supported Services** means Private Services as defined and described in this Contract, and Covered Services, as identified in the Primary Contract, for UIS Members with the exception of pregnancy-related services and emergency services as they are described in the Primary Contract.

D. **Unsatisfactory Immigration Status (UIS) Member** means a Member enrolled under the Primary Contract for whom, by virtue of their immigration status, federal financial participation is only available for emergency services and qualifying pregnancy-related services as they are described in the Primary Contract, and who is included in any of the following groups:

1) Qualified Non-Citizen (QNC), subject to and have not met the five-year bar;

2) Permanently Residing Under Color Of Law (PRUCOL);

3) Senate Bill 75 (Chapter 18, Statutes of 2015), under the age of 19;

4) Young Adult Expansion (YAE), under the age of 26;

5) Trafficking and Crime Victim Assistance Program (TCVAP); and

6) Older Adult Expansion (OAE), 50 years of age or older.

Contract Section	DHCS' Summary of Changes *(Substantive changes have been bolded below by CalOptima Health staff for emphasis)*	Additional Detail
Exhibit A, Provision 1.A	1. Service Overview Covered services for UIS Members	
Exhibit A, Provision 1.B	1. Service Overview **Language pulled from existing Secondary contract, but "State-Supported Services" is changed to "Private Services".**	CalOptima Health must provide services and interact with UIS Members on an equal basis as with Members covered under the Primary Contract. CalOptima Health, including but not limited to CalOptima Health's Network Providers and Subcontractors, are required to cover and provide services to UIS Members in a manner that is indistinguishable from the rest of CalOptima Health's Members covered under the Primary Contract.
Exhibit A, Provision 1.C	1. Service Overview Equal treatment for UIS Members	
Exhibit A, Provision 2	2. Service Location Same language as pulled from existing Secondary contract.	
Exhibit A, Provision 3	3. Project Representatives Same information required as in current Secondary contract.	
Exhibit A, Provision 4.A	4. All State-Supported Services to be Performed Language and codes pulled from existing Secondary contract, with update to Private Services.	CalOptima Health agrees to provide, or arrange to provide, to eligible Members enrolled under either this Contract or the Primary Contract, the following Private Services: 1) Current Procedural Terminology Codes*: 59840 through 59857; 2) CMS Common Procedure Coding System Codes*: X1516, X1518, X7724, X7726, Z0336
Exhibit A, Provision 4.B	4. All State-Supported Services to be Performed Language pulled from existing Secondary contract.	
Exhibit A, Provision 4.C	4. All State-Supported Services to be Performed Language added for UIS Members.	

Exhibit A, Provision 5.A	5. Primary Contract Covered Services Excluded from This Contract Language added for UIS Members.	
Exhibit A, Provision 5.B	5. Primary Contract Covered Services Excluded from This Contract Language added for UIS Members.	
Exhibit B, Provision 1	1. Overview Replaced first couple provisions from existing Secondary contract with a reference to the Primary Contract.	
Exhibit B, Provision 2.A	2. Capitation Rates **Language is unchanged, but existing rate categories now include the flag "PS" for Private Services or UIS for UIS Members.**	DHCS shall remit to CalOptima Health a Capitation Payment for each month for period January 1, 2023 through December 31, 2023 that a Member appears on the approved list of Members supplied to CalOptima Health by DHCS. Capitation Payments shall be made in accordance with the schedule of Capitation Payment rates to be set forth in this section.
Exhibit B, Provision 2.B	2. Capitation Rates **Removed old payment schedule and updated reference to aid codes.**	
Exhibit B, Provision 2.C	2. Capitation Rates **Language pulled from existing Secondary contract, but updated to monthly payments.**	
Exhibit B, Provision 2.D	2. Capitation Rates **New language added for capitation payments and rate certifications.**	
Exhibit E, Provision 1.A, B	1. Additional Incorporated Exhibits Updated Primary Contract references in Paragraph A, all other language remains the same as in the existing Secondary contract	DHCS outlines the Exhibits and Provisions from the Primary Contract that shall be excluded from this Contract.
Exhibit E, Provision 2.A-C	2. Governing Law No change from existing Secondary contract.	

Exhibit E, Provision 3	3. Entire Agreement No change from existing Secondary contract.	
Exhibit E, Provision 4	4. Amendment Process Updated to align with current language.	
Exhibit E, Provision 5	5. Notices Same information required as in current Secondary contract.	
Exhibit E, Provision 6	6. Term Added language to tie contract term to Primary Contract.	The Contract will become effective January 1, 2023, and will continue in full force and effect through the term of the Primary Contract, subject to the provisions of Exhibit B, Provision 1, Budget Contingency Clause, of the Primary Contract.
Exhibit E, Provision 7	7. Non-Cancellation **Removed "Contract Extension" language as this contract will expire at the end of 2023.** Non-Cancellation language is unchanged from existing Secondary contract.	
Exhibit E, Provision 8	8. Termination for Cause and Other Terminations No change from existing Secondary contract.	
Exhibit E, Provision 9	9. Administrative Duties/Responsibilities No change from existing Secondary contract.	
Exhibit E, Provision 10.A	10. Definitions Definition of "Primary Contract" remains unchanged.	
Exhibit E, Provision 10.B	10. Definitions The former definition of "State-Supported Services", has been replaced with "Private Services".	
Exhibit E, Provision 10.C	10. Definitions	

	The definition of “State-Supported Services”, has been updated to include “Private Services” and services for UIS Members, as is now described.	
Exhibit E, Provision 10.D	10. Definitions **A definition for “UIS Member” has been included in the contract.**	

CalOptima Health Board Action Agenda Referral

Action To Be Taken December 1, 2022
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

6. Approve CalOptima Health's Calendar Year 2023 OneCare Member Health Rewards and Incentives

Contacts

Dr. Richard Pitts, Chief Medical Officer, (714) 246-8491
Marie Jeannis, Executive Director, Quality and Population Health Management, (714) 246-8591

Recommended Actions

1. Approve CalOptima Health's Calendar Year 2023 OneCare Member Health Rewards and Incentives Program; and
2. Authorize unbudgeted expenditures and appropriate funds in an amount not to exceed $500,000 from existing reserves to fund OneCare Member Rewards and Incentives Program during the current fiscal year, through June 30, 2023.

Background

CalOptima Health provides health Rewards and Incentives (R&I) in the form of physical gift cards to eligible members to improve member health and quality outcomes. CalOptima Health OneCare Connect (OCC) program has member R&I for breast and colorectal screenings. The OCC program sunsets on December 31, 2022, and OCC members will transition into the OneCare program, effective January 1, 2023. Currently, OneCare does not have a member R&I program.

Discussion

Health R&Is motivate members to establish relationships with their primary care providers and get recommended preventive care and screenings. The OneCare population is extremely vulnerable and would benefit from an R&I program that promotes annual wellness visits, chronic condition management, and preventive screens.

Staff recommends implementing a OneCare Member Health R&I Program to engage, motivate, and encourage members to participate in preventive care screenings by providing non-monetary R&I (i.e., gift cards) to OneCare members for the following:

- Annual Wellness Visit – $50
- Breast Cancer Screening – $25
- Colorectal Cancer Screening – $25
- Diabetes Care- Blood sugar controlled – $25
- Diabetes Care- Eye Exam – $25
- Osteoporosis Management in Women who had a Fracture – $25

Annual wellness exams are a key component of effectively managing a senior's health status. Additionally, diabetes care, cancer screening, and osteoporosis management are focus areas with the greatest opportunity for improvement. R&I payment to a OneCare member is contingent upon a

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complete member encounter with appropriate and complete coding. Staff assumes a member participation rate of 50% and the total estimated cost for implementing the OneCare Member Health R&I Program is approximately $1 million.

Fiscal Impact
The recommended action for the OneCare Member Health R&I Program has an estimated fiscal impact of $1 million for CY 2023. An appropriation to cover unbudgeted expenditures of up to $500,000 from existing reserves will fund this action for the period of January 1, 2023, through June 30, 2023.

Management will include expenses for the period of July 1, 2023, through December 31, 2023, in the Fiscal Year 2023-24 CalOptima Health Operating Budget.

Rationale for Recommendation
The OneCare Member Health R&I Program will strengthen the primary care provider-patient relationship, improve the quality of care delivered to OneCare members by promoting preventive care, and identify opportunities to coordinate care for special needs members.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachment
None

/s/ Michael Hunn — *11/23/2022*
Authorized Signature — **Date**

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 1, 2022
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

7. Authorize an Amendment to the Kaiser Foundation Health Plan Inc. Medi-Cal Health Maintenance Organization Contract for Health Care Services

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 923-8834
Michael Gomez, Executive Director, Network Operations, (714) 347-3292

Recommended Actions

Amend the Kaiser Foundation Health Plan Inc. Medi-Cal Health Maintenance Organization Contract for Health Care Services to extend the calendar year 2022 supplemental capitation payment for behavioral health treatment under the current terms and conditions through December 31, 2023.

Background and Discussion

Kaiser is contracted with CalOptima Health as a fully delegated health maintenance organization (HMO) health network. Staff requests that the Board approve an amendment to Attachment E of the Kaiser HMO Contract, which comprises capitation payment rate information, including supplemental capitation payments for behavioral health treatment (BHT). Supplemental capitation payments for BHT at the current rates are set to end on December 31, 2022.

Supplemental BHT capitation rates are set by the Department of Health Care Services (DHCS) and are renewed on a yearly basis. As of this writing, the calendar year (CY) 2023 Medi-Cal capitation rates, including supplemental BHT capitation rates, have not yet been released by DHCS. Amending the contract to extend BHT supplemental capitation through December 31, 2023, would mitigate disruption of those supplemental payments and associated services.

To mitigate any disruption of supplemental BHT payments and continuity of care for Kaiser assigned members, staff recommends approving the amendment to extend BHT supplemental capitation payments through December 31, 2023, under the current terms and conditions.

Fiscal Impact

The recommended action to extend the supplemental capitation payment for BHT, under the current terms and conditions of the Kaiser HMO Contract, is a budgeted item in the current fiscal year. Management will include expenses for the period of July 1, 2023, through December 31, 2023, in the CalOptima Health Fiscal Year 2023-24 Operating Budget.

Rationale for Recommendation

Amending Kaiser's contract to extend current BHT supplemental capitation payment rates will preserve continuity of member services for CalOptima Health's Kaiser HMO members.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

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Attachments

1. Entities Covered by this Recommended Action
2. Proposed Kaiser HMO Contract Amendment

/s/ Michael Hunn *11/23/2022*
Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Kaiser Foundation Health Plan Inc.	393 E. Walnut St.	Pasadena	CA	91188

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AMENDMENT XII TO
CONTRACT FOR HEALTH CARE SERVICES

THIS AMENDMENT XII TO THE CONTRACT FOR HEALTH CARE SERVICES ("Amendment") is effective as of January 1, 2023 (unless otherwise stated below), by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and, **Kaiser Foundation Health Plan, Inc.** ("HMO"), with respect to the following facts:

RECITALS

A. CalOptima and HMO have entered into a Contract for Health Care Services ("Contract"), by which HMO has agreed to provide or arrange for the provision of Covered Services to Members.

B. CalOptima and HMO desire to amend the Contract to continue the Behavioral Health Supplemental Capitation payments rates through December 31, 2023.

NOW, THEREFORE, the parties agree as follows:

1. Attachment E shall be deleted in its entirety and replaced with the attached Attachment E – Amendment XII "Capitation Rates".

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

IN WITNESS WHEREOF, CalOptima and **Kaiser Foundation Health Plan, Inc.** have executed this Amendment:

FOR HMO:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	_____
PRINT NAME	PRINT NAME
_____	Chief Operating Officer
TITLE	TITLE
_____	_____
DATE	DATE

ATTACHMENT E – AMENDMENT XII

Capitation Rates

Payments by CalOptima to HMO for Covered Services rendered to Members in accordance with the Contract for Health Care Services shall be on a Per Member/Per Month (PMPM) basis, and shall be provided herein in the following, except for carved out services and items as provided for in CalOptima Policies.

I. Temporary Assistance for Needy Families (TANF) and Seniors and Persons with Disabilities (SPD)
Effective July 1, 2020 through December 31, 2021

Aid Code Category	Age in years and Gender Group	Hospital Capitation	Professional Capitation	Pharmacy Capitation	Total Capitation
TANF					
	00-00 M & F	[redacted]	[redacted]	[redacted]	[redacted]
	01-14 M & F				
	15-18 F				
	15-18 M				
	19-39 F				
	19-39 M				
	40-64 M & F				
	65- M & F				

Aid Code Category	Age in years and Gender Group	Hospital Capitation	Professional Capitation	Pharmacy Capitation	Total Capitation
SPD					
	00-00 M & F	[redacted]	[redacted]	[redacted]	[redacted]
	01-14 M & F				
	15-18 F				
	15-18 M				
	19-39 F				
	19-39 M				
	40-64 M & F				
	65- M & F				

II. TANF and SPD
Effective January 1, 2022 through June 30, 2023

Aid Code Category	Age in years and Gender Group	Hospital Capitation	Professional Capitation	Total Capitation
TANF				
	00-00 M & F	[redacted]	[redacted]	[redacted]
	01-14 M & F	[redacted]	[redacted]	[redacted]
	15-18 F	[redacted]	[redacted]	[redacted]
	15-18 M	[redacted]	[redacted]	[redacted]
	19-39 F	[redacted]	[redacted]	[redacted]
	19-39 M	[redacted]	[redacted]	[redacted]
	40-64 M & F	[redacted]	[redacted]	[redacted]
	65- M & F	[redacted]	[redacted]	[redacted]

Aid Code Category	Age in years and Gender Group	Hospital Capitation	Professional Capitation	Total Capitation
SPD				
	00-00 M & F	[redacted]	[redacted]	[redacted]
	01-14 M & F	[redacted]	[redacted]	[redacted]
	15-18 F	[redacted]	[redacted]	[redacted]
	15-18 M	[redacted]	[redacted]	[redacted]
	19-39 F	[redacted]	[redacted]	[redacted]
	19-39 M	[redacted]	[redacted]	[redacted]
	40-64 M & F	[redacted]	[redacted]	[redacted]
	65- M & F	[redacted]	[redacted]	[redacted]

III. Adult Expansion Members (MCE)
Effective July 1, 2020 through January 31, 2021

Aid Code Category	Age in years and Gender Group	Hospital Capitation	Professional Capitation	Pharmacy Capitation	Total Capitation
MCE					
	19-39 F	[redacted]	[redacted]	[redacted]	[redacted]
	19-39 M				
	40-64 M & F				
	65- M & F				

IV. Adult Expansion Members (MCE)
Effective February 1, 2021 through December 31, 2021

Aid Code Category	Age in years and Gender Group	Hospital Capitation	Professional Capitation	Pharmacy Capitation	Total Capitation
MCE					
	19-39 F	[redacted]	[redacted]	[redacted]	[redacted]
	19-39 M				
	40-64 M & F				
	65- M & F				

V. Adult Expansion Members (MCE)
Effective January 1, 2022 through June 30, 2023

Aid Code Category	Age in years and Gender Group	Hospital Capitation	Professional Capitation	Total Capitation
MCE				
	19-39 F	[redacted]	[redacted]	[redacted]
	19-39 M			
	40-64 M & F			
	65- M & F			

VI. Supplemental Capitation
Behavioral Health (BHT)
Effective January 1, 2022 through December 31, 2023

Age in years and Gender Group	Supplemental Capitation
0-6 M&F	[redacted]
7-20 M&F	

- Payment will be processed within 30 days from Kaiser's BHT supplemental file submission.

VII. Whole Child Model Members
Effective July 1, 2020 through June 30, 2023

Type	Administrative Services Capitation
CCS eligible Members assigned to HMO	[redacted]

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 1, 2022
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

8. Authorize Contract Amendment Related to CalOptima Health's Key Operational System Vendors for Office Ally Inc., Change Healthcare Technologies LLC, and Health Management Systems, Inc.

Contacts

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

Recommended Actions

Authorize the Chief Executive Officer to amend and extend the contracts, under the current terms and conditions, for an additional two years with the following vendors:

a. Office Ally Inc., for front-end claims electronic data interchange clearinghouse services, for a contract extension of two-year extension from January 1, 2024, through December 31, 2025;
b. Change Healthcare Technologies LLC, formerly Emdeon, for claims electronic data interchange clearinghouse services, for a contract extension of two-years from January 1, 2024, through December 31, 2025; and
c. Health Management Systems Inc., for coordination of benefits recovery cost containment services, for a contract extension of two-year from May 15, 2023, through May 14, 2025.

Background

Office Ally Inc. (Office Ally) is one of the claims administration clearinghouses that interacts with providers to submit claims electronically to CalOptima Health for payment consideration. Once the claims are submitted to Office Ally, Office Ally sends the claim files to CalOptima Health for processing. Office Ally has provided CalOptima Health electronic data interchange (EDI) clearinghouse services since July 1, 2004.

Change Healthcare Technologies LLC (Change) is a secondary EDI clearinghouse for providers to submit long-term care and facility claim types. Change has provided CalOptima Health with EDI clearinghouse services since October 12, 2000.

Health Management Systems Inc. (HMS) performs other health coverage (OHC) review and detection of potential primary benefit coverages through another health plan. This service includes identifying and recovering overpayments due to OHC for CalOptima Health Direct (COD) and CalOptima Health Community Network (CCN) members. HMS has the expertise and technology to detect and/or identify OHC using CalOptima Health's claims file. Once OHC is identified, HMS initiates the recovery process by billing the appropriate health plan as part of the vendor recovery solution. Additionally, HMS performs OHC review of claims that were adjudicated without the COB indicator or segment based on the eligibility file received from the Department of Health Care Services (DHCS). These overpayment recoveries are requested directly from CalOptima Health's network providers. HMS has provided recovery services through a post-payment solution since May 15, 2008.

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Discussion

All three vendors listed above have established a good working relationship with CalOptima Health and, most importantly, CalOptima Health's provider community. Replacing these providers would require significant data mapping and logic changes from CalOptima Health. Changing clearinghouse vendors would also impact the provider community, as most of CalOptima Health's providers are currently contracted with Office Ally and Change Healthcare.

The Office Ally contract expires on December 31, 2023. By extending the contract term to add two years, beginning January 1, 2024, CalOptima Health will be able to maintain current business operations without disrupting and impacting CalOptima Health's providers' ability to submit their claims electronically.

The Change contract expires on December 31, 2023. By extending the contract term to add two years, beginning January 1, 2024, CalOptima Health will eliminate transitional costs of a new vendor without disrupting the current adjudication workflow or delaying payment to providers. Additionally, Change will upgrade the current file submission by adding a feature and automation that will allow CalOptima Health to redirect claims billed to the incorrect health network through electronic file routing. This will eliminate the need for CalOptima Health claims administration staff to manually print and send specific misdirected claims to the appropriate health network based on division of financial responsibility.

The HMS contract expires on May 14, 2023. Staff recommends amending and extending the contract term to add two years, beginning May 15, 2023. HMS is a contingency contract at 23% from the net recovered overpayments for improper claims payments related to COB. The overall recovery savings from January 2021 to September 2022 are $3,762,041. In addition to the recovery solution, HMS is providing CalOptima Health the necessary reporting required by DHCS as it relates to cost avoidance and post-payment recovery for OHC.

Fiscal Impact

The CalOptima Fiscal Year 2022-23 Operating Budget included the annual fees for the listed contracted vendors through June 30, 2023. Specifically, the budget included the following amounts: approximately $1.1 million for Office Ally, $580,000 for Change, and $900,000 for HMS. Management will include expenses for the recommended contract extension periods on or after July 1, 2023, in future operating budgets.

Rationale for Recommendation

Extension of these contracts will ensure there is no disruption to the services provided by these solutions and the continuation of appropriate claims payment to CalOptima Health's providers.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

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Attachments

1. Entities Covered by This Recommended Board Action
2. MC 03193 HMS Contract
3. MC 03193 HMS Amendment 1
4. MC 03193 HMS Amendment 2
5. MC 03193 HMS Amendment 3
6. MC 03193 HMS Amendment 4
7. CalOptima Health HMS Post-Close Letter
8. Change Healthcare Payer Agreement
9. Change Healthcare Payer Amendment 1
10. Change Healthcare Payer Amendment 2
11. Mc 03299 Office Ally Contract
12. Mc 03299 Office Ally Amendment 1
13. Mc 03299 Office Ally Amendment 2
14. Mc 03299 Office Ally Amendment 3
15. Mc 03299 Office Ally Amendment 4
16. Mc 03299 Office Ally Amendment 5
17. Mc 03299 Office Ally Amendment 6
18. Mc 03299 Office Ally Amendment 7
19. Mc 03299 Office Ally Amendment 8
20. Mc 03299 Office Ally Amendment 9
21. Mc 03299 Office Ally Amendment 10
22. Mc 03299 Office Ally Amendment 11
23. Mc 03299 Office Ally Amendment 12

Board Action

Board Meeting Dates	Action	Term	Not to Exceed Amount
March 5, 2020	Approved	3-year contract extension	N/A

/s/ Michael Hunn *11/23/2022*
Authorized Signature **Date**

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CONTRACTED ENTITY COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Office Ally	1300 SE Cardinal Court Suite 190	Vancouver	WA	98683
Change Healthcare Technologies, LLC	424 Church Street	Nashville	TN	37219
Health Management System (HMS)	9020 Stony Point Parkway Suite 165	Richmond	VA	23235

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CONTRACT NO. MC 03193

BETWEEN

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

AND

HEALTH MANAGEMENT SYSTEMS, INC.

(VENDOR)

THIS CONTRACT is entered into as of May 15, 2008, by and between the Orange County Health Authority, a Public Agency, dba Orange Prevention and Treatment Integrated Medical Assistance, dba CalOptima ("CalOptima"), 1120 West La Veta Avenue, Orange, CA 92868, and Health Management Systems, 1000 S. Fremont Ave., Unit 65, Building A-10, Alhambra, CA 91803 ("VENDOR"), with respect to the following facts:

A. CalOptima requires professional VENDOR services to perform Coordination of Benefit (COB) and Overpayment Recovery Services; and

B. VENDOR provides such services; and

C. VENDOR represents and warrants that it has the requisite personnel and experience and is capable of performing such services; and

D. VENDOR desires to perform these services; and

E. CalOptima and VENDOR desire to enter into this Contract on the terms and conditions set forth herein below.

NOW, THEREFORE, the parties agree as follows:

ARTICLE I – DOCUMENTS CONSTITUTING CONTRACT

This Contract shall include, in addition to this document and its exhibits and attachments, VENDOR's proposal, dated November 27, 2007, and the best and final offer, dated February 29, 2008, and all documents cited herein or incorporated by reference. The invalidity in whole or in part of any term or condition of the Contract shall not affect the validity of other terms or

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conditions. CalOptima's failure to insist on any one or more instances upon VENDOR's performance of such terms or conditions of this Contract shall not be construed as a waiver or relinquishment of CalOptima's right to such performance or to future performance of such terms or conditions, and VENDOR's obligation in respect thereto shall continue in full force and effect. Changes hereto shall not be binding upon CalOptima except when specifically confirmed in writing by an authorized representative of CalOptima and issued in accordance with Article III hereof. In the event of any conflict of provisions among the documents constituting the Contract, the provisions shall prevail in the following descending order of precedence: (1) the provisions of this Contract, including all exhibits and attachments; (2) VENDOR's proposal dated November 27, 2007; (3) VENDOR's best and final offer dated February 29, 2008; and (4) all other documents cited herein or incorporated by reference.

ARTICLE II – VENDOR RESPONSIBILITIES

A. STATEMENT OF WORK

1. VENDOR shall perform the work necessary to complete, in a manner satisfactory to CalOptima and the Centers for Medicare and Medicaid Services ("CMS"), the services set forth in Exhibit A entitled "Scope of Work," which is attached hereto and incorporated herein by this reference. VENDOR shall also perform in accordance with its proposal to CalOptima, dated November 27, 2007, and supplemental other information submitted to CalOptima on February 29, 2008.

2. Any conflicts between the requirements of Exhibit A and VENDOR's proposal shall be referred to CalOptima for resolution. All services shall be provided at the times and places designated by CalOptima.

3. VENDOR shall provide the personnel listed below to perform the above-specified services, which persons are hereby designated as key personnel under this Contract.

Name	Function/Title
Christina Dragonetti	Senior Vice President
James Carlouch	Vice President Client Services

No person named in this Article, or his/her successor approved by CalOptima, shall be removed or replaced by VENDOR, nor shall his/her agreed-upon function or level of commitment hereunder be changed without the prior written consent of CalOptima.

B. INSURANCE

1. During performance hereunder, and entirely at VENDOR's sole expense, VENDOR shall maintain the following insurance, which shall be full-coverage insurance not subject to self-insurance provisions, and VENDOR shall not of its own initiative cause such insurance to be canceled or materially changed during the term of this Contract.

a. Comprehensive General Liability, including Contractual, Independent Contractors, Products/Completed Operations and Personal Injury Liability; and Automobile Liability, including any autos; with at least the following limits of liability:

i. Primary Bodily Injury Liability limits of $1,000,000 per occurrence; and

ii. Primary Property Damage Liability limits of $1,000,000 per occurrence; or

iii. Combined single limits of liability for Primary Bodily Injury and Primary Property Damage of $2,000,000 per occurrence and in aggregate.

b. Automobile Liability with the following limits of liability:

i. Primary Bodily Injury with limits of $600,000 per occurrence; and

ii. Primary Property Damage with limits of $600,000 per occurrence; or

iii. Combined single limits of liability for Primary Bodily and Primary Property Damage of $1,200,000 per occurrence and in aggregate.

c. Workers' Compensation Insurance within the limits established and required by the State of California.

d. Employer's Liability with limits of $1,000,000

e. Professional Liability with a combined single limit of at least $1,000,000 per occurrence and in aggregate.

2. Prior to commencement of any work hereunder, VENDOR shall furnish to CalOptima's Procurement Department broker-issued certificate(s) of insurance showing the required insurance coverages for VENDOR and further providing that:

a. CalOptima is named as an additional insured on Comprehensive General Liability and Automobile Liability insurance with respect to performance hereunder; and

b. The coverage shall be primary and noncontributory as to any other insurance with respect to performance hereunder; and

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

3. "Occurrence," as used herein, means any event or related exposure to conditions which result in bodily injury or property damage.

C. INDEPENDENT CONTRACTOR

VENDOR acknowledges that it is at all times acting as an independent contractor under this Contract and, except as specifically provided herein, not as an agent, employee, or partner of CalOptima. VENDOR agrees to be solely responsible for all matters relating to compensation of its employees, including, but not limited to, compliance with laws governing workers' compensation, Social Security, withholding and payment of any and all federal, state and local personal income taxes, disability insurance, unemployment, and any other taxes for such persons, including any related employer assessment or contributions required by law, and all other regulations governing such matters, and the payment of all salary, vacation and other employee benefits. At VENDOR's expense as described herein, VENDOR agrees to defend, indemnify, and hold harmless CalOptima, its officers, agents, employees, members, subsidiaries, joint venture partners, and predecessors and successors in interest from and against any claim, action, proceeding, liability, loss, damage, cost, or expense, including, without limitation, attorneys' fees as provided herein arising out of VENDOR's alleged failure to pay, when due, all such taxes and obligations (collectively referred to for purposes of this paragraph as "Employment Claim(s)"). VENDOR shall pay to CalOptima any expenses or charges relating to or arising from any such Employment Claim(s) as they are incurred by CalOptima.

D. ASSIGNMENTS AND SUBCONTRACTING

Except as specifically permitted hereunder, this Contract is not assignable by VENDOR, either in whole or in part, without the prior written consent of CalOptima, which consent may be withheld in its sole and absolute discretion. For purposes of this Section and this Contract,

assignment is (1) the change of more than twenty-five percent (25%) of the ownership or equity interest in VENDOR (whether in a single transaction or in a series of transactions), (2) the change of more than twenty-five percent (25%) of the directors or trustees of VENDOR (whether in a single transaction or in a series of transactions), (3) the merger, reorganization, or consolidation of VENDOR with another entity with respect to which VENDOR is not the surviving entity, and/or (4) a change in the management of VENDOR from management by persons appointed, elected or otherwise selected by the governing body of VENDOR (e.g. the Board of Directors) to a third-party management person, company, group, team or other entity. VENDOR represents and warrants that any individual or entity acting as a subcontractor to this Contract has the appropriate skill and expertise to perform the subcontracted work.

E. NON-EXCLUSIVE RELATIONSHIP

It is understood by the parties that this is a non-exclusive relationship between CalOptima and VENDOR. CalOptima shall have the right to enter into contractual arrangements with one or more vendors who can provide CalOptima with similar or like services.

F. COMPLIANCE WITH APPLICABLE LAW

VENDOR warrants that, in the performance of this Contract, it shall observe and comply with federal, state, and local laws in effect when this Contract is signed or which may come into effect during the term of this Contract.

G. NONDISCRIMINATION CLAUSE COMPLIANCE

During the performance of this Contract, VENDOR and its subcontractor(s) shall not unlawfully discriminate, harass, or allow harassment, against any employee or applicant for employment because of sex, race, color, ancestry, religious creed, national origin, physical disability, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), mental disability, medical condition (including cancer), age (over 40), marital status, and the use of family and medical care leave and pregnancy disability leave. VENDOR and subcontractor(s) shall insure that the evaluation and treatment of their employees and applicants for employment are free from discrimination and harassment. VENDOR and subcontractor(s) shall comply with the provisions of the Fair

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

VENDOR shall include the nondiscrimination and compliance provisions of Article II.G. in all subcontracts under this Contract.

H. PROHIBITED INTERESTS

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

ARTICLE III – TERM; TERMINATION; CHANGES

A. TERM

This Contract shall commence on May 15, 2008, and shall continue in full force and effect through May 14, 2011, unless earlier terminated, as provided in this Contract. VENDOR shall complete all work in accordance with the project schedule specified in Exhibit A.

B. TERMINATION WITHOUT CAUSE

CalOptima may terminate this Contract at any time by giving VENDOR thirty (30) days written notice hereof. Upon termination, CalOptima may pay VENDOR its allowable cost incurred as of the date of termination. Thereafter, VENDOR shall have no further claims against CalOptima under this Contract.

C. TERMINATION FOR UNAVAILABILITY OF FUNDS

In recognition that CalOptima is a governmental entity and its operations and budgets are determined on an annual basis, CalOptima shall have the right to terminate this Contract as follows:

1. CalOptima may terminate this Contract if it does not receive funding from the state of California or the federal government, as applicable, for any fiscal year.

2. In the event of Termination for Unavailability of Funds, as provided in this Article, CalOptima agrees to promptly pay VENDOR all fees and other charges due and payable as of the termination date.

3. In the event of Termination for Unavailability of Funds, as provided in this Article, and funds are received by CalOptima from the State of California within one-hundred twenty (120) days of the date of termination, then CalOptima shall promptly notify VENDOR in writing and CalOptima shall have the right to reinstate this Contract for that period for which funds are received by CalOptima or the unexpired term of this Contract as of the date of termination, whichever period is shorter in duration. Notwithstanding the foregoing, CalOptima may only reinstate this Contract two (2) times during the Term of this Contract.

D. TERMINATION FOR DEFAULT

Subject to a ten (10) day cure period, CalOptima may terminate this Contract for VENDOR's default, or if a federal or state proceeding for the relief of debtors is undertaken by or against VENDOR, or if VENDOR makes an assignment for the benefit of creditors, as defined in Article II, paragraph D., or if VENDOR breaches any term(s) or violates any provision(s) of this Contract and does not cure such breach or violation within ten (10) days after written notice thereof by CalOptima. In the event of Termination for Default, as provided by this Article, VENDOR shall be liable for any and all reasonable costs incurred by CalOptima as a result of such default, including, but not limited to, reprocurement costs of the same or similar services defaulted by VENDOR under this Contract.

E. TERMINATION BY VENDOR

1. For Cause. In the event that CalOptima fails to perform any of its duties and obligations under this Agreement or breaches any representations or agreements hereunder and such failure or breach is, in aggregate, such failures or breaches are, material and are not substantially cured within a Cure Period ("Cure Period") defined as ten (10) working days (in the event of non-payment) or sixty (60) working days (in the event that CalOptima does not provide

data files or other information as specified in Exhibit A) after written notice is given to CalOptima specifying the default, VENDOR may, by giving written notice therof to CalOptima, terminate this agreement not less than thirty (30) days from the expiration of the Cure Period.

2. For Convenience. Not sooner than twelve (12) months from the execution date of this Agreement, Vendor may terminate this Agreement in whole or in part without cause, Such termination shall be effected by written notice delivered to CalOptima not less than ninety (90) days prior to the date of termination specified un such notice.

3. Work in Process. For one hundred-eighty (180) days ("Wind-Down Period") from termination of this Agreement for whatever reason, VENDOR shall be permitted to continue providing Services associated with work already in progress. Additionally, VENDOR shall have the right to payment for all associated recoveries received by CalOptima within twelve (12) months of the termination date. CalOptima shall continue to provide assistance reasonably requested by VENDOR related to such activities during the Wind-Down Period. The Wind-Down Period may be extended by mutual written agreement of the parties based on special circumstances.

4. MODIFICATIONS

CalOptima reserves the right to modify the Contract at any time should such modification be required by CMS or applicable law or regulation. Modifications shall be executed by a written amendment to the Contract, signed by CalOptima and VENDOR. Execution of amendments shall be contingent upon VENDOR's notification to CalOptima, and CalOptima's approval, of any increase or decrease in the price of this Contract or in the time required for its performance.

ARTICLE IV – RECORDS; CONFIDENTIALITY

A. VERIFICATION OF CALOPTIMA COSTS BY GOVERNMENT

Until the expiration of ten (10) years after the later of furnishing of any service pursuant to this Contract or completion of any audit, or longer as required by applicable regulations, VENDOR will make available, upon written request of the Secretary of Health and Human Services or the Comptroller General of the United States or any of their duly authorized

representatives, or the California Department of Health Services, or the California Department of Managed Health Care, or the Department of Justice, or the Bureau of Medical Fraud, copies of this Contract and any financial statements, books, documents, records, patient care documentation, and other records or data of VENDOR that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under this Contract, or as are otherwise necessary to certify the nature and extent of costs incurred by CalOptima for such services. This provision shall also apply to any agreement between a subcontractor and an organization related to the subcontractor by control or common ownership. VENDOR further agrees that regulating entities have the right to inspect, evaluate and audit any pertinent information, and, to facilitate the review of the items referenced herein, to make available its premises, physical facilities and equipment, records related to Medicare enrollees, and any additional relevant information that regulating entities may require. VENDOR further agrees and acknowledges that this provision will be included in any and all agreements with VENDOR'S subcontractors.

B. PAYMENT

CalOptima and VENDOR mutually agree to the payment terms defined in Exhibit B, which is attached hereto and incorporated herein by this reference.

C. CONFIDENTIALITY AGREEMENT

VENDOR agrees to complete a CalOptima Confidentiality Agreement, which is attached hereto as Exhibit C and incorporated herein by this reference. All materials covered under this Confidentiality Agreement shall be designated confidential, to the extent permitted by California law.

D. BUSINESS ASSOCIATE AGREEMENT

VENDOR agrees to sign a Business Associate Agreement, which is attached hereto as Exhibit D and incorporated herein by this reference.

ARTICLE V – MEDICARE ADVANTAGE PROGRAM

A. In addition to compliance with the provisions of Article II.F, above, VENDOR expressly warrants that VENDOR and VENDOR's subcontractors, if any, shall comply with all

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applicable Medicare laws, regulations, and CMS instructions. VENDOR further agrees and acknowledges that this provision will be included in any and all agreements with VENDOR's subcontractors.

B. For any medical records or other health and enrollment information VENDOR maintains with respect to Medicare enrollees, VENDOR shall establish procedures to:

1. Abide by all Federal and State laws regarding confidentiality and disclosure of medical records and other health and enrollment information. VENDOR shall safeguard the privacy of any information that identifies a particular enrollee and shall have procedures that specify (a) the purpose or purposes the information will be used within VENDOR's organization; and (b) to whom and for what purpose VENDOR will disclose the information.

2. Ensure that the medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas.

3. Maintain the records and information in an accurate and timely manner.

4. Ensure timely access by enrollees to the records and information that pertain to them.

C. VENDOR shall comply with the reporting requirements provided in Title 42 of the Code of Federal Regulations, Section 422.516 as well as the encounter data submission requirements of 42 CFR section 422.257.

D. In addition to the termination provisions of Article III of this Contract, VENDOR agrees and acknowledges that CalOptima may terminate the Contract if CMS or CalOptima determines that VENDOR has not satisfactorily performed its obligations under the Contract. Under such circumstances, CalOptima may pay VENDOR its allowable costs incurred to the date of termination. Thereafter, VENDOR shall have no further claims against CalOptima for matters pertaining to this Contract.

E. While CalOptima maintains ultimate responsibility for adhering to and complying with all terms and conditions of its contract with CMS, Contractor shall comply with all such requirements at the direction of CalOptima.

F. CalOptima shall review, approve, and audit on an ongoing basis, the credentialing of

medical professionals, if any, associated with VENDOR and VENDOR's performance of this Contract.

G. Notwithstanding the delegation by CalOptima to VENDOR the selection of providers, contractors, or subcontractors, CalOptima expressly retains the right to approve, suspend, or terminate any such arrangement.

H. Notwithstanding the written delegation by CalOptima to VENDOR of any other activities under this Contract, CalOptima maintains ultimate responsibility for adhering to and complying with all terms and conditions of its contract with CMS, and expressly retains the right to approve, suspend, or terminate any such arrangement with VENDOR. With all such delegated activities, CalOptima shall monitor VENDOR's performance on an ongoing basis to ensure compliance with all applicable CalOptima and CMS requirements.

ARTICLE VI – MISCELLANEOUS

A. TIME IS OF THE ESSENCE WITH THIS CONTRACT

B. CalOptima DESIGNEE

The Chief Executive Officer of CalOptima, or his designee, shall have the authority to act for and exercise any of the rights of CalOptima, as set forth in this Contract, subsequent to and in accordance with the authority granted by the Board of Directors.

C. INDEMNIFICATION

VENDOR shall defend, indemnify and hold harmless CalOptima, its officers, directors, and employees from and against any and all claims (including attorneys' fees and reasonable expenses for litigation or settlement) for any loss or damages for bodily injuries, including death, or loss of property, or damage to the use of property caused by negligent acts, errors or omissions or willful misconduct by VENDOR, its officers, directors, employees, agents, subcontractors, or suppliers in connection with or arising out of performance of this Contract.

D. OMISSIONS

In the event that either party hereto discovers any material omission in the provisions of this Contract which such party believes is essential to the successful performance of this Contract, the party may so inform the other party in writing, and the parties hereto shall thereafter

promptly negotiate in good faith with respect to such matters for the purpose of making such reasonable adjustments, as may be necessary to perform the objectives of this Contract.

E. CHOICE OF LAW

This Contract shall be governed by and construed in accordance with the laws of the State of California. In the event any party institutes legal proceedings to enforce or interpret this Contract, venue and jurisdiction shall be in any state court of competent jurisdiction sitting in Orange County, California.

F. FORCE MAJEURE

When satisfactory evidence of a cause beyond a party's control is presented to the other party, and nonperformance is unforeseeable, beyond the control, and not due to the fault of the party not performing, a party shall be excused from performing its obligations under this Contract during the time and to the extent that it is prevented from performing by such cause, including, but not limited to, any incidence of fire, flood, acts of God, commandeering of material, products, plants or facilities by the federal, state or local government, or a material act or omission by the other party.

G. OWNERSHIP OF REPORTS AND DOCUMENTS

The originals of all letters, documents, reports, and other data produced for the purposes of this Contract shall be delivered to, and become the property of CalOptima. Copies may be made for VENDOR's records, but shall not be furnished to others without written authorization from CalOptima. Such deliverables shall become the sole property of CalOptima and all rights in copyright therein shall be retained by CalOptima.

H. PATENT AND COPYRIGHT INFRINGEMENT

In lieu of any other warranty by CalOptima or VENDOR against infringement, statutory or otherwise, it is agreed that VENDOR shall defend, at its expense, any suit against CalOptima based on a claim that any item furnished under this Contract, or the normal use or sale thereof, infringes on any United States letters patent, patent, or copyright, and shall pay costs and damages finally awarded in any such suit, provided that VENDOR is notified in writing of the suit and given authority, information, and assistance at VENDOR's expense for the defense of

the suit. VENDOR, at no expense to CalOptima, shall obtain for CalOptima the right to use and sell said item, or shall substitute an equivalent item acceptable to CalOptima and extend this patent indemnity thereto.

I. NAMES AND MARKS

Neither party shall use the name, logo or other proprietary mark of the other in any press release, advertising, promotional, marketing, or similar publicly disseminated material without first submitting such material to the other party and obtaining the other party's express written approval of the material and consent to such use.

J. NOTICES

All notices hereunder and communications regarding the interpretation of the terms of this Contract, or changes thereto, shall be effected by delivery of the notices in person or by depositing the notices in the U.S. mail, registered or certified mail, return receipt requested, postage prepaid, and addressed as follows:

To VENDOR:	To CalOptima:
Health Management Systems, Inc.	CalOptima
401 Park Avenue South	1120 West La Veta Avenue
New York, NY 10016	Orange, CA 92868
Attention: Christina Dragonetti	Attention: Mark Finch, C.P.M.
Senior Vice President	Purchasing Manager

K. NOTICE OF LABOR DISPUTES

Whenever VENDOR has knowledge that any actual or potential labor dispute may delay this Contract, VENDOR shall immediately notify and submit all relevant information to CalOptima. VENDOR shall insert the substance of this entire clause in any subcontract hereunder as to which a labor dispute may delay this Contract.

L. DISPUTES

This Contract shall be construed and all disputes hereunder be settled in accordance with the laws of the State of California. Pending final resolution of a dispute hereunder, VENDOR shall proceed diligently with the performance of this Contract.

M. NO LIABILITY OF COUNTY OF ORANGE

As required under Ordinance No. 3896 of the County of Orange, State of California, the parties hereto acknowledge and agree that the obligations of CalOptima under this Contract are solely the obligations of CalOptima, and the County of Orange, State of California, shall have no obligation or liability therefor.

N. ATTORNEYS FEES

Should either party to this Contract institute any action or proceeding to enforce this Contract or any provision hereof, or for damages by reason of any alleged breach of this Contract, otherwise arising under this Contract, or for a declaration of rights hereunder, the prevailing party in any such action or proceeding shall be entitled to receive from the other party all costs and expenses, including, without limitation, reasonable attorneys' fees, incurred by the prevailing party in such arbitration, action or proceeding.

O. ENTIRE AGREEMENT

This Contract contains the entire agreement between VENDOR and CalOptima with respect to the subject matter of this Contract, and it supersedes all other prior contemporary agreements, understandings, and commitments between VENDOR and CalOptima with respect to the subject matter of this Contract.

P. HEADINGS

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

ARTICLE VII – SIGNATURES

This Contract shall be made effective upon execution by both parties.

IN WITNESS WHEREOF, the parties hereto have caused this Contract No. MC 03193 to be executed on the date first above written.

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HEALTH MANAGEMENT SYSTEMS	CalOptima
By: Christina Dragonetti	By:
Name: Christina Dragonetti	Name: ~~Keith Quinlivan~~ Greg Bucher, MD
Title: Senior Vice President	Title: Chief ~~Financial~~ Operating Officer
Date: 5/19/08	Date: 5/22/08

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SCOPE OF WORK

The following are the services to be performed as the project known as Coordination of Benefit ("COB") and Overpayment Recovery Services. Health Management Systems, Inc. ("HMS") proposes to perform said services on behalf of CalOptima for its Medicaid and Medicare Managed Care member populations ("Program Members"). Expressly excluded from this Agreement are third party lien claims held by the State of California or held for by CalOptima's contracted Providers.

SECTION 1. DATA RECEIPT

1.1 Data Receipt. CalOptima shall provide VENDOR with the following standard data files electronically in a format agreed to by both parties:

1.1.1. Eligibility (monthly)

1.1.2. Known COB/other party resource file (monthly)

1.1.3. Adjudicated Claims/Encounter Data (monthly)

1.1.4. Provider File (monthly)

1.2. Data Programming Fee. A one-time charge of twenty-five cents ($.25) per Program Member will be charged for implementation and initial data programming associated with this project. Fifty (50) per cent of the fees will be billed in equal parts on the date of the Project Kick-Off Meeting and fifty (50) per cent of the fees will be billed on the date the first Billing Cycle is released. This charge shall be based on the number of Program Members as of the date the Agreement is executed by CalOptima.

However, if CalOptima should provide VENDOR with source data from a system or systems different from the core system(s) in use at the time this Agreement is executed, VENDOR will charge a one-time data programming fee of twenty-five thousand dollars

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($25,000) to accommodate CalOptima's data from each additional non-core system it may use.

SECTION 2: INSURANCE BILLING AND PROVIDER RECOUPMENTS

VENDOR will generate complete billings to commercial insurers and TRICARE, and submit such billings to individual carriers, as may be applicable, in connection with patient services paid for by CalOptima but for which a third party is liable.

2.1 Services

2.1.1. Match to Paid Claims/Encounter Data. VENDOR shall match the paid claim/encounter data to VENDOR eligibility database of other third party resources to identify any claims paid by CalOptima to providers that may be the responsibility of another payor.

2.1.2. Perform Recovery. Where direct billing to liable third parties is the most effective recoupment method, VENDOR shall:

2.1.2.1. Bill claims in required format to liable third parties including commercial insurers, Tricare, and Medicare.

2.1.2.2. Receive checks and other remittance documentation in bank lockbox that CalOptima establishes for this project.

2.1.2.3. Where appropriate, rebill and appeal inappropriately denied claims.

2.1.2.4. Supply to CalOptima monthly reports documenting results.

2.1.3. Provider Recoupments. Where recoupment from the provider of service is the effective recoupment method, VENDOR shall:

2.1.3.1 Submit documentation to providers regarding previous payments from CalOptima, as well as coverage information required for the provider to bill the liable third party. All such documentation will be submitted to CalOptima for review and approval prior to being sent to providers.

2.1.3.2. Provide customer service to providers during recoupment period.

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2.1.3.3. Receive checks and other remittance documentation in bank lockbox that CalOptima establishes for the project.

2.1.3.4. Address provider appeals where appropriate.

2.1.3.5 Submit recoupment files to CalOptima at the end of the recoupment period.

2.2 Fees. For the Services within this Scope of Work CalOptima agrees to pay VENDOR the following fees:

2.2.1. Payment of Fees. A contingency fee of Twenty-Five percent (25%) of funds recovered.

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PAYMENT

For VENDOR's full and complete performance of its obligations under this Contract, CalOptima shall pay VENDOR on a contingency fee basis in accordance with the provisions of this Exhibit and subject to the maximum cumulative payment obligations specified below.

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

Invoices shall be submitted to CalOptima's Accounts Payable Office. Each invoice shall cite Contract No. MC 03193; specify the actual funds recovered; the time period covered by the invoice and the amount of payment requested; and be accompanied by a monthly report. CalOptima shall remit payment within thirty (30) days of receipt and approval of each invoice. No amount shall be invoiced or no amount shall be due or payable by CalOptima prior to receipt by CalOptima of the funds for the recovery or recoupment from Third Party Payors or Providers.

VENDOR's rate shall be a Contingency Fee of Twenty-Five percent (25%) of funds recovered. Additionally, a one time charge of Twenty-five cents ($.25) per member, based on member enrollment as of the date this Agreement is executed by CalOptima, will be charged for implementation and initial data programming associated with this project. This rate is fixed for the duration of the Contract. VENDOR agrees to extend this rate to CalOptima for a period of one year after Contract termination. CalOptima shall not pay VENDOR for time spent traveling.

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CONFIDENTIALITY AGREEMENT

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

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

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

HEALTH MANAGEMENT SYSTEMS, INC. further agrees that this Confidentiality Agreement shall remain in full force and effect after the termination of this Contract.

By: Christin Dragonetti Dated: _____

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BUSINESS ASSOCIATE PROTECTED HEALTH INFORMATION DISCLOSURE AGREEMENT

This Business Associate Protected Health Information Disclosure Agreement ("Agreement') is entered into as of May 15, 2008 by and between CalOptima ("Plan") and Health Management Systems, Inc. ("Business Associate").

RECITALS

WHEREAS, the parties have executed an agreement(s) whereby Business Associate provides services to Plan, and Business Associate receives, has access to or creates Protected Health Information in order to provide those services ("Services Agreement(s)");

WHEREAS, Plan is subject to the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act of 1996, and regulations promulgated thereunder, including the Standards for Privacy of Individually Identifiable Health Information at 45 Code of Federal Regulations Parts 160 and 164 ("Privacy Regulations") and the Security Standards for Electronic Protected Health Information ("Security Regulations") at 45 Code of Federal Regulations Parts 160 and 164 (together, the "Privacy and Security Regulations");

WHEREAS, the Privacy and Security Regulations require Plan to enter into a contract with Business Associate in order to mandate certain protections for the privacy and security of Protected Health Information, and those Regulations prohibit the disclosure to or use of Protected Health Information by Business Associate if such a contract is not in place;

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:

DEFINITIONS

1.1 "Disclose" and "Disclosure" mean, with respect to Protected Health Information, the release, transfer, provision of access to, or divulging in any other manner of Protected Health Information outside Business Associate's internal operations or to other than its employees.

1.2 "Electronic Media" means:

(a) Electronic storage media including memory 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

(b) Transmission media used to exchange information already in electronic storage media. Transmission media include, for example, the internet (wide-open), extranet (using internet technology to link a business with information accessible only to collaborating parties), 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.

1.3 "Electronic Protected Health Information" means Protected Health Information that is transmitted or maintained in electronic media.

1.4 "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.

1.5 "Individual" means the person who is the subject of Protected Health Information and shall include a person who qualifies as a personal representative in accordance with 45 C.F.R. § 164.502(g).

1.6 "Protected Health Information" has the same meaning as the term "protected health information" in 45 C.F.R. § 164.501, limited to the information created or received by Business Associate from or on behalf of Plan. Protected Health Information includes information that (i) 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; (ii) identifies the Individual (or for which there is a reasonable basis for believing that the information can be used to identify the Individual); and (iii) is received by Business Associate from or on behalf of Plan, or is created by Business Associate, or is made accessible to Business Associate by Plan. "Protected Health Information" includes Electronic Protected Health Information.

1.7 "Security Incident" means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information in, or interference with system operations of, an Information System which contains Electronic Protected Health Information. However, Security Incident does not include attempts to access an Information System when those attempts are not reasonably considered by Business Associate to constitute an actual threat to the Information System.

1.8 "Required By Law" means a mandate contained in law that compels an entity to make a Use or Disclosure of Protected Health Information 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 any 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.

1.9 "Services" has the same meaning as in the Services Agreement(s).

1.10 "Use" or "Uses" mean, with respect to Protected Health Information, the sharing, employment, application, utilization, examination or analysis of such Information within Business Associate's internal operations.

1.11 Terms used, but not otherwise defined, in this Agreement shall have the same meaning as those terms in the Privacy Regulations.

OBLIGATIONS OF BUSINESS ASSOCIATE

2.1 Permitted Uses and Disclosures of Protected Health Information. Business Associate:

(a) shall Use and Disclose Protected Health Information as necessary to perform the Services , and as provided in Sections 2.3, 2.4, 2.5, 2.6, 2.7, 2.8, 3.3 and 4.1 of this Agreement;

(b) shall Disclose Protected Health Information to Plan upon request;

(c) may, as necessary for the proper management and administration of its business or to carry out its legal responsibilities:

(i) Use Protected Health Information; and

(ii) Disclose Protected Health Information if the Disclosure is required by law.

Business Associate shall not Use or Disclose Protected Health Information for any other purpose.

2.2 Adequate Safeguards for Protected Health Information. Business Associate warrants that it shall implement and maintain appropriate safeguards to prevent the Use or Disclosure of Protected Health Information in any manner other than as permitted by this Agreement.

Specifically as to Electronic Protected Health Information, Business Associate warrants that it shall implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of Electronic Protected Health Information.

2.3 Reporting Non-Permitted Use or Disclosure and Security Incidents. Business Associate shall report to Plan each Use or Disclosure that is made by Business Associate, its employees, representatives, agents or subcontractors but is not specifically permitted by this Agreement , as well as each Security Incident of which Business Associate becomes aware. The initial report shall be made by telephone call to Denise Corley, telephone number (714) 246-8594 (Plan's Privacy Officer) within five (5) business days from the time the Business Associate becomes aware of the non-permitted Use or Disclosure or Security Incident, followed by a full written report to the Privacy Officer no later than twenty (20) business days from the date the Business Associate becomes aware of the non-permitted Use or Disclosure or Security Incident. If Business Associate is unable to provide a full written report within the stated time frames, Business Associate may request an extension of up to ten (10) additional business days. Such requests shall be in written form (facsimile is acceptable), and submitted to Plan's Privacy

Officer within the original twenty (20) business day deadline, and must contain an explanation for the basis of the requested extension. Plan retains the right to approve or deny such requested extensions, however Plan shall not unreasonably deny such requests.

2.4 Mitigation of Harmful Effect. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a Use or Disclosure of Protected Health Information by Business Associate in violation of the requirements of this Agreement.

2.5. Availability of Internal Practices, Books and Records to Government Agencies. Business Associate agrees to make its internal practices, books and records relating to the Use and Disclosure of Protected Health Information available to the Secretary of the federal Department of Health and Human Services for purposes of determining Plan's compliance with the Privacy and Security Regulations. Business Associate shall immediately notify Plan of any requests made by the Secretary and provide Plan with copies of any documents produced in response to such request.

2.6 Access to Protected Health Information. Business Associate shall, to the extent Plan determines that any Protected Health Information constitutes a "designated record set" as defined by 45 C.F.R. § 164.501, make the Protected Health Information specified by Plan available to the Individual(s) identified by Plan as being entitled to access and copy that Protected Health Information. Business Associate shall provide such access for inspection of that Protected Health Information within thirty (30) calendar days after receipt of request from Plan. Business Associate shall also provide copies of that Protected Health Information within thirty (30) calendar days after receipt of request from Plan.

2.7 Amendment of Protected Health Information. Business Associate shall, to the extent Plan determines that any Protected Health Information constitutes a "designated record set" as defined by 45 C.F.R. § 164.501, make any amendments to Protected Health Information that are requested by Plan. Business Associate shall make such amendment within thirty (30) calendar days after receipt of request from Plan in order for Plan to meet the requirements under 45 C.F.R. § 164.526.

2.8 Accounting of Disclosures. Upon Plan's request, Business Associate shall provide to Plan an accounting of each Disclosure of Protected Health Information made by Business Associate or its employees, agents, representatives or subcontractors.

Any accounting provided by Business Associate under this Section 2.8 shall include:

(a) the date of the Disclosure;

(b) the name, and address if known, of the entity or person who received the Protected Health Information;

(c) a brief description of the Protected Health Information disclosed; and

(d) a brief statement of the purpose of the Disclosure.

For each Disclosure that could require an accounting under this Section 2.8, Business Associate shall document the information specified in (a) through (d), 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). Business Associate shall not, however, be required to maintain such information for disclosures of Protected Health Information:

(a) to carry out treatment, payment, and health care operations on behalf of Plan, or that are incident to such disclosures;

(b) to individuals of protected health information about them; or

(c) pursuant to a written authorization given by or behalf of the individual.

Business Associate shall provide to Plan, within thirty (30) calendar days after receipt of request from Plan, information collected in accordance with this Section 2.8 to permit Plan to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. § 164.528.

TERM AND TERMINATION

3.1 Term. This Agreement shall remain in effect as long as any Services Agreement is in effect. Business Associate's obligations under Sections 2.1 (as modified by Section 4.2), 2.3, 2.4, 2.5, 2.6, 2.7, 2.8, and 4.3 shall survive the termination or expiration of this Agreement.

3.2 Termination for Cause. In addition to and notwithstanding the termination provisions set forth in the Services Agreement(s), upon Plan's knowledge of a material breach by Business Associate, Plan shall either:

(a) Provide an opportunity for Business Associate to cure the breach or end the violation and terminate this Agreement if Business Associate does not cure the breach or end the violation within the time specified by Plan;

(b) Immediately terminate this Agreement if Business Associate has breached a material term of this Agreement and cure is not possible; or

(c) If neither termination nor cure is feasible, Plan shall report the violation to the Secretary of the federal Department of Health and Human Services.

3.3 Disposition of Protected Health Information Upon Termination or Expiration.

(a) Except as provided in paragraph (b) of this section, upon termination for any reason of this Agreement and the Services Agreement(s), Business Associate shall return or destroy all Protected Health Information received from Plan, or created or received by Business Associate on behalf of Plan. This provision shall apply to Protected Health Information that is in

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the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.

(b) In the event that Business Associate determines that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to Plan notification of the conditions that make it infeasible. If return or destruction is infeasible, Business Associate shall extend the protections of this Agreement to such Protected Health Information and limit further Uses and Disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

MISCELLANEOUS

4.1 Use of Subcontractors and Agents. Business Associate shall require each of its agents and subcontractors that receive Protected Health Information from Business Associate, or create Protected Health Information for Business Associate, on behalf of Plan, to execute a written agreement obligating the agent or subcontractor to comply with all the terms of this Agreement.

4.2 Regulatory References. A reference in this Agreement to a section in the Privacy and Security Regulations means the section as in effect or as amended.

4.3 Interpretation. Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits Plan to comply with the Privacy and Security Regulations.

4.4 Amendment. The parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Plan to comply with the requirements of the Privacy and Security Regulations.

EXECUTION

Subject to the execution of the State Contract by CalOptima and the State, this Agreement shall become effective as of May 15, 2008 ("Effective Date").

In witness thereof, the parties have executed this Contract:

Health Management Systems, Inc.	CalOptima
Christina Dragonetti	Mark Finch, C.P.M.
Print Name	Print Name
Christina Dragonetti	
Signature	Signature
Senior Vice President	Purchasing Manager
Title	Title
5/19/08	5.8.2008
Date	Date

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AMENDMENT NO. 1 TO CONTRACT MC 03193

BETWEEN

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

AND

HEALTH MANAGEMENT SYSTEMS, INC. "HMS"
(VENDOR)

AMENDMENT NO. 1 TO THIS CONTRACT is entered into as of the 21st day of April, 2011, with respect to the following facts:

A. CalOptima and VENDOR entered into Contract MC 03193 on May 15, 2008 for Coordination of Benefit "COB" and Overpayment Recovery Services; and

B. CalOptima and VENDOR agree to delete the key personnel listed within Article II, Section 3 and replace with the following:

Name	Function/Title
Ronald D. Singh	Executive Vice President
James Carlough	Vice President Client Development

C. CalOptima and VENDOR agree to extend the Term of the Contract to May 14, 2014; and

D. CalOptima and VENDOR agree to delete the addressee information within Article VI, Section J and replace with the following:

Health Management Systems, Inc.	CalOptima
401 Park Avenue South	1120 W. La Veta Avenue
New York, NY 10016	Orange, CA 92868
Attention: Ronald D. Singh	Attention: Kathy Hoppe
Executive Vice President	Contract Administrator

E. CalOptima and VENDOR agree to delete Exhibit D, entitled "Business Associate Protected Health Information Disclosure Agreement" dated May 15, 2008 and replace with Attachment A to this Amendment No. 1 entitled "Business Associate Protected Health Information Disclosure Agreement" dated April 21, 2011 which is attached hereto and incorporated herein by this reference; and

F. CalOptima and VENDOR agree to incorporate, and VENDOR agrees to fill out, sign and return to CalOptima, Attachment B, entitled "Offshore Contractors Attestation" which is attached hereto and incorporated herein by this reference; and

G. CalOptima and VENDOR agree that if CalOptima purchases an additional service from VENDOR at any time throughout the duration of this Contract, CalOptima shall receive a three percent (3%) reduction in its rate for the Coordination of Benefit "COB" and Overpayment Recovery Services listed within this Contract.

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SIGNATURES -- This Amendment No. 1 to the Contract shall be made effective upon execution by both parties. IN WITNESS WHEREOF, the parties hereto have caused this Amendment No. 1 to the Contract to be executed on the date first above written.

Health Management Systems, Inc. (HMS)

By: _____

Ronald D. Singh
Executive Vice President

CalOptima

By: _____ for

Richard Chambers
Chief Executive Officer

By: _____ for

Michael Engelhard
Chief Financial Officer

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Business Associate Protected Health Information Disclosure Agreement

This Business Associate Protected Health Information Disclosure Agreement ("Agreement") is entered into by and between the Orange County Health Authority, a California local public agency, doing business as CalOptima ("Plan"), and Health Management Systems, Inc., ("Business Associate"), on this 21st day of April, 2011.

RECITALS

WHEREAS, the parties have executed an agreement(s) whereby Business Associate provides services to Plan, and Business Associate receives, has access to or creates Protected Health Information in order to provide those services ("Services Agreement(s)");

WHEREAS, as a Covered Entity, Plan is subject to the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act of 1996, and regulations promulgated thereunder, including the Standards for Privacy of Individually Identifiable Health Information at 45 Code of Federal Regulations Parts 160 and 164 ("Privacy Regulations") and the Security Standards for Electronic Protected Health Information ("Security Regulations") at 45 Code of Federal Regulations Parts 160 and 164 (together, the "Privacy and Security Regulations");

WHEREAS, as a Business Associate, VENDOR is subject to certain provisions of the Health Insurance Portability and Accountability Act of 1996, and regulations promulgated thereunder, as required by the HITECH Act, pursuant to Title XIII3 of the American Recovery and Reinvestment Act of 2009;

WHEREAS, the Privacy and Security Regulations require Plan to enter into a contract with Business Associate in order to mandate certain protections for the privacy and security of Protected Health Information, and those Regulations prohibit the disclosure to or use of Protected Health Information by Business Associate if such a contract is not in place;

WHEREAS, the Plan's regulator(s) have adopted certain administrative, technical and physical safeguards deemed necessary and appropriate by it/them to protect Protected Health Information and have required that Plan incorporate such requirements in its subcontracts with subcontractors that require access to the regulator(s)' Protected Health Information;

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:

DEFINITIONS

1.1 "Disclose" and "Disclosure" mean, with respect to Protected Health Information, the release, transfer, provision of access to, or divulging in any other manner of Protected Health Information outside Business Associate's internal operations or to other than its employees.

1.2 "Electronic Media" means:

(1) Electronic storage media including memory 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

(2) Transmission media used to exchange information already in electronic storage media. Transmission media include, for example, the internet (wide-open), extranet (using internet technology to link a business with information accessible only to collaborating parties), 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.

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1.3 "Electronic Protected Health Information" means Protected Health Information that is transmitted or maintained in electronic media.

1.4 "HHS" means the federal Department of Health and Human Services.

1.5 "HITECH Act" means the Health Information Technology for Economic and Clinical Health (HITECH) Act, codified at 42 U.S.C. §§ 17921–17954.

1.6 "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.

1.7 "Individual" means the person who is the subject of Protected Health Information and shall include a person who qualifies as a personal representative in accordance with 45 C.F.R. § 164.502(g).

1.8 "Protected Health Information" has the same meaning as the term "protected health information" in 45 C.F.R. § 164.501, limited to the information created or received by Business Associate from or on behalf of Plan. Protected Health Information includes information that (i) 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; (ii) identifies the Individual (or for which there is a reasonable basis for believing that the information can be used to identify the Individual); and (iii) is received by Business Associate from or on behalf of Plan, or is created by Business Associate, or is made accessible to Business Associate by Plan. "Protected Health Information" includes Electronic Protected Health Information.

1.9 "Security Incident" means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information in, or interference with system operations of, an Information System which contains Electronic Protected Health Information. However, Security Incident does not include attempts to access an Information System when those attempts are not reasonably considered by Business Associate to constitute an actual threat to the Information System.

1.10 "Required By Law" means a mandate contained in law that compels an entity to make a Use or Disclosure of Protected Health Information 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 any 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.

1.11 "Services" has the same meaning as in the Services Agreement(s).

1.12 "Use" or "Uses" mean, with respect to Protected Health Information, the sharing, employment, application, utilization, examination or analysis of such Information within Business Associate's internal operations.

1.13 "Unsecured Protected Health Information" means Protected Health Information that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of technology or methodology specified by the Secretary of HHS.

1.14 Terms used, but not otherwise defined, in this Agreement shall have the same meaning as those terms in the Privacy Regulations.

OBLIGATIONS OF BUSINESS ASSOCIATE

2.1 HITECH Compliance. Business Associate will comply with the requirements of Title XIII, Subtitle D of the HITECH Act, which are applicable to business associates, and will comply with all regulations issued by HHS to implement these referenced statutes, as of the date by which business associates are required to comply with such

referenced statutes and HHS regulations. Business Associate is also required to comply with the specific security administrative, physical and technical safeguards identified on Attachment A which is attached hereto and incorporated herein by this reference.

2.2 Permitted Uses and Disclosures of Protected Health Information. Business Associate:

(a) shall Use and Disclose Protected Health Information as necessary to perform the Services, and as provided in Sections 2.3, 2.4, 2.5, 2.6, 2.7, 2.8, 3.3 and 4.1 of this Agreement;

(b) shall Disclose Protected Health Information to Plan upon request;

(c) may, as necessary for the proper management and administration of its business or to carry out its legal responsibilities:

(i) Use Protected Health Information; and

(ii) Disclose Protected Health Information if the Disclosure is required by law.

Business Associate shall not Use or Disclose Protected Health Information for any other purpose.

2.3 Adequate Safeguards for Protected Health Information. Business Associate warrants that it shall implement and maintain appropriate safeguards to prevent the Use or Disclosure of Protected Health Information in any manner other than as permitted by this Agreement.

Specifically as to Electronic Protected Health Information, Business Associate warrants that it shall implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of Electronic Protected Health Information.

2.4 Notification of Breach. During the term of this Agreement:

(a) Discovery of Suspected or Actual Breach, Security Incident, Intrusion or Unauthorized Use or Disclosure of PHI or Loss of Confidential Data. Business Associate agrees to notify CalOptima immediately by telephone call plus e-mail or fax upon the discovery of breach of security of PHI in computerized form, or any suspected Security Incident, intrusion or unauthorized Use or Disclosure of PHI in violation of this Agreement, or potential or actual loss of confidential data related to the Services Agreement(s). Notification shall be provided to the CalOptima Privacy Officer (CalOptima's Director of Compliance), telephone number (714) 246-8594. Business Associate shall take:

(i) Prompt corrective action to mitigate any risks or damages involved with the breach, Security Incident, intrusion or unauthorized Use or Disclosure of PHI or potential or actual loss of confidential data and to protect the operating environment. Notwithstanding the foregoing, all corrective actions are subject to the approval of Plan and the Plan's regulator(s).

(ii) Any action pertaining to such breach, Security Incident, intrusion or unauthorized Use or Disclosure of PHI or potential or actual loss of confidential data required by applicable Federal and State laws and regulations.

(iii) Any additional corrective actions required by Plan or Plan's regulator(s).

(b) Investigation of Suspected or Actual Breach, Security Incident, Intrusion or Unauthorized Use or Disclosure of PHI or Loss of Confidential Data. Business Associate agrees to immediately investigate such Security Incident, breach, or unauthorized Use or Disclosure of PHI or potential or actual loss of confidential data. Within three (3) working days of the discovery, Business Associate shall notify the CalOptima Privacy Officer of matters described below:

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(i) The nature of the data elements involved and the extent of the data involved in the breach,

(ii) A description of the unauthorized persons known or reasonably believed to have improperly Used or Disclosed PHI or confidential data,

(iii) A description of where the PHI or confidential data is believed to have been improperly transmitted, sent, or utilized,

(iv) A description of the probable causes of the improper Use or Disclosure;

(v) 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 Protected Health Information;

(vi) 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

(vii) Whether Section 13402 of the HITECH Act (codified at 42 U.S.C. § 17932), Civil Code sections 1798.29 or 1798.82 or any other federal or state laws requiring individual notifications of breaches are triggered.

(c) Written Report. Business Associate shall provide a comprehensive written report to Plan no later than ten (10) working days after discovery of the Security Incident, breach, or other unauthorized Use or Disclosure of PHI or confidential data, providing a comprehensive discussion of the above matters identified in section 2.3(b) above and the following matters:

(i) The potential impacts of the incident, e.g. potential misuse of data, identity theft, etc;

(ii) The steps taken in mitigation to reduce the harmful effects of the breach, as required by Section 2.4; and

(iii) 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 Plan and the Plan's regulator(s).

2.5 Mitigation of Harmful Effect. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a Use or Disclosure of Protected Health Information by Business Associate in violation of the requirements of this Agreement.

2.6 Notification of Breach to Individuals. Business Associate shall comply with federal and state laws requiring notice to individuals of breaches of PHI or confidential data including, without limitation, Section 13402 of the HITECH Act, codified at 42 U.S.C. § 17932. Business Associate shall comply with all regulations issued by HHS to implement Section 13402, as of the date by which business associates are required to comply with such referenced statutes and HHS regulations. All such notifications to affected individuals shall be coordinated with Plan and Plan shall approve the time, manner, content and method for notice to individuals including, without limitation, requiring Business Associate to directly send and pay for such notices at Plan's discretion. Business Associate will immediately indemnify and pay Plan for (i) any and all fees and expenses Plan incurs in investigating, responding to, and/or mitigating a breach of PHI or confidential data caused by Business Associate or its subcontractors or agents; (ii) any damages, attorneys fees, costs, liabilities or other sums actually incurred by Plan due to a claim, lawsuit, or demand by a third party arising out of a breach of PHI or confidential data caused by Business Associate or its subcontractors or agents; and/or (iii) for fines, assessments and/or penalties assessed or imposed against Plan by any government agency/regulator based on a breach of PHI or confidential data caused by Business Associate or

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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.

2.7 Employee Training and Discipline. Business Associate agrees to train and use reasonable measures to ensure compliance with the requirements of this Agreement by employees, volunteers and, if permitted, subcontractors who assist in the performance of functions or activities under this Agreement and Use or Disclose PHI. Business Associate agrees to discipline such employees, volunteers and subcontractors who intentionally violate any provisions of this Agreement, including by termination of employment or subcontract.

2.8 Availability of Internal Practices, Books and Records to Government Agencies. Business Associate agrees to make its internal practices, books and records relating to the Use and Disclosure of Protected Health Information available to the Secretary of HHS for purposes of determining Plan's compliance with the Privacy and Security Regulations. . Business Associate also agrees to make its internal practices, books and records relating to the Use and Disclosure of Protected Health Information available to the Plan and the Secretary of HHS for purposes of determining Business Associate's compliance with the applicable Privacy and Security Regulations. Business Associate shall immediately notify Plan of any requests made by the Secretary of HHS and provide Plan with copies of any documents produced in response to such request.

2.9 Access to Protected Health Information. Business Associate shall, to the extent Plan determines that any Protected Health Information constitutes a "designated record set" as defined by 45 C.F.R. § 164.501, make the Protected Health Information specified by Plan available to the Individual(s) identified by Plan as being entitled to access and copy that Protected Health Information. Business Associate shall provide such access for inspection of that Protected Health Information within thirty (30) calendar days after receipt of request from Plan. Business Associate shall also provide copies of that Protected Health Information within thirty (30) calendar days after receipt of request from Plan.

2.10 Amendment of Protected Health Information. Business Associate shall, to the extent Plan determines that any Protected Health Information constitutes a "designated record set" as defined by 45 C.F.R. § 164.501, make any amendments to Protected Health Information that are requested by Plan. Business Associate shall make such amendment within thirty (30) calendar days after receipt of request from Plan in order for Plan to meet the requirements under 45 C.F.R. § 164.526.

2.11 Accounting of Disclosures. Upon Plan's request, Business Associate shall provide to Plan an accounting of each Disclosure of Protected Health Information made by Business Associate or its employees, agents, representatives or subcontractors.

Any accounting provided by Business Associate under this Section 2.11 shall include:

(a) the date of the Disclosure;

(b) the name, and address if known, of the entity or person who received the Protected Health Information;

(c) a brief description of the Protected Health Information disclosed; and

(d) a brief statement of the purpose of the Disclosure.

For each Disclosure that could require an accounting under this Section 2.11, Business Associate shall document the information specified in (a) through (d), 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). Business Associate shall not, however, be required to maintain such information for disclosures of Protected Health Information:

(a) to carry out treatment, payment, and health care operations on behalf of Plan, or that are incident to such disclosures;

(b) to individuals of protected health information about them; or

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(c) pursuant to a written authorization given by or on behalf of the individual.

Business Associate shall provide to Plan, within thirty (30) calendar days after receipt of request from Plan, information collected in accordance with this Section 2.11 to permit Plan to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. § 164.528.

2.12 Audits, Inspection and Enforcement. From time to time, Plan 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 any provision of this Agreement and shall certify the same to the Plan in writing. The fact that Plan inspects, or fails to inspect, or has the right to inspect, Business Associate's facilities, systems and procedures does not relieve Business Associate of its responsibility to comply with this Agreement, nor do the following constitute acceptance of Plan's:

(a) Failure to detect or

(b) Detection, but failure to notify Business Associate or require Business Associate's remediation of any unsatisfactory practices constitutes acceptance of such practice or a waiver of CalOptima's enforcement rights under this Agreement.

TERM AND TERMINATION

3.1 Term. This Agreement shall remain in effect as long as any Services Agreement is in effect. Business Associate's obligations under Sections 2.1, 2.2, 2.4, 2.5, 2.6, 2.7, 2.8, 2.9, 2.10, 2.11, 2.12 and 3.3 shall survive the termination or expiration of this Agreement.

3.2 Termination for Cause. In addition to and notwithstanding the termination provisions set forth in the Services Agreement(s), upon Plan's knowledge of a material breach by Business Associate, Plan shall either:

(a) Provide an opportunity for Business Associate to cure the breach or end the violation and terminate this Agreement if Business Associate does not cure the breach or end the violation within the time specified by Plan; or

(b) Immediately terminate this Agreement if Business Associate has breached a material term of this Agreement and cure is not possible.

If neither termination nor cure is feasible, Plan shall report the violation to the Secretary of HHS.

3.3 Disposition of Protected Health Information upon Termination or Expiration.

(a) Except as provided in paragraph (b) of this section, upon termination for any reason of this Agreement and the Services Agreement(s), Business Associate shall return or destroy all Protected Health Information received from Plan, or created or received by Business Associate on behalf of Plan in accordance with data destruction methods specified in Attachment A to this Agreement. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.

(b) In the event that Business Associate determines that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to Plan notification of the conditions that make it infeasible. Subject to the approval of Plan's regulator(s) if necessary, if return or destruction is infeasible, Business Associate shall extend the protections of this Agreement to such Protected Health Information and limit further Uses and Disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

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MISCELLANEOUS

4.1 Use of Subcontractors and Agents. Business Associate shall require each of its agents and subcontractors that receive Protected Health Information from Business Associate, or create Protected Health Information for Business Associate, on behalf of Plan, to execute a written agreement obligating the agent or subcontractor to comply with all the terms of this Agreement.

4.2 Regulatory References. A reference in this Agreement to a section in the Privacy and Security Regulations means the section as in effect or as amended.

4.3 Interpretation. Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits Plan to comply with the Privacy and Security Regulations.

4.4 Amendment. The parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Plan to comply with the requirements of the Privacy and Security Regulations.

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Attachment A

Business Associate Data Security Requirements
Subcontractors with Access to DHCS Data and PHI

DEFINITIONS

A. "DHCS Data" means for purposes of this Attachment A, all information provided by DHCS to the Plan which is accessed by Business Associate under the Services Agreement.

B. "DHCS PHI" means for purposes of this Attachment A, Protected Health Information and a subset of DHCS Data.

C. "Approved Technical Encryption Solution" means an industry recognized encryption solution or an encryption solution approved by CalOptima's regulator(s).

I. GENERAL SECURITY CONTROLS

1.1 Confidentiality Statement. All persons that will be working with DHCS PHI must sign an annual confidentiality statement prior to access to DHCS PHI. Business Associate shall retain each person's written confidentiality statement for CalOptima inspection for a period of three (3) years following contract termination.

1.2 Background check. Before a member of the Business Associate's workforce may access DHCS PHI, Business Associate must conduct a thorough background check of that worker and evaluate the results to assure that there is no indication that the worker may present a risk for theft of confidential data. The Business Associate shall retain each workforce member's background check documentation for CalOptima inspection for a period of three (3) years following contract termination.

1.3 Workstation/Laptop encryption. All workstations and laptops that process and/or store Protected Health Information must be encrypted with an Approved Technical Encryption Solution.

1.4 Minimum Necessary. Only the minimum necessary amount of DHCS PHI may be downloaded to a laptop or hard drive when absolutely necessary for current business purposes.

1.5 Removable media devices. All electronic files that contain DHCS PHI must be encrypted when stored on any removable media type device (i.e. USB thumb drives, floppies, CD/DVD, etc.) with an Approved Technical Encryption Solution

1.6 Email security. All emails that include DHCS PHI must be sent in an encrypted method using an Approved Technical Encryption Solution.

1.7 Antivirus software. All workstations, laptops and other systems that process and/or store DHCS PHI must have a commercial third-party anti-virus software solution with a minimum daily automatic update.

1.8 Patch Management. All workstations, laptops and other systems that process and/or store DHCS PHI must have security patches applied and up-to-date.

1.9 User IDs and Password Controls. All users must be issued a unique user name for accessing DHCS PHI. Passwords are not to be shared, must be at least eight characters, be a non-dictionary word, stored in readable format on the computer, changed every 60 days, and changed if revealed or compromised. Passwords must be composed of characters from at least three of the following four groups from the standard keyboard:

- Upper case letters (A-Z)
- Lower case letters (a-z)
- Arabic numerals (0-9)
- Non-alphanumeric characters (punctuation symbols)

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1.10 Data Destruction. All PHI must be wiped from systems when the data is no longer necessary. The wipe method must conform to Department of Defense standards for data destruction (known as DoD 5220.22-M) or other solution approved in advance by CalOptima's regulator(s). All paper containing DHCS data must be shredded. Once data has been destroyed, CalOptima must be notified.

1.11 Remote Access. Any remote access to DHCS PHI must be executed over an Approved Technical Encryption Solution. All remote access must be limited to minimum necessary and least privilege principles.

II. SYSTEM SECURITY CONTROLS

2.1 System Timeout. The system must provide an automatic timeout after no more than 20 minutes of inactivity.

2.2 Warning Banners. All systems containing DHCS PHI must display a warning banner stating that data is confidential, systems are logged, and system use is for business purposes only. Users must be directed to log off the system if they do not agree with these requirements.

2.3 System Logging. The system must log success and failures of user authentication at all layers. The system must log all system administrator/developer access and changes if the system is processing and/or storing DHCS PHI. The system must log all user transactions at the database layer if processing and/or storing DHCS PHI.

2.4 Access Controls. The system must use role based access controls for all user authentications, enforcing the principle of least privilege.

2.5 Transmission encryption. All data transmissions must be encrypted end-to-end using an Approved Technical Encryption Solution when transmitting PHI such as solutions using 128bit SSL, FTPS or SFTP.

III. AUDIT CONTROLS

3.1 System Security Review. All systems processing and/or storing DHCS PHI must have at least an annual system security review. Reviews must include administrative and technical vulnerability scanning tools.

3.2 Log Reviews. All systems processing and/or storing DHCS PHI must have a routine procedure in place to review system logs for unauthorized access.

3.3 Change Control. All systems processing and/or storing DHCS PHI must have a documented change control procedure that ensures separation of duties and protects the confidentiality, integrity and availability of data.

IV. BUSINESS CONTINUITY / DISASTER RECOVERY CONTROLS

4.1 Emergency Mode Operation Plan. Business Associate must establish a documented plan to enable continuation of critical business processes and protection of the security of electronic PHI in the event of an emergency. Emergency means any circumstance or situation that causes normal computer operations to become unavailable for use in performing the work required under the Services Agreement(s) for more than 24 hours.

4.2 Data Backup Plan. Business Associate must have established documented procedures to backup DHCS PHI to maintain retrievable exact copies of DHCS PHI. The plan must include a regular schedule for making backups, storing backup's offsite, an inventory of backup media, and the amount of time to restore DHCS PHI should it be lost. At a minimum, the schedule must be a weekly full backup and monthly offsite storage of CalOptima data.

V. PAPER DOCUMENT CONTROLS

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5.1 Supervision of Data. DHCS PHI in paper form shall not be left unattended at any time, unless it is locked in a file cabinet, file room, desk or office. Unattended means that information is not being observed by an employee authorized to access the information. DHCS PHI in paper form shall not be left unattended at any time in vehicles or planes and shall not be checked in baggage on commercial airplanes.

5.2 Escorting Visitors. Visitors to areas where DHCS PHI is contained shall be escorted and DHCS PHI shall be kept out of sight while visitors are in the area.

5.3 Confidential Destruction. DHCS PHI must be disposed of through confidential means, such as cross cut shredding and pulverizing.

5.4 Removal of Data. If CalOptima provides Business Associate with access to DHCS PHI to perform services off-site (i.e. not at CalOptima's business premises), Business Associate shall not remove DHCS PHI to any overseas or offshore location. In the event that Business Associate is permitted to deliver DHCS PHI to any party as part of its obligations under the Services Agreement(s), then Business Associate shall comply with all safeguard requirements related to the transmission and/or delivery of DHCS PHI set forth in this Attachment.

5.5 Faxing. Faxes containing DHCS PHI shall not be left unattended and fax machines shall be in secure areas. Faxes shall contain a confidentiality statement notifying persons receiving faxes in error to destroy them. Fax numbers shall be verified with the intended recipient before sending.

5.6 Mailing. DHCS PHI shall only be mailed using secure methods. Large volume mailings of PHI shall be by a secure, bonded courier with signature required on receipt. Disks and other transportable media sent through the mail must be encrypted with an Approved Technical Encryption Solution.

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CalOptima
A Public Agency
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MC 03193
Amendment No. 1
Attachment B

Offshore Contractors Attestation

Check which CalOptima line/s of business this form pertains to:

√ OneCare
√ Medi-Cal
√ Healthy Families

Are any administrative or other functions conducted on behalf of your organization by entities located offshore? ("X" where appropriate)

No [X] if no, please complete Part I and return the document with Amendment No. 1 to khoppe@caloptima.org.

Yes [ ] if yes, please complete Parts II – VI of this form and return the document with Amendment No. 1 to khoppe@caloptima.org.

Part I – Our Firm is Not Using Offshore Subcontractors

Name of Organization:	HEALTH MANAGEMENT SYSTEMS
Federal Tax I.D. No:	13-2770433
Name of Authorized Person:	SANDRA MCMANUS
Title:	SR. OPERATIONS DIRECTOR
Signature:	
Date:	5/6/11

Part II – Offshore Subcontractor Information

Subcontractor Name:	
Subcontractor Country:	
Subcontractor Address:	

Describe Offshore Subcontractor Functions:

State Proposed or Actual Effective Date for Offshore Subcontractor: _____

Part III – Precautions for Protected Health Information (PHI)

1. Describe the PHI that will be provided to the Offshore Subcontractor:

2. Discuss why providing PHI is necessary to accomplish the Offshore Subcontractor objectives:

3. Describe alternatives considered to avoid providing PHI, and why each alternative was rejected:

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CalOptima
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MC 03193
Amendment No. 1
Attachment B

Part IV – Attestation of Safeguards to Protect Beneficiary Information in the Offshore Subcontract

Item	Attestation	Response Yes / No
A.	Offshore subcontracting arrangement has policies and procedures in place to ensure that Medi-Cal beneficiary protected health information (PHI) and other personal information remains secure.	
B.	Offshore subcontracting arrangement prohibits subcontractor's access to Medi-Cal data not associated with CalOptima's contract with the offshore subcontractor.	
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.	
D.	Offshore subcontracting arrangement includes all required DHCS language as stipulated within your contract with CalOptima.	

Part V – Attestation of Audit Requirements to Ensure Protection of PHI

Item	Attestation	Response Yes / No
A.	Your organization will conduct an annual audit of the Offshore subcontractor.	
B.	Audit result will be used by your organization to evaluate the continuation of its relationship with the Offshore subcontractor.	
C.	Your organization agrees to share Offshore subcontractor's audit results with CalOptima, upon request.	

Part VI – Organization Information

Name of Organization:	
Federal Tax I.D. No:	
Name of Authorized Person:	
Title:	
Signature:	
Date:	

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AMENDMENT NO. 2 TO CONTRACT MC 03193

BETWEEN

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

AND

HEALTH MANAGEMENT SYSTEMS, INC. "HMS"
(VENDOR)

AMENDMENT NO. 2 TO THIS CONTRACT is entered into as of the May 15, 2014, with respect to the following facts:

A. CalOptima and VENDOR entered into Contract MC 03193 on May 15, 2008 for Coordination of Benefit "COB" and Overpayment Recovery Services.

B. CalOptima and VENDOR desire to extend the Contract Term.

C. CalOptima and VENDOR desire to reduce the Contingency Percentage Fee for COB and Overpayment Recovery Services for Medi-Cal and Rx.

D. CalOptima requires VENDOR to provide updated Offshore Contractors Attestation information.

E. CalOptima and VENDOR entered into Amendment No. 1 to this Contract on April 21, 2011.

NOW, THEREFORE, THE PARTIES AGREE AS FOLLOWS:

1. CalOptima and VENDOR agree to extend the Term of the Contract to May 14, 2017, after which the contract shall automatically terminate unless renewed via written Amendment signed by both parties. within thirty (30) days of the expiration date of the current term. .

2. Amend the Original Contract Exhibit B, paragraph 4, first sentence in its entirety and replace with "VENDOR's rate shall be a Contingency Fee of Twenty-Three percent (23%)".

3. VENDOR shall complete, sign and return Attachment No. 1 to this Amendment No. 2, entitled "Offshore Contractors Attestation" which is attached hereto and incorporated herein by this reference.

4. The flowchart attached hereto as Attachment No. 2 to this Amendment No. 2 is being added to help all parties understand the flow of data between each party and includes guidelines on what collections can be made by VENDOR.

5. All invoices shall be submitted electronically to accountspayable@caloptima.org and shall cite "Contract MC 03193, Amendment No. 2.

6. All other terms and conditions listed within the Contract not affected by this Amendment No. 2 shall remain in full force and effect.

7. SIGNATURES – This Amendment No. 2 to the Contract shall be made effective upon execution by both parties.

[Remainder of Page Left Intentionally Blank]

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IN WITNESS WHEREOF, the parties hereto have caused this Amendment No. 2 to the Contract to be executed on the date first above written.

Health Management Systems, Inc. (HMS)
By: H. Brent Sanders

Ronald D. Singh
Executive Vice President

H. Brent Sanders
Vice President, Commercial sales

CalOptima
By: _____

Chet Uma
Chief Financial Officer

By: _____

Michael Schrader
Chief Executive Officer

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Offshore Contractors Attestation

Check which CalOptima line/s of business this form pertains to:

- √ OneCare
- √ Medi-Cal
- √ Healthy Families

Are any administrative or other functions conducted on behalf of your organization by entities located offshore? ("X" where appropriate)

No ☐ If no, please complete Part I and return the document as part of Amendment No. 2.

Yes ☒ If yes, please complete Parts II through VI of this form and return the document as part of Amendment No. 2.

Part I – Our Firm is Not Using Offshore Subcontractors

Name of Organization:	
Federal Tax I.D. No:	
Name of Authorized Person:	
Title:	
Signature:	
Date:	

Part II –Offshore Subcontractor Information

Subcontractor Name:	***See Attached List***
Subcontractor Country:	
Subcontractor Address:	

Describe Offshore Subcontractor Functions:

State Proposed or Actual Effective Date for Offshore Subcontractor: _____

Part III –Precautions for Protected Health Information (PHI)

1. Describe the PHI that will be provided to the Offshore Subcontractor:
There is remittance that is available to the employee, but data RESIDES in the US.

2. Discuss why providing PHI is necessary to accomplish the Offshore Subcontractor objectives:
PHI is at the heart of what HMS does (Coordination of Benefits)

3. Describe alternatives considered to avoid providing PHI, and why each alternative was rejected:
The data is critically necessary for each function, so there is no way to avoid it.

Part IV – Attestation of Safeguards to Protect Beneficiary Information in the Offshore Subcontract

Item	Attestation	Response Yes / No
A.	Offshore subcontracting arrangement has policies and procedures in place to ensure that Medi-Cal beneficiary protected health information (PHI) and other personal information remains secure.	Yes
B.	Offshore subcontracting arrangement prohibits subcontractor's access to Medi-Cal data not associated with CalOptima's contract with the offshore subcontractor.	Yes
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
D.	Offshore subcontracting arrangement includes all required DHCS language as stipulated within your contract with CalOptima.	Yes

Part V – Attestation of Audit Requirements to Ensure Protection of PHI

Item	Attestation	Response Yes / No
A.	Your organization will conduct an annual audit of the Offshore subcontractor.	Yes
B.	Audit result will be used by your organization to evaluate the continuation of its relationship with the Offshore subcontractor.	Yes
C.	Your organization agrees to share Offshore subcontractor's audit results with CalOptima, upon request.	Yes

Part VI – Organization Information

Name of Organization:	Health Management Systems, Inc.
Federal Tax I.D. No:	
Name of Authorized Person:	Beau Fidler
Title:	VP Account Management
Signature:	
Date:	3/4/15

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HMS Off-Shore Contractors

Subcontractor Name:	HOVG
Subcontractor Country:	USA
Subcontractor Address:	1901 W. 10th Street - Antioch, CA 94509 - 925-757-4533
Describe Offsore Subcontractor Functions:	
Claims Recovery	

Subcontractor Name:	MiraMed
Subcontractor Country:	Chennai, India
Subcontractor Address:	Donna.perry@ajubanet.net - 877-702-5822 - ext 6502
Describe Offsore Subcontractor Functions:	
Claims Recovery	

Subcontractor Name:	Datamatics
Subcontractor Country:	Chennai, India
Subcontractor Address:	Sunil_dixit@datamaticstech.com - 734-525-5228
Describe Offsore Subcontractor Functions:	
Health Plan Verifications	

Subcontractor Name:	Source HOV
Subcontractor Country:	Chennai, India
Subcontractor Address:	Ramith.anthony@hovservices.com
Describe Offsore Subcontractor Functions:	
Keypunch & Lockbox Imaging	

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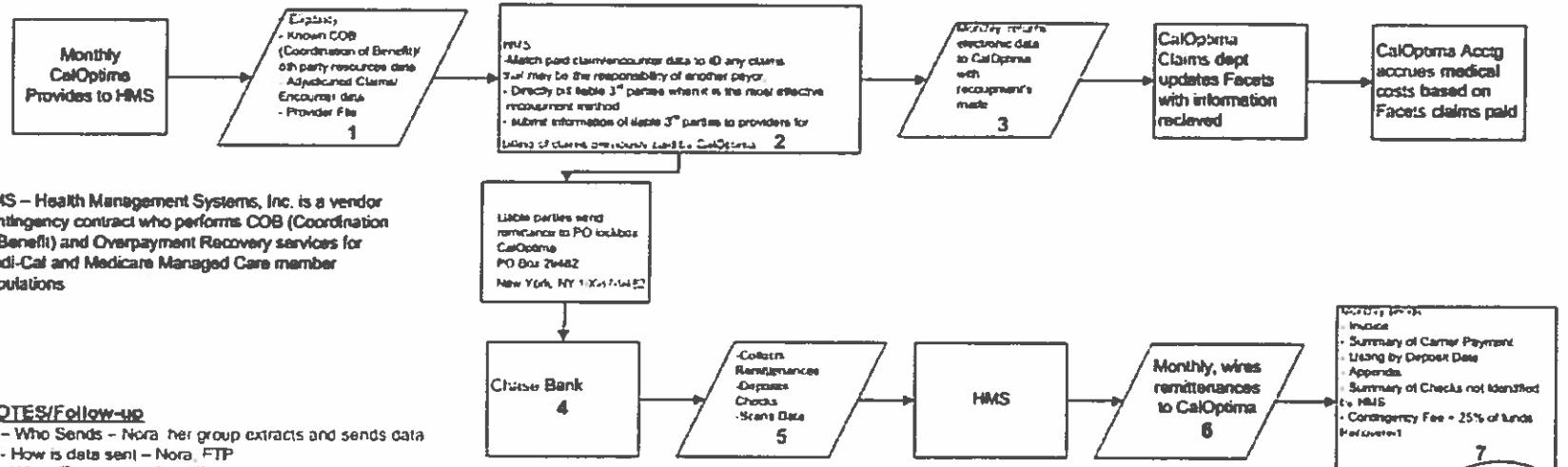
HMS – Health Management Systems, Inc., Interaction Flow



HMS – Health Management Systems, Inc. is a vendor contingency contract who performs COB (Coordination of Benefit) and Overpayment Recovery services for Medi-Cal and Medicare Managed Care member populations

NOTES/Follow-up

1. – Who Sends – Nora her group extracts and sends data
   - How is data sent – Nora, FTP
   - When/Frequency of sending – Nora, Monthly. Alberta only new claims (latest info) is sent
   - What other data is passed – Nora, None
2. – Not verified with vendor (HMS) Verified with HMS
3. – Who receives – Nora, received from HMS via FTP Posted to G Drive for Claims review
   Alberta, lately, returns have been sporadic
   - How is this received? – See above
   - What is done with data? – See above Alberta her team does the review If other insurances are discovered, identified changes are passed to Member Services for COB update (in FACETS) This is then updated to the State System (sent to SSA) via forms State sends data back to update CalOptima data
   - Are these booked to the member? Nora, not by IS
4. – HMS set-up lock box with Chase under CalOptima name. Who has access? This serves as a central repository Carriers can send payment to this PO Box HMS only has read only access and will log in for reconciliation purposes (monies that are received and EOBs)! HMS will provide list of authorized users
   - Do we have a BAA with Chase? HMS will send a copy
5. – Not verified
6. - Who reconciles remittenances? Monthly Chase will initiate wire transfer all monies collected Budget has reconciled
   Invoices received to monthly remittenances for Calendar 2014. We have no evidence that this was performed in the past.
   - How are payments booked to member (how are claims adjusted to member)?
   - What back-up data is received and to who?
7. – Invoices are addressed to Marsha Buford. Is there addt'l info sent to CalOptima?
   Match wire transfer to? – Alberta Marsha was previous Claims Director Michelle Hoban validates the monthly report to ensure the Claims are in our system There is no detailed review of the data Note an additional sheet with member data is received (Ken-we have not reviewed this sheet. We have not reviewed the validation procedures). Alberta EOB comes from the carrier EOB should (835's electronic remit) comes with the payment
8. – Source: HMS
9. – As stated by the Director. This has not been verified

Note: HMS will only follow-up on items going back 3 years from date of service. Most collections are made within the first 90 days. 120 days and greater less of collection chance. It is in HMS best interest to track down the EOB from the carrier. When asked how CalOptima could have received a collection for a non-CalOptima member, HMS replied that it could happen via human error. Collection sent to the wrong lock box

Legend:
Nora Onishi, 12-5-14
Alberta Forester, 12-8-14
HMS 12-16-14
Budget

Follow-up, 2-13-15:

- *On-going maintenance to reconcile HMS invoice to funds received via Wire Transfer – Accounting*
- *Reconcile received HMS FTP file to our membership - Claims*
- *Link Claims received to member file (for RDT purposes) – Claims & IS*
- *Review HMS processes to ensure 1. Contract terms are enforce and, 2. Scenarios which occurred are addressed in HMS workflow. - Finance*

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AMENDMENT NO. 3 TO CONTRACT MC 03193
BETWEEN
ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, DBA ORANGE
PREVENTION AND TREATMENT INTEGRATED MEDICAL ASSISTANCE,
DBA CALOPTIMA
AND
HEALTH MANAGEMENT SYSTEMS, INC. "HMS"
(VENDOR)

AMENDMENT NO. 3 TO THIS CONTRACT is entered into as of the date last executed below, with respect to the following facts:

A. CalOptima and VENDOR entered into Contract MC 03193 on May 15, 2008 for Coordination of Benefit "COB" and Overpayment Recovery Services.

B. CalOptima and Vendor entered into Amendment No. 1 on April 21, 2011 and Amendment No. 2 on May 15th, 2014.

C. CalOptima and VENDOR desire to extend the Contract Term.

NOW, THEREFORE, THE PARTIES AGREE AS FOLLOWS:

1. Extend the Contract to May 14th, 2020.

2. All invoices shall be submitted electronically to accountspayable@caloptima.org and shall cite Contract MC 03193, Amendment No. 3.

3. All other terms and conditions listed within the Contract and previous two Amendments not affected by this Amendment No. 3 shall remain in full force and effect.

4. SIGNATURES – This Amendment No. 3 to the Contract shall be made effective upon execution by both parties.

IN WITNESS WHEREOF, the parties hereto have caused this Amendment No. 3 to the Contract to be executed on the date last executed below.

Health Management Systems, Inc. (HMS)

Name: Richard Fidler

Signature: _____

Title: VP, Health Plan Solutions

Date: 4/5/17

CalOptima

Name: Nancy Huang

Signature: _____

Title: Int. CFO & treasurer

Date: 4-7-17

Name: Michael Schrader

Signature: _____

Title: CEO

Date: 4-10-17

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AMENDMENT NO. 4 TO CONTRACT MC 03193
BETWEEN
ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, DBA ORANGE
PREVENTION AND TREATMENT INTEGRATED MEDICAL ASSISTANCE,
DBA CALOPTIMA
AND
HEALTH MANAGEMENT SYSTEMS, INC. "HMS"
(VENDOR)

AMENDMENT NO. 4 TO THIS CONTRACT is entered into as of the date last executed below, with respect to the following facts:

A. CalOptima and VENDOR entered into Contract MC 03193 on May 15, 2008 for Coordination of Benefit "COB" and Overpayment Recovery Services.

B. CalOptima and Vendor entered into Amendment No. 1 on April 21, 2011, Amendment No. 2 on May 15th, 2014, and Amendment No. 3 on April 10, 2017.

C. CalOptima and VENDOR desire to extend the Contract Term.

NOW, THEREFORE, THE PARTIES AGREE AS FOLLOWS:

1. Extend the Contract to May 14th, 2023.

2. All invoices shall be submitted electronically to accountspayable@caloptima.org and shall cite Contract MC 03193, Amendment No. 4.

3. All other terms and conditions listed within the Contract and previous three Amendments not affected by this Amendment No. 4 shall remain in full force and effect.

4. SIGNATURES – This Amendment No. 4 to the Contract shall be made effective upon execution by both parties.

IN WITNESS WHEREOF, the parties hereto have caused this Amendment No. 4 to the Contract to be executed on the date last executed below.

Health Management Systems, Inc. (HMS)

Name: Maria Perrin

Signature: DocuSigned by: Maria Perrin C7CE114128A349B...

Title: EVP, Chief Growth Officer

Date: 4/23/2020

CalOptima

Name: Nancy Huang

Signature: DocuSigned by: Nancy Huang D22E3B87032946F...

Title: CFO, CalOptima

Date: 04/27/2020

Name: Richard Sanchez

Signature: DocuSigned by: Richard Sanchez 234AD421BDEC4D9...

Title: Interim CEO, CalOptima

Date: 04/27/2020

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May 13, 2021

VIA FEDEX

CalOptima
1120 W. La Veta Ave.
Orange, CA 92868
Attn: Mark Finch, C.P.M., Purchasing Manager

Dear Mr. Finch:

We are writing in follow up to our March 31, 2021 notice regarding the pending acquisition of HMS Holdings Corp. (together with its subsidiaries, "HMS") by Gainwell Acquisition Corp. ("Gainwell"). We are pleased to inform you that the transaction has now closed, resulting in a change of control for HMS.

As a Gainwell Technologies Company, HMS will continue with its Medicaid, Managed Care and Medicare Advantage coordination of benefits operations, and Cotiviti, Inc. ("Cotiviti") acquired the HMS capabilities focused on population health management, payment integrity for the commercial, Medicare and Medicaid markets and coordination of benefits for the commercial markets (collectively, the "Transaction"). The Transaction does not have any impact on your agreements with HMS (collectively, the "Agreements"), as the contracting entity remains Health Management Systems, Inc. and the payment information remains the same. The combination of Gainwell and HMS will enable us to bring new innovative technologies and solutions to you and help you deliver great health and human services outcomes in the communities we both serve.

In further fulling our contractual obligations, we respectfully request that you return a signed copy of this letter to us by email at legal@hms.com by May 31, 2021, which will constitute your acknowledgment and agreement, that any notice or consent requirements related to the Transaction under the Agreements have been fulfilled and that you waive any termination rights that you may have with respect to the Transaction. A digital or scanned and emailed signature will be deemed an original signature. If you would like to discuss this matter further, please contact your HMS account manager. We are excited about the opportunities this transaction will offer and appreciate your prompt attention to this matter.

Sincerely,

Maria Perrin
Chief Growth Officer

Acknowledged and Agreed to as of this ____ day of _____ 2021:

By: _____
Name:_____
Title:_____

Emdeon Payer Agreement

Customer #: _____
File #: _____
Contract ID: MC 04123

This agreement ("Agreement") is entered into between the Payer identified below ("Payer") and Envoy LLC, an Emdeon company ("Emdeon"). This Agreement governs the use of the Emdeon Services selected below. This Agreement includes the General Terms and Conditions set forth below as well as the Terms and Conditions contained in the selected Emdeon Services Schedule(s) (individually, a "Service Schedule" and collectively, the "Service Schedules").

SECTION 1 - PAYER ADDRESSES AND CONTACT INFORMATION.

Payer Information		**Billing Information** (for Invoices)	
Payer Tax ID 33-0599891		X *Same as Payer*	
Payer Name **ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, D/B/A ORANGE PREVENTION AND TREATMENT INTEGRATED MEDICAL ASSISTANCE D/B/A CALOPTIMA**		Payer Name	
Primary Contact Mark Finch, C.P.M., CPPO	Email address: mfinch@caloptima.org	Primary Contact Linda Rodriguez	email address: lrodriguez@caloptima.org
Address 1120 West La Veta Avenue		Address Same	
City Orange		City Same	
State CA	Zip 92868	State Same	Zip Same
Telephone 714-246-8660	Fax	Telephone 714-246-8566	Fax

SECTION 2 - SELECTION OF EMDEON SERVICES.

X Emdeon E-Services (Governed by the additional Terms and Conditions outlined on **Emdeon E-Services Schedule**)

SECTION 3 - GENERAL TERMS AND CONDITIONS.

A. Fees.

1. Payment Terms. Payer shall pay all fees and expenses outlined in the applicable Services Schedule(s). Payments for all fees and expenses are due in full within thirty (30) days from the original invoice date, and all payments shall be made in U.S. dollars. Payer agrees to pay a late charge of one and one-half percent (1.5%) per month or the maximum lawful rate, whichever is less, for all amounts that remain due and payable by Payer to Emdeon for more than thirty (30) days. In the event Payer has a good faith dispute related to an invoiced amount, Payer shall notify Emdeon within ten (10) days of receipt of the disputed invoice. Payer shall pay the remaining balance of the undisputed invoiced amount in accordance with this section. Both parties shall work diligently and in good faith to resolve any disputed invoice amounts within thirty (30) days of notice of a dispute. Any invoice issued under this Agreement that is not disputed in good faith by Payer within ninety (90) days of such invoice's original date shall be deemed accepted by Payer and Payer agrees to waive any and all claims related thereto.

2. Taxes. Payer shall be responsible for and pay all federal, state, and local taxes or other levies ("Taxes") that are imposed, designated, levied, or based upon the services and products provided for herein, excluding those taxes based on net income derived by Emdeon. Payer shall indemnify and hold Emdeon harmless from all claims and liability resulting from Payer's failure to pay such amounts. All fees set forth in any Services Schedule are quoted exclusive of all Taxes.

B. Term.

1. Term of Agreement. This Agreement shall commence on the Effective Date and shall remain in effect so long as any Services Schedule is in effect and has neither expired nor been terminated.

2. Termination.

a. Either party may terminate this Agreement and any Services Schedule: (i) if the other party fails to perform its material obligations under this Agreement, and such failure is not corrected within thirty (30) days after receipt of written notice of the same, except in the case of failure to pay fees, which must be cured within ten (10) days after receipt of notice from Emdeon; or (ii) if a trustee is appointed to either party for the benefit of creditors, or either party becomes insolvent, bankrupt or initiates a voluntary dissolution; or (iii) as provided for within each Services Schedule. If Payer fails to make payments to Emdeon in accordance with this Agreement, such failure shall be considered substantial nonperformance and cause for termination or, at Emdeon's option, cause for suspension of all services in accordance with Section 3.B.3. below.

b. Termination for Unavailability of Funds -- In recognition that Payer is a governmental entity and its operations and budgets are determined on an annual basis, Payer shall have the right to terminate this agreement, contract, or purchase order if it does not receive funding from the State of California for any fiscal year. Payer agrees to promptly pay Emdeon all fees and other charges due and payable as of the termination date. In the event of Termination for Unavailability of Funds, and funds are received by Payer from the State of California within one-hundred twenty (120) days of the date of termination, then Payer shall promptly notify Emdeon in writing and Payer shall have the right to reinstate this Agreement, contract or purchase order for that period for which funds are received by Payer or the unexpired term of this Agreement, contract or purchase order as of the date of termination, whichever period is shorter in duration, and Payer shall pay all sums due prior to such termination and any expenses incurred in the interruption and resumption of services. Notwithstanding the foregoing, Payer may only reinstate this Agreement, contract or purchase order two (2) times during its term.

3. Suspension. If Emdeon elects to suspend services pursuant to Section 3.B.2., Emdeon shall give Payer ten (10) days prior notice (unless Emdeon deems immediate suspension necessary to prevent harm to Emdeon or its business) and Emdeon shall have no liability to Payer for delay or damage caused Payer by such suspension. Before resuming services, Emdeon shall be paid all sums due prior to suspension and any expenses incurred in the interruption and resumption of the services. If services are suspended, Emdeon reserves the right to terminate this Agreement in accordance with the last sentence of Section 3.B.2., at any time by giving not less than five (5) days prior written notice.

4. Effect of Termination. Upon termination of this Agreement for any reason, all rights granted to Payer hereunder shall terminate, and Payer shall immediately discontinue use of all products and services authorized under this Agreement and the Service Schedule(s) (the "Emdeon Products and Services") and pay all outstanding amounts due to Emdeon hereunder. In addition, Payer shall promptly return all data, drawings, diagrams, designs, documents, software, specifications, input formats, manuals, hardware and materials supplied by Emdeon to Payer ("Emdeon Materials"). In such event, Payer shall certify in writing to Emdeon that every and all such Emdeon Materials in Payer's possession have been returned to Emdeon. In the event of any termination or expiration of this Agreement, Sections 3.B.4., 3.C, 3.D, 3.F, 3.G and 3.H of the General Terms and Conditions shall survive such termination and continue in effect.

C. Confidentiality.

1. Definition. For purposes of this Agreement, "Confidential Information" shall mean any data or information disclosed by one party to the other in connection with this Agreement that is not generally known to the public, and is clearly identified as confidential or, by its nature, should reasonably be considered confidential, including, but not limited to: (a) the terms and conditions of this Agreement (excluding the existence of this Agreement); (b) information about product plans, marketing strategies, finance, operations, customer relationships, customer profiles, customer lists, sales estimates or financial performance of either party; (c) any computer software or computer database (including the software, embedded software, documentation or any portion thereof), including the source code or object code thereof, and any specifications, data, reports, formulae, data models, data formats, field or record layouts, or improvements related thereto; and (d) any individually identifiable medical or financial information. Confidential Information shall not include information that: (v) is or becomes a part of the public domain through no fault of the receiving party; (w) was lawfully received by the receiving party from a third party free of any obligation of confidence; (x) was already in the lawful possession of the receiving party prior to receipt from the disclosing party; or (y) the receiving party can show by a preponderance of documentary evidence was subsequently and independently developed by its employees, consultants or agents without reference to the Confidential Information of the disclosing party; or (z) is disclosed as a result of a request under the California Public Records Act per California Government Code Section 6250 et seq.

2. Confidentiality Obligations. Each party acknowledges that the Confidential Information of the other party is proprietary and confidential and may contain valuable trade secrets. Each party shall hold the Confidential Information of the other in confidence and protect the same with at least the same degree of care with which it protects its own most sensitive confidential information, but in any event no less than reasonable care. Each party shall use the Confidential Information of the other solely in connection with the exercise of its rights, and the performance of its obligations, under this Agreement and shall restrict disclosure of and access to the Confidential Information of the other party to its employees who require access to such Confidential Information in connection with this Agreement. Each party shall require its employees to comply with the obligations of confidentiality set forth herein and shall be liable for any employee's failure to so comply. If a receiving party is required by judicial, administrative or other governmental order to disclose any Confidential Information of the other party, it shall notify the other party prior to making any such legally required disclosure in a timely manner and provide reasonable cooperation in order to allow such party to seek a protective order or other appropriate remedy. Provided such notification is given, the receiving party is hereby authorized to comply with such judicial, administrative or governmental order.

3. Ownership. All Confidential Information shall remain the property of the disclosing party providing the Confidential Information. Nothing in this Agreement is intended to grant any rights in or to the Confidential Information of the other party except as expressly set forth herein. All Confidential Information shall be returned to the disclosing party upon written request or termination of this Agreement.

4. Equitable Relief. Except for either party's compliance with Section 3.H.17. of this Agreement, in the event of a breach by a party of Sections 3.C.2. or 3.C.3., the non-breaching party may not have an adequate remedy solely in money damages and any such breach will cause the non-breaching party irreparable harm. In the event of such breach, the non-breaching party may seek, without the requirement of posting a bond or other security, equitable relief, including an injunction or specific performance.

D. Proprietary Information.

1. Proprietary Rights. With the exception of the limited use rights expressly granted in this Agreement, Emdeon (on behalf of itself and its third party licensors) reserves any and all right, ownership, title, and interest in the Emdeon Products and Services and the Emdeon Materials (collectively, the "Emdeon IP"), and Payer shall treat the Emdeon IP as the property of Emdeon. This Agreement does not effect any transfer of title in any Emdeon IP. Payer acknowledges and agrees that the Emdeon IP, and all intellectual property rights (including, without

limitation, copyright, patent, trade secrets, confidential information rights, and moral rights) derived or devolving from the Emdeon IP, and all derivative works of the Emdeon IP, and such intellectual property rights (including, without limitation, data compilations, abstracts, aggregations and statistical summaries), and all information regarding the foregoing (including but not limited to technology and know-how information) and all copies of the foregoing, regardless of by whom prepared, are owned by and are valuable, special and unique assets of Emdeon and may be provided to third parties by Emdeon and its affiliates consistent with law. Payer further expressly acknowledges and agrees that the foregoing are the confidential property and trade secrets of Emdeon and "Confidential Information" of Emdeon subject to Section 3.C above, whether or not any portion thereof is or may be validly trademarked, copyrighted or patented.

2. Restrictions. Payer will make no attempt to ascertain the circuit diagrams, source code, schematics, logic diagrams, components, operation of, or otherwise attempt to decompile or reverse engineer, any portion of the Emdeon IP. Except as specifically authorized by Emdeon in writing, Payer may not copy any portion of the Emdeon IP, or modify or transfer the Emdeon IP, or any copy or merged portion thereof, in whole or in part, or prepare any derivative works of the Emdeon IP. To the extent that Payer or its employees or contractors conceive, reduce to practice, develop or otherwise participate in the creation or development of technology related to the Emdeon IP, including any derivatives, improvements, enhancements or extensions of such technology, Payer, on behalf of itself and its employees and contractors, hereby assigns to Emdeon all right, title and interest, including (without limitation) all intellectual property rights, therein. Payer shall cooperate with Emdeon in any claim or litigation against third parties that Emdeon may determine to be appropriate to enforce its property rights respecting Emdeon IP. The breach or threatened breach by Payer of any provision of this Section 3.D will subject Payer, at Emdeon's option, to the immediate termination of all Payer's rights hereunder, and Emdeon shall be entitled to an injunction restraining such breach without limiting Emdeon's other remedies for such breach or threatened breach, including recovery of damages from Payer.

E. Indemnification.

1. Indemnification by Emdeon. Emdeon agrees to indemnify, defend and hold Payer harmless from and against any loss, claim, judgment, liability, damage, action or cause of action (including reasonable attorneys' fees and court costs) (collectively, "Losses") directly resulting from a third party claim that Payer's proper use of the Emdeon IP infringes or misappropriates a valid U.S. patent or copyright issued or registered prior to the Effective Date; provided, however, that Emdeon shall have no obligation to indemnify, defend or hold Payer harmless with respect to such third party claims unless Payer promptly notifies Emdeon in writing of the claim, allows Emdeon to exclusively control the defense of such claim, and cooperates reasonably with Emdeon in the defense of the claim or in any related settlement negotiations.

2. Limitation on Indemnification Obligations. The indemnity against infringement set forth in Section 3.E.1. shall not apply to any claim arising out of: (a) the combination, operation or use of the Emdeon IP with any product, data or apparatus not furnished by or on behalf of Emdeon or not specified by Emdeon in writing (b) Emdeon's compliance with Payer's designs, specifications or instructions, (c) Payer's modification of the Emdeon IP, (d) use of the Emdeon IP in a manner that conflicts with the prescribed uses in the applicable specifications, (e) use of the Emdeon IP other than in accordance with this Agreement, or (f) use of other than a current release of any Emdeon software.

3. Quiet Enjoyment of the Emdeon IP. If an infringement claim has been brought, or Emdeon believes such an infringement claim is reasonably likely, Emdeon may, at its sole option and expense: (a) use commercially reasonable efforts to procure the right to continue using the infringing Emdeon IP; (b) replace or modify the same so that it becomes non-infringing; or (c) terminate this Agreement. If this Agreement is so terminated, Emdeon shall refund to Payer all amounts paid by Payer for the applicable Emdeon IP during the one year preceding Emdeon's refund. THIS SECTION 3.E STATES EMDEON'S ENTIRE LIABILITY TO PAYER WITH RESPECT TO ANY INTELLECTUAL PROPERTY INFRINGEMENT CLAIMS BROUGHT BY ANY THIRD PARTY AND SUCH LIABILITY IS FURTHER LIMITED BY THE LIMITATIONS APPEARING IN SECTIONS 3.F AND 3.G BELOW. THERE IS NO WARRANTY WITH RESPECT TO PAYER'S QUIET ENJOYMENT OF THE EMDEON IP OR AGAINST INFRINGEMENT.

4. Indemnification by Payer. Payer agrees to indemnify, defend and hold Emdeon harmless from and against any Losses resulting from any infringement of a U.S. patent, copyright, trademark, trade secret or similar intellectual property right of a third party resulting from Payer's unauthorized use or modification of the Emdeon IP; provided, however, that Payer shall have no obligation to indemnify, defend or hold Emdeon harmless with respect to such third party claims unless Emdeon promptly notifies Payer in writing of the claim, allows Payer to control the defense of such claim, and cooperates with Payer in the defense of the claim or in any related settlement negotiations.

F. Warranties.

DISCLAIMER OF WARRANTIES. EXCEPT FOR THE LIMITED WARRANTIES EXPRESSLY SET FORTH IN THIS AGREEMENT AND THE SELECTED SERVICES SCHEDULE(S), EMDEON MAKES NO PROMISES, REPRESENTATIONS OR WARRANTIES CONCERNING THE EMDEON PRODUCTS AND SERVICES OR THE EMDEON MATERIALS. EMDEON DISCLAIMS, FOR ITSELF AND ANY THIRD PARTY LICENSORS, ANY AND ALL OTHER EXPRESS OR IMPLIED REPRESENTATIONS AND WARRANTIES WITH RESPECT TO THE EMDEON PRODUCTS AND SERVICES AND THE EMDEON MATERIALS PROVIDED HEREUNDER, INCLUDING ANY EXPRESS OR IMPLIED WARRANTY OF MERCHANTABILITY, FITNESS FOR A PARTICULAR PURPOSE, WARRANTIES CONCERNING INFRINGEMENT, TITLE, CONDITION OR THE EXISTENCE OF ANY LATENT OR PATENT DEFECTS, WARRANTIES ARISING FROM COURSE OF DEALING, USAGE OR TRADE PRACTICE, OR WARRANTIES THAT THE EMDEON PRODUCTS AND SERVICES AND THE EMDEON MATERIALS WILL BE UNINTERRUPTED, ERROR-FREE OR COMPLETELY SECURE.

G. Limitation Of Liability.

1. LIMITATION ON CUMULATIVE LIABILITY. EXCEPT FOR ANY LIABILITY ARISING OUT OF EMDEON'S INDEMNIFICATION OBLIGATIONS, THE CUMULATIVE LIABILITY OF EMDEON TO PAYER FOR ANY ACTUAL OR ALLEGED

DAMAGES ARISING OUT OF, BASED ON OR RELATING TO THIS AGREEMENT, WHETHER BASED UPON BREACH OF CONTRACT, TORT (INCLUDING NEGLIGENCE), WARRANTY OR ANY OTHER LEGAL THEORY, SHALL NOT EXCEED THE AMOUNT OF THE PROCESSING FEES PAID UNDER THIS AGREEMENT BY PAYER TO EMDEON FOR THE APPLICABLE EMDEON PRODUCT OR SERVICE INVOLVED DURING THE ONE (1) YEAR PRECEDING PAYER'S CLAIM.

2. LIMITATION ON SPECIFIED DAMAGES. IN NO EVENT SHALL EMDEON OR ITS THIRD PARTY LICENSORS BE LIABLE TO PAYER FOR ANY INDIRECT, SPECIAL, INCIDENTAL, CONSEQUENTIAL, PUNITIVE, OR EXEMPLARY DAMAGES (INCLUDING DAMAGES RELATED TO DELAYS, LOSS OF DATA, INTERRUPTION OF SERVICE OR LOSS OF BUSINESS OR PROFITS OR REVENUE), EVEN IF EMDEON OR SUCH THIRD PARTY LICENSORS HAVE BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES. EXCEPT AS SET FORTH IN SECTION 3.E, IN NO EVENT SHALL EMDEON OR ANY THIRD PARTY LICENSOR BE LIABLE FOR ANY THIRD PARTY CLAIM.

3. Assertion of Claims. Any claim or cause of action arising out of, based on, or relating to this Agreement not presented by Payer within one (1) year from the discovery of the claim or cause of action shall be deemed waived. Payer shall have the duty to mitigate damages for which Emdeon may become responsible under this Agreement.

H. Miscellaneous.

1. Compliance with Laws. The parties shall comply with all applicable federal, state and local laws, and each party shall secure any license, permit, or authorization required by law in connection with this Agreement.

2. Independent Contractors. The parties will act as independent contractors and this Agreement does not constitute either party as the agent or partner of the other party.

3. Notices. Notices hereunder shall be in writing, signed by an officer of the notifying party, and delivered via facsimile, personally or sent by registered or certified mail, charges prepaid, or overnight courier service to the addresses noted in this Agreement (or to such other address as the recipient may have previously designated by written notice), and will be deemed given when so delivered or four days after the date of mailing, whichever occurs first, or upon electronic confirmation of delivery via facsimile transmission. All notices delivered to Emdeon should be sent with a copy to Emdeon Business Services, Attention General Counsel, 3055 Lebanon Pike, Nashville, Tennessee 37214. All notices delivered to Payer should be sent to CalOptima, Attention: Mark Finch, C.P.M., CPPO, 1120 West La Veta Avenue, Orange, CA 92868.

4. Assignment. Neither party shall assign, sell or otherwise transfer this Agreement or any rights hereunder without the express prior written consent of the other party, which consent shall not be unreasonably withheld. An assignment hereunder shall be deemed to include the transfer of control or a majority equity ownership of Payer. Notwithstanding the foregoing, Emdeon may terminate this Agreement in its sole discretion, if Payer merges or consolidates with a competitor of Emdeon, effective immediately upon notice to Payer. Furthermore, any purported assignment or transfer in violation of this section shall be null and void, and shall entitle the non-assigning party to terminate this Agreement effective immediately upon notice to the assigning party. This Agreement shall be binding upon and shall inure to the benefit of the parties hereto and their respective successors and assigns.

5. Third Parties. Except as expressly set forth herein, nothing in this Agreement shall be construed as giving any person or entity, other than the parties hereto and their successors and permitted assigns, any right, remedy or claim under or in respect of this Agreement or any provision hereof, provided that Emdeon's third party licensors shall be third-party beneficiaries to this Agreement.

6. Force Majeure. Except for Payer's payment obligations hereunder, neither party shall be responsible for delays or failures in performance resulting from acts or events beyond its reasonable control, including but not limited to, acts of nature, governmental actions, fire, labor difficulties or shortages, civil disturbances, transportation problems, interruptions of power, supply or communications or natural disasters, provided such party takes reasonable efforts to minimize the effect of such acts or events.

7. Entire Agreement/Severability. No representations have been made to induce either party to enter into this Agreement except for the representations explicitly stated in this Agreement. This Agreement supersedes all prior or contemporaneous written or oral agreements or expressions of intent or understanding and is the entire agreement between the parties with respect to its subject matter. In the event of a conflict or inconsistency between the General Terms and Conditions and the terms and conditions of any of the Services Schedules, the terms and conditions of the Services Schedule shall take precedence. If any provision of this Agreement is held by a court of competent jurisdiction to be invalid, void or unenforceable, the remaining provisions will nevertheless continue in full force without being impaired or invalidated in any way. The invalid, void or unenforceable provisions shall be adjusted rather than voided, if possible, in order to achieve the intent of the parties to this Agreement to the extent possible, unless such modification would materially alter the original intent of this Agreement. All terms, conditions or provisions which may appear on any purchase or sales order or invoice issued pursuant to this Agreement, to the extent inconsistent with the terms and conditions of this Agreement, shall be of no force or effect, notwithstanding the fact that such order or invoice may have been executed subsequent to the date of this Agreement, and, in any event, preprinted terms of any such order or invoice shall have no force or effect.

8. Amendment. This Agreement cannot be terminated (other than as set forth herein) or changed except pursuant to a writing signed by an authorized officer of Emdeon and an authorized officer of Payer. No waiver of any of the provisions of this Agreement shall be effective unless in writing and signed by an authorized officer of the party charged with such waiver and any such waiver shall be strictly limited to the terms of such writing.

9. Costs. Except as expressly set forth herein, each party shall bear its own costs, expenses, taxes and other charges whatsoever incurred in connection with the execution and performance of this Agreement.

10. Announcements. All media releases, public announcements or other public disclosures by Payer or its employees or agents relating to this Agreement or its subject matter, including without limitation, promotional or marketing materials, shall be coordinated with and approved by an officer of Emdeon prior to release, but this restriction shall not apply to any disclosure solely for internal distribution by Payer or any disclosure required by legal, accounting or regulatory requirements.

11. Counterparts. This Agreement and any amendments hereto may be executed in one (1) or more counterparts, each of which shall be an original, but all of which together shall constitute one (1) instrument.

12. Headings. The section headings of this Agreement are inserted for reference and convenience purposes only and do not constitute a part, nor shall affect the meaning or interpretation of, this Agreement.

13. Governing Law. This Agreement is governed by the laws of the State of California both as to interpretation and enforcement, without regard to the conflicts of law principles of that State. Exclusive jurisdiction and venue for any dispute relating to this Agreement shall reside in (i) any state court of competent jurisdiction sitting in Orange County, California if such a dispute is brought by Emdeon or (ii) any state court of competent jurisdiction sitting in Davidson County, Tennessee if such a dispute is brought by Payer. The parties agree and expressly consent to the exercise of personal jurisdiction in said court in connection with any such dispute.

14. No Liability of County of Orange. As required under Ordinance No. 3896 of the County of Orange, State of California, the parties hereto acknowledge and agree that the obligations of Payer under this Agreement are solely the obligation of Payer, and the County of Orange, State of California, shall have no obligation or liability therefor.

15. Prohibited Interests. Emdeon represents that, for the term of this Contract, no director, member, officer, or employee of Payer during his/her tenure has any interest, direct or indirect, in this contract, agreement or purchase order, or the proceeds thereof.

16. Offshore Performance.

a. Due to security and identity protection concerns, direct services under this Contract shall not be performed by offshore subcontractors, unless otherwise authorized in writing by Payer.

b. Emdeon acknowledges that Payer requires Emdeon to obtain approval from it of Emdeon's use of any offshore subcontractor whereby offshore subcontractor will have access to any type of confidential Payer Member information, including, but not limited to, protected health information. Emdeon represents and warrants that it has disclosed to Payer any and all such offshore subcontractors and that it has obtained Payer's written approval to use such offshore subcontractors prior to the effective date of this Agreement.

c. Any new subcontract with an offshore entity under which the offshore entity will have access to any confidential Payer Member or other protected health information must be approved in writing by Payer prior to execution of the subcontract.

d. Unless specifically stated otherwise in this Agreement, the restrictions of this Section do not apply to indirect or "overhead" services, or services that are incidental to the performance of the underlying contracted services under the Agreement, such as development work, testing IT support tasks and customer support services.

e. The provisions of this Section apply to work performed by subcontractors at all tiers.

17. California Public Records Act. As a local public agency, Payer is subject to the California Public Records Act (California Government Code Sections 6250 et seq.) (the "Public Records Act"). Emdeon hereby acknowledges that any materials, documents, data, or similar items are subject to disclosure upon public request, unless they are exempt from disclosure under the provisions of the Public Records Act. Payer may be required to reveal certain information believed to be proprietary or confidential by Emdeon pursuant to the Public Records Act. In the event that Emdeon discloses information which it believes to be proprietary or confidential to Payer, it shall mark such information as "Confidential," "Proprietary," or "Restricted" or other similar marking. Unless Emdeon marks its materials as "Confidential," "Proprietary," or "Restricted," and also notifies Payer in writing that Emdeon has so marked each piece of material, then Payer will not be responsible to take any actions to protect any of Emdeon's materials under the Public Records Act that are not so marked. In the event Payer receives a request under the Public Records Act that potentially encompasses Emdeon materials that have been properly marked, Payer will provide Emdeon with prompt notice thereof to allow Emdeon to take actions it deems appropriate to prevent disclosure of the marked material, including, but not limited to, seeking an injunction. In addition, Payer will cooperate with Emdeon in its attempt to prevent disclosure of the marked material to the extent allowed under the Public Records Act. Emdeon agrees to waive its right to bring any claim, action or other proceeding against Payer for any liability, loss, damage, cost or expense arising out of Payer's compliance with the Public Records Act so long as Payer acted in accordance with this Section 3.H.17. and provided Emdeon notice of requests of Emdeon marked material in a time and manner allowing Emdeon to take the necessary actions to protect its confidential information.

SIGNATURES ON FOLLOWING PAGE

IN WITNESS HEREOF, EMDEON AND PAYER, INTENDING TO BE LEGALLY BOUND, HAVE CAUSED THIS AGREEMENT TO BE EXECUTED BY THEIR AUTHORIZED REPRESENTATIVES AS OF THE EFFECTIVE DATE SET FORTH BELOW.

ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, D/B/A ORANGE PREVENTION AND TREATMENT INTEGRATED MEDICAL ASSISTANCE D/B/A CALOPTIMA

"PAYER"

Address: 1120 West La Veta Avenue
Orange, CA 92868
Phone: 714/246-8660
Fax:

By: Michael Engelhard

Name: MICHAEL ENGELHARD

Title: CFO

Date: 9/1/11

Tax ID Number:

ENVOY LLC, an Emdeon company

Address: 3055 Lebanon Pike
Nashville, TN 37214
Phone: (615) 932-3000
Fax: (615) 340-6049

By:

Name: Lowell Stokes

Title: Vice President, Deputy General Counsel

Date: MAR 25 2011

Emdeon E-Services Schedule

This Emdeon E-Services Schedule by and between Envoy LLC, an Emdeon company ("Emdeon"), and **ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, D/B/A ORANGE PREVENTION AND TREATMENT INTEGRATED MEDICAL ASSISTANCE D/B/A CALOPTIMA** ("Payer") sets forth the specific terms and conditions governing Payer's use of the Emdeon E-Services, and is incorporated into the Emdeon Payer Agreement ("Agreement").

SECTION 1 - SERVICES.

Payer selects E-Services (for purposes of this Schedule, the "E-Services") set forth in Exhibit A to this Schedule.

SECTION 2 - DEFINITIONS.

2.1. "Affiliate" shall mean any entity owned or controlled by, under common ownership or control with, or which owns or controls either party or any of its subsidiaries.

2.2. "E-Services Effective Date" shall mean the date this Schedule is signed by Emdeon

2.3. "EDI Materials" shall mean all specifications and materials (including but not limited to any and all training materials, EDI Specifications, designs and design documents, information manuals, and all other documentation) pertaining to E-Services supplied to Payer by Emdeon.

2.4. For purposes of this Schedule, "EDI Products" shall mean all equipment, hardware, firmware and software (whether in source or object code form), and all modifications, updates, enhancements, or replacements for any of the foregoing furnished to Payer by Emdeon to facilitate use of the E-Services, including but not limited to those specified in this Schedule.

2.5. "Submitters" shall mean the entities, including, without limitation, direct submitting providers (including pharmacies, physicians, hospitals, dentists, and other medical service related providers), vendors, bill paying services, commercial insurance companies, self-insured organizations, managed care organizations, TPAs, PPOs, fee negotiators, governmental agencies and other entities providing transaction submission services who are authorized by Emdeon and Payer to submit Transactions through the E-Services on behalf of Payer.

2.6. "EDI Specifications" shall mean the specifications published by Emdeon in effect from time to time applicable for each specific Transaction and similar documentation relating to the E-Services.

2.7. "Transactions" shall mean transactions submitted to E-Services by Submitters, whether or not Payer accepts, adjudicates or re-prices such transactions.

2.8. "Batch Transactions" shall mean transactions initiated and processed during separate telecommunication sessions.

2.9. "Real-Time Transactions" shall mean transactions initiated, processed and a response returned to the initiating party during the same telecommunications session.

SECTION 3 - PAYER'S RIGHTS TO USE THE E-SERVICES.

3.1. Subject to the terms and conditions of this Agreement, Emdeon grants to Payer a non-exclusive and non-transferable license right for the term of this Agreement to use the E-Services and, if applicable, the EDI Products, in accordance with the EDI Specifications for the applicable Transactions only at physical site(s) owned or managed by or under the control of Payer solely for Transactions being submitted on behalf of Payer or any of its Affiliates. Payer shall utilize E-Services solely for the purpose of facilitating use of E-Services and only in compliance with the procedures and guidelines set forth in the EDI Specifications. No rights are granted to the E-Services except as explicitly set forth in this Agreement.

3.2. Except for the EDI Products specifically identified in this Schedule, Payer shall be solely responsible for acquiring, operating and maintaining hardware and software with respect to Payer's use of the E-Services, Emdeon shall have no responsibility for any costs incurred in connection with modifications or enhancements to Payer's system necessary for implementing Payer's interface with the E-Services or in connection with Payer's use of the E-Services, unless otherwise expressly set forth in this Schedule.

3.3. Emdeon may from time to time in its sole discretion, without liability to Payer, suspend, revise, modify, update or replace any E-Services and EDI Products in whole or in part; provided the E-Services are not adversely affected in any material manner and Emdeon notifies Payer of any such event, either electronically or in writing, with reasonable promptness after determining that such event will occur. Emdeon shall furnish Payer with appropriate EDI Materials in connection therewith in a manner reasonably calculated to allow implementation and testing by Payer before the effective date of such event.

SECTION 4 - FEES.

4.1. Payer shall pay Emdeon the fees and charges set forth in Exhibit A to this Schedule in a timely fashion as required by this Agreement.

4.2. Emdeon may at any time without prior notice pass through any applicable access fees and/or increase in communications tariffs related to the E-Services, including, without limitation, government imposed access fees, fees resulting from changes in regulation or statute or any third party imposed access fees related to the E-Services, or any other fees assessed against Emdeon and outside of Emdeon's reasonable control. Upon request, Emdeon shall make available to Payer documentation relating to these pass through fees in connection with the E-Services. In the situation where any new or increased pass through fees increase the cost to Payer by ten percent (10%) or more of the then current cost to Payer, Emdeon will provide notification and reasonable supporting documentation to Payer without unreasonable delay.

4.3. If Payer fails to provide an average response time for any Real-Time Transaction of seven (7) seconds or less, Emdeon may request at any time a price increase for such Transaction. If Payer fails to accept such price increase at the time requested by Emdeon, Emdeon shall have the right to terminate the use of the E-Services for such Transactions.

4.4. Any technical support, software customization or training services requested in writing by Payer which are not required to be performed by Emdeon hereunder shall be evidenced by an Amendment, subject to the availability of Emdeon's technical staff and shall be billed at Emdeon's then current time and material rates plus out-of-pocket expenses, and subject to such other terms and conditions which may be agreed upon in writing by the parties before such services are performed.

4.5. Any optional enhancements, modifications, features, modules or products that may from time to time be developed by Emdeon with respect to the E-Services will be offered to Payer and, if Payer elects to utilize such enhancements, modifications, features, modules or products, Payer shall pay applicable fees, if any.

SECTION 5 - TERM.

Except as otherwise expressly set forth in the Agreement, the initial term of this Schedule shall commence on the E-Services Effective Date and shall continue for a period of one (1) year thereafter, with up to four (4) one (1) year renewals, subject to Payer's discretion.

SECTION 6 - IMPLEMENTATION.

6.1. Commencing promptly after the Effective Date, Payer and Emdeon shall use commercially reasonable efforts to implement the E-Services for Payer in accordance with the Emdeon implementation procedures (the "Implementation Phase"). Each party shall designate a project manager who will work with their counterpart to develop and agree upon the specific implementation plan and schedule in accordance with the Implementation Procedures which will include the projected date for the commencement of the use of the E-Services by Payer (the "Projected Live Date"). During the Implementation Phase, Emdeon shall assist Payer in implementing the E-Services, add Payer to the Emdeon system, receive from and submit to Payer test data and provide the technical support and training services as reasonably required to bring Payer to a live status ready to use the E-Services. Until the Acceptance Date (as defined in Section 6.2 below), Payer shall utilize the E-Services solely for implementation and testing of such E-Services to determine acceptability.

6.2. Payer shall notify Emdeon no later than five (5) business days before the Projected Live Date if Payer determines that the E-Services are not acceptable because such do not conform to the EDI Specifications and EDI Materials. With such notice Payer shall identify with specificity the discrepancies between the E-Services as delivered and the E-Services as described in the EDI Specifications and EDI Materials. Emdeon shall then have twenty (20) business days to correct such discrepancies and Payer shall have an additional fifteen (15) business days following delivery of the corrected E-Services to evaluate the E-Services for acceptability. If Payer still reasonably determines that the E-Services fail to conform to the EDI Specifications and EDI Materials, Payer shall (a) give written notice to Emdeon of its decision not to accept the E-Services, (b) treat this Agreement as immediately terminated without any obligation imposed on Payer to make any further payment for the E-Services, and (c) take all action required under Article 3.B of the General Terms of the Agreement. Thereafter, neither party shall have any further obligation to the other except that both parties shall continue to be bound by the provisions relating to confidentiality hereunder. If Payer fails to give notice to Emdeon of a rejection of the E-Services by the fifth (5^{th}) business day before the Projected Live Date, the E-Services shall be deemed accepted. The Projected Live Date or, where applicable, the date the E-Services are accepted by Payer after a notice of discrepancy under this Section 6.2 shall be deemed for all purposes of this Agreement as the "Acceptance Date". Notwithstanding the foregoing, if Payer has not "accepted" the E-Services and completed the Implementation Phase within one-hundred eighty (180) days of Effective Date, Emdeon in its sole discretion may terminate this Agreement immediately upon written notice to Payer.

SECTION 7 - EMDEON OBLIGATIONS.

7.1. Emdeon shall perform services in accordance with Payer's Exhibit B Scope of Services which is attached hereto and incorporated herein.

7.2. Emdeon shall operate the E-Services in accordance with the EDI Specifications applicable to each such EDI Service, and the E-Services shall be available to Payer during the hours designated in the EDI Specifications. Emdeon may change such hours of availability with reasonable advance notice if such change is applicable to all entities participating in the E-Services in like manner as Payer with substantially equivalent or greater Transaction volume as Payer.

7.3. Batch Transactions through the E-Services shall be transmitted in batch mode within twenty-four (24) hours of receipt by E-Services (excluding Saturdays, Sundays, and holidays) except as may otherwise be set forth in the EDI Specifications for such Transactions.

7.4. Real-Time Transactions through the E-Services shall be available seven (7) days a week, twenty-four (24) hours a day, except during planned downtime or as may otherwise be set forth in the EDI Specifications for such Transaction.

7.5. In the event that Payer requests Emdeon to effect modifications or enhancements in the E-Services, EDI Products, or any related

software to accommodate specific Payer requirements, Emdeon shall promptly after receiving such request, evaluate the requirements and provide Payer a proposal setting forth a description of the changes and/or development involved, cost estimates, projected time for completion and other appropriate terms and conditions, and, if Payer accepts such proposal in writing evidenced by an Amendment, Emdeon shall use commercially reasonable efforts to complete the development effort in accordance with such proposal. Upon completion of the changes necessary to effect such proposal, the fees and charges provided for in Article 4 above may be superseded and, if so superseded, Payer shall thereafter pay for fees and charges as set forth in Emdeon's proposal.

7.6. Emdeon shall respond to inquiries and complaints from Submitters directly relating to the transmission of Transactions through the E-Services and refer to Payer inquiries and complaints it receives from Submitters with respect to Payer which do not relate to such transmission of Transactions through the E-Services.

7.7. Emdeon shall maintain all records and correspondence relating to Payer's use of the E-Services for a period which shall be the greater of that required by applicable law or ten (10) years after the termination or expiration of this Agreement. Emdeon shall, and is hereby authorized by Payer to, make such records and correspondence available for examination, audit and inspection by any applicable regulatory agency.

7.8. Emdeon shall provide reasonable ongoing technical support through telephone consultations with respect to the E-Services and shall provide a local or alternative toll free telephone number for access to Emdeon's technical support facility for this purpose. In addition, if determined to be necessary by Emdeon and Payer, Emdeon shall provide on site visits to assist Payer in using the E-Services. Emdeon shall not charge for such visit unless the visit is requested by Payer and not determined to be necessary by Emdeon, in which case such visits in excess of once per year shall be subject to the availability of Emdeon's support staff and may be charged to Payer at Emdeon's then time and material rates for such support (which rates shall be made available to Payer by Emdeon from time to time at Payer's request) plus reasonable out-of-pocket expenses.

7.9. Emdeon agrees to participate in quarterly conference calls related to Contract Administration.

7.10. Emdeon shall perform, at its election, automated data checks of the data submitted through the E-Services for completeness, logic, and satisfaction of statistical requirements of the then applicable EDI Specifications. Payer acknowledges any Transactions not in compliance with such requirements will be rejected.

7.11. Emdeon agrees to produce an SAS70 or equivalent report to Payer upon its reasonable request.

SECTION 8 - PAYER OBLIGATIONS.

8.1. Payer agrees to receive and accept from Emdeon all Transactions submitted through the E-Services by a Submitter for routing to Payer (or Payer's designated agent) and otherwise to participate in and perform its obligations hereunder relating to the E-Services. In furtherance hereof:

a) Payer shall operate its system to ensure that Emdeon may at all times telecommunicate directly with Payer for the E-Services without the requirement that Emdeon communicate with or through any third party on each business day in accordance with the applicable EDI Specifications commencing promptly following the Acceptance Date; and

b) Payer shall accept all Transactions submitted through the E-Services to Payer each business day.

8.2. Payer shall use the E-Services for all Transactions only in accordance with the procedures, data element standards, formats, codes, protocols and edits as are set forth in the then relevant EDI Specifications for such Transactions. Payer shall promptly report to Emdeon any performance problems related to the E-Services including a description of the circumstances surrounding their occurrence. Payer shall conform to any non-optional modification, feature, enhancement, module or product of the E-Services within the number of days (not less than ninety (90) days) which Emdeon shall designate in the notice regarding such change.

8.3. Payer shall maintain a telephone number for Submitters and answer telephonic inquiries from Submitters regarding electronic submission procedures in connection with the E-Services and assist Emdeon in providing status reports of claims in process. Payer also shall handle inquiries and complaints from Submitters concerning any matter other than a matter regarding the use by the Submitter of the E-Services, including questions concerning Payer's handling of claim re-pricing, claim settlements, claim denial or coverage questions in general. Any such inquiries or complaints received by Emdeon shall be referred by Emdeon to Payer for resolution.

8.4. If Real-Time Transactions are selected in Exhibit A:

a) Payer shall not access and shall take no action to obtain access to any information resident on the Emdeon system, except for data, reports and messages relating to Real-Time Transactions submitted to or received by Payer.

b) Except for reasonable periods of scheduled downtime, Payer shall accept the submission of Real-Time Transactions and respond to Real-Time Transactions interactively Monday through Saturday for eighteen (18) hours per day which shall include 7:00 A.M. Central Time through 10:00 P.M. Central Time plus 7:00 A.M. Central Time through 7:00 P.M. Central Time on Sunday. The term "respond" for this purpose shall mean such term as defined in the EDI Specifications. Payer also shall furnish to Emdeon reasonable advance notice of any scheduled suspension of services for Real-Time Transactions and shall advise Emdeon promptly following any unscheduled suspension of such services.

c) Payer's system shall provide to the Submitter of Real-Time Transactions a final resolution message for ninety percent (90%) of all Real-Time Transactions received through the E-Services within seven (7) seconds of receipt of each such Transaction.

8.5. With respect to Transactions submitted by Payer to the E-Services (e.g. Real-Time Eligibility Responses, Claim Status Responses, Roster Batch Transactions, Electronic Remittance Advice), Payer shall guarantee that the same data available through means other than the E-Services to requesting entities using the E-Services for such Transactions shall be available to each such entity through the E-Services.

8.6. Payer shall provide Emdeon a list of all of the Submitters of Payer one time per calendar year during the Term of this Agreement. Such information shall be provided disk formatted in accordance with Emdeon's then standard EDI Specifications.

8.7. Payer shall provide the following support to assist Emdeon in Submitter adoption of the E-Services: (a) provide reasonable assistance to the Submitters community regarding the use of the E-Services such as furnishing messages on re-pricing pages, on explanation of benefit statements, supporting the use of electronic transmissions or furnishing other substantially similar promotional material to Submitters; and (b) provide Emdeon with a listing of Submitters using paper methods to create a phone campaign to increase adoption of E-Services.

8.8. Payer and Emdeon each agree that the other shall retain records relative to Payer's and Emdeon's use of the E-Services in accordance with sound business practices and Emdeon and Payer may request access to such records as are reasonably necessary to examine Payer's and Emdeon's compliance with its obligations and the E-Services provided pursuant to this Agreement during normal business hours upon reasonable advance prior notice.

SECTION 9 - REPRESENTATIONS AND WARRANTIES.

9.1. Emdeon represents and warrants that the E-Services and EDI Products provided hereunder shall conform to the applicable EDI Specifications in all material respects. In the event of a documented and reproducible flaw in the E-Services inconsistent with these warranties are discovered, Emdeon's sole responsibility shall be to use commercially reasonable efforts to correct such flaw in a timely manner. These warranties do not apply to any media or documentation which has been subjected to damage or misuse or to any claim resulting, in whole or in part, from a breach of Payer's obligations hereunder or from any changes in the operating characteristics of computer hardware or computer operating systems which are made after the release of the applicable EDI Product or EDI Service, or which resulted from problems in the interaction of the E-Services with non-Emdeon software or equipment, or from breach by Payer of its obligations hereunder.

9.2. In the event information to be transmitted through the E-Services is not transmitted by Emdeon or is not accurately transmitted as a result of Emdeon's failure to perform the E-Services in accordance with the terms of this Agreement and such failure results in damage to Payer, then Emdeon's sole obligation and liability to Payer for such event (subject to reasonable mitigation by Payer and the limitations of liability set forth in Article 3.G of the General Terms) shall be limited to furnishing credits on subsequent invoices from Emdeon to Payer in an aggregate amount equal to Payer's actual damages incurred for retransmitting the data, including reasonable out-of-pocket expenses (subject to reasonable mitigation by Payer) which Payer can demonstrate it has sustained and which are directly attributable to such failure. Other than as expressly set forth in this Section 9.2, Emdeon shall not be liable for any actual monetary loss resulting from the event or from acts or omissions of Payer or any third party in reliance on data to be transmitted or transmitted through the E-Services, whether or not transmitted or transmitted accurately or inaccurately. Payer further agrees that Emdeon shall not be liable in any way for any inaccuracy which can be attributed to or demonstrated as resulting from errors or omissions or negligent or other wrongful acts of any employee of Payer, its Affiliates, or of the applicable Submitters. Any claim against Emdeon by Payer must be asserted in writing within sixty (60) days after Emdeon should have transmitted accurate information received from a Submitter or the transmission of inaccurate information on which the claim is based, whichever is applicable. Payer hereby agrees to promptly supply to Emdeon documentation reasonably requested by Emdeon to support any claim of Payer. THIS SECTION STATES THE ENTIRE LIABILITY OF EMDEON WITH RESPECT TO CLAIMS THAT INFORMATION WAS NOT TRANSMITTED OR WAS TRANSMITTED INACCURATELY BY EMDEON AND SUCH LIABILITY IS FURTHER LIMITED BY THE LIMITATIONS OF LIABILITY APPEARING IN SECTION 3.G OF THE GENERAL TERMS AND CONDITIONS.

IN WITNESS HEREOF, EMDEON AND PAYER, INTENDING TO BE LEGALLY BOUND, HAVE CAUSED THIS SCHEDULE TO BE EXECUTED BY THEIR AUTHORIZED REPRESENTATIVES AS OF THE E-SERVICES EFFECTIVE DATE SET FORTH BELOW.

ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, D/B/A ORANGE PREVENTION AND TREATMENT INTEGRATED MEDICAL ASSISTANCE D/B/A CALOPTIMA	**ENVOY LLC, an Emdeon company**
"PAYER"	
By: Michael Engelhard	By:
Name: MICHAEL ENGELHARD	Name: Lowell Stokes
Title: CFO	Title: Vice President, Deputy General Counsel
Date: 9/6/11	Date: MAR 25 2011

EMDEON E-SERVICES SCHEDULE - EXHIBIT A (Pricing)

Annual Service Fees:
Paid Annually — $ **WAIVED**

Batch Transaction Services:	**Implementation Fees Per Payer ID**	**Per Transaction Fee**
Core Claiming Services*:		
☒ Claims/Encounters to Payer, non-repriced (from Providers and Vendors)		
☒ Professional (Medical) Claims	$ **WAIVED**	$ 0.25 per claim
☒ Institutional (Hospital) Claims	$ **WAIVED**	$ 0.25 per claim

* The parties agree that Payer shall pay for all claims delivered to Payer by Emdeon after passing through Emdeon edits.

AGREED AND ACKNOWLEDGED:

ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, D/B/A ORANGE PREVENTION AND TREATMENT INTEGRATED MEDICAL ASSISTANCE D/B/A CALOPTIMA	**ENVOY LLC, an Emdeon company**
"PAYER"	
By: Michael Engelhard	By: Lowell Stokes
Name: MICHAEL ENGELHARD	Name: Lowell Stokes
Title: CFO	Title: Vice President, Deputy General Counsel
Date: 9/6/11	Date: MAR 25 2011

** CONFIDENTIAL AND PROPRIETARY INFORMATION BETWEEN CALOPTIMA AND EMDEON **

EXHIBIT B

SCOPE OF SERVICES
Claim Clearinghouse Services

Objective:

Allow providers to submit claims data electronically in multiple formats inclusive of those accepted by the State Medi-Cal program for claims (ANSI 837, NSF, Proprietary, etc.) and forward those files to Payer in an ANSI-compliant or otherwise stated format.

Clearinghouse Requirements

- Submit all provider claim transactions to Payer in a secure and compliant manner according to the ANSI standardized file layouts or State recognized requirements:
  - 837P/I
  - Long Term Care file converted to ANSI 837
- Ensure quality of files by checking for HIPAA errors in layouts and performing periodic audits to ensure compliance.
- Emdeon will guarantee that all claim files are sent to Payer within 48 hours of receipt from the provider. **Batch Claims received by Emdeon before 3 p.m. Eastern on a business day will be ready for Payer pick up by 8 a.m. Eastern the next day. Batch Claims received after 3 p.m. Eastern shall be deemed to be received the next business day.**
- Emdeon shall pro-actively communicate any issues prohibiting required turnaround times.
- Develop, test and implement all State and/or Federal regulated changes for new file formats and support Payer and its providers by communicating timelines and allowing for transition periods (i.e. HIPAA-regulated ANSI X12 004010a1 to 005010 transition).
- Emdeon will maintain and support member and provider level edits to reject claims back to providers within 24 hours.
- Provide reports on reject rates and activity by provider and a total record count daily for reconciliation.
- Emdeon will be able to receive Payer claims from other Clearinghouse to Emdeon's and convert them to Payer standards.
- Emdeon shall supply reasonable telephone support to Payer and its providers.
- Emdeon will assign a Account Manager that will provide Payer with one-on-one support and will ensure resolution to issues in a timely manner as follows:
  - Urgent issues will be acknowledged within 24 hours/resolved in no more than 14 calendar days, Routine issues will be acknowledged within 72 hours/resolved in no more than 30 business days
    - Urgent issues are defined as problems causing a cease in production claims files or HIPAA Level 1 or 2 errors found in files transmitted to Payer. Routine issues are all other issues.
- Emdeon shall provide reasonable support visits no more than once a year and as mutually agreed upon by the parties.

ADDENDUM TO AGREEMENT
Between
ENVOY LLC
and
ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY,
D/B/A ORANGE PREVENTION AND TREATMENT INTEGRATED MEDICAL ASSISTANCE
D/B/A CALOPTIMA

The Emdeon Business Services Payer Agreement, by and between Envoy LLC, an Emdeon company ("Emdeon") and Orange County Health Authority, a Public Agency, d/b/a Orange Prevention And Treatment Integrated Medical Assistance d/b/a CalOptima ("Payer") dated as of September 1, 2011, and any addenda or riders thereto (collectively the "Agreement") is hereby amended as follows:

1. Section 2 – Selection of Emdeon Business Services of the Agreement is hereby amended to add the following Emdeon Service to the Emdeon Services currently selected by Payer:

   ☒ Emdeon Claims Payment and Communication Services (Governed by the additional Terms and Conditions outlined on **Emdeon Claims Payment and Communications Services Schedule** attached hereto)

2. The Addendum Effective Date shall be the date this document is signed by Emdeon.

3. The definitions of terms appearing in the Agreement shall apply to such terms as used in this Addendum.

4. Except as modified by this Addendum, the terms and conditions of the Agreement shall remain in full force and effect and this Addendum shall be deemed a part of the Agreement. In the event of a conflict between a provision of this Addendum and a provision of the Agreement, the provision of this Addendum shall govern.

AGREED TO AND ACCEPTED BY:

Orange County Health Authority, a Public Agency, d/b/a Orange Prevention And Treatment Integrated Medical Assistance d/b/a CalOptima

By: Michael Engelhard
Name: Michael Engelhard
Title: CFO
Date: 9/28/11
By: Richard Chambers
Name: Richard Chambers
Title: CEO
Date: 10/26/11

ENVOY LLC, an Emdeon company

By: [signature]
Name: Lowell Stokes
Title: ~~Vice President, Deputy General Counsel~~
Date: OCT 18 2011

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Emdeon Claims Payment and Communication Services Schedule

This Claims Payment and Communication Services Schedule (the "CPCS Schedule") by and between ENVOY LLC, an Emdeon company ("Emdeon"), and **Orange County Health Authority, a Public Agency, d/b/a Orange Prevention and Treatment Integrated Medical Assistance d/b/a CalOptima** ("Payer") is incorporated into the Emdeon Payer Agreement ("Agreement").

SECTION 1 - SERVICES.

Payer selects the following CPCS services (for purposes of this CPCS Schedule, the "CPCS Services"):

- ☒ Print and Mail
- ☒ Client Access System
- ☒ Healthpayers USA
- ☒ Terrorist Watch
- ☐ PDF Image Delivery
- ☒ Web API
- ☐ **Electronic Remittance Advice ("ERA")**:
  - ☐ Payer generated ERAs
  - ☐ Emdeon generated ERAs
- ☐ eEOB
- ☒ Intelligent Mail Service
- ☐ Other _____

SECTION 2 - DEFINITIONS.

2.1. "Claims Communications" shall mean any document type that Emdeon processes for Payer hereunder, which document types may include negotiable checks, remittance advices, explanation of benefits, provider statements, system letters or other informational requests, premium billing statements, HIPAA Certifications or COBRA notifications.

2.2. "CPCS Services Effective Date" shall mean the date this CPCS Schedule is signed by Emdeon.

2.3. "CPCS Materials" shall mean all specifications and materials (including but not limited to any and all training materials, CPCS Specifications, designs and design documents, information manuals, and all other documentation) pertaining to CPCS Services supplied to Payer by Emdeon.

2.4. "CPCS Specifications" shall mean the specifications published by Emdeon in effect from time to time applicable for each specific CPCS Service.

2.5. "System" shall mean the proprietary system developed by Emdeon to deliver the CPCS Services.

SECTION 3 - PAYER'S RIGHTS TO USE THE CPCS SERVICES.

3.1. Subject to the terms and conditions of the Agreement and this CPCS Schedule, Emdeon grants to Payer a non-exclusive and non-transferable right for the term of this CPCS Schedule to use the CPCS Services in accordance with the CPCS Specifications solely for Claims Communications created by Payer. No rights are granted to the CPCS Services except as explicitly set forth in this CPCS Schedule.

3.2. Payer shall be solely responsible for acquiring, operating and maintaining hardware and software with respect to Payer's use of the CPCS Services, Emdeon shall have no responsibility for any costs incurred in connection with modifications or enhancements to Payer's system necessary for implementing Payer's interface with the CPCS Services or in connection with Payer's use of the CPCS Services, unless otherwise expressly set forth in this CPCS Schedule.

3.3. Emdeon may from time to time in its sole discretion, without liability to Payer, revise, modify, update or replace any CPCS Services in whole or in part; provided the CPCS Services as delivered to Payer are not adversely affected in any material manner and Emdeon notifies Payer of any such event, either electronically or in writing, with reasonable promptness after determining that such event will occur. Emdeon shall furnish Payer with appropriate CPCS Materials in connection therewith.

SECTION 4 - FEES.

4.1. Payer shall pay Emdeon the fees and charges set forth in Exhibit A to this CPCS Schedule in a timely fashion as required by the Agreement and this CPCS Schedule.

4.2. Any technical support, software customization or training services requested in writing by Payer which are not required to be performed by Emdeon hereunder shall be subject to the availability of Emdeon's technical staff and shall be billed at Emdeon's then current time and material rates plus out-of-pocket expenses, and subject to such other terms and conditions which shall be agreed upon in writing by the parties before such services are performed.

4.3. Any optional enhancements, modifications, features, modules or products that may from time to time be developed by Emdeon with respect to the CPCS Services will be offered to Payer and, if Payer elects to utilize such enhancements, modifications, features, modules or products, Payer shall pay applicable fees, if any.

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SECTION 5 - TERM.

5.1. Except as otherwise expressly set forth in the Agreement, the initial term of this CPCS Schedule shall commence on the CPCS Services Effective Date and shall continue for a period of three (3) years thereafter. This CPCS Schedule shall then automatically renew for additional one (1) year terms unless either party gives notice to the other at least ninety (90) days before the end of the next expiration date of its decision not to renew this CPCS Schedule.

5.2. Upon termination or non-renewal of this CPCS Schedule for any reason: (a) Emdeon shall, within sixty (60) days following such termination, (i) return to Payer any excess funds in Payer's Postage Account (as such term is defined below) less any outstanding amounts due Emdeon, and (ii) return to Payer all of Payer's confidential or proprietary information (including electronic signature plates and online image files) in its possession, and (b) Payer shall, within thirty (30) days following such termination, pay to Emdeon any and all amounts owed Emdeon at the time of termination.

SECTION 6 - IMPLEMENTATION.

6.1. Commencing promptly after the Effective Date, Payer and Emdeon shall use commercially reasonable efforts to implement the CPCS Services for Payer in accordance with the Emdeon implementation procedures (the "Implementation Phase"). Each party shall designate a project manager who will work with their counterpart to develop and agree upon the specific implementation plan and schedule in accordance with the Implementation Procedures which will include the projected date for the commencement of the use of the CPCS Services by Payer (the "Projected Live Date"). During the Implementation Phase, Emdeon shall assist Payer in implementing the CPCS Services, receive from and submit to Payer test data and provide the technical support and training services as reasonably required to bring Payer to a live status ready to use the CPCS Services. Until the Acceptance Date (as defined in Section 6.2 below), Payer shall utilize the CPCS Services solely for implementation and testing of such CPCS Services to determine acceptability.

6.2. No later than five (5) business days before the Projected Live Date, Payer shall execute an "Authorization Order," which shall be substantially similar to the form contained within the CPCS Specifications, as final approval for Emdeon to begin the CPCS Services. Payer may provide the Authorization Order via email, facsimile, or regular mail. In the alternative, if Payer determines that the CPCS Services are not acceptable because such do not conform to the CPCS Specifications, Payer shall notify Emdeon no later than five (5) business days before the Projected Live Date of such determination. With such notice Payer shall identify with specificity the discrepancies between the CPCS Services as delivered and the CPCS Services as described in the CPCS Specifications. Emdeon shall then have twenty (20) business days to correct such discrepancies and Payer shall have an additional fifteen (15) business days following delivery of the corrected CPCS Services to evaluate the CPCS Services for acceptability. If Payer still reasonably determines that the CPCS Services fail to conform to the CPCS Specifications, Payer shall (a) give written notice to Emdeon of its decision not to accept the CPCS Services, (b) treat this CPCS Schedule as immediately terminated without any obligation imposed on Payer to make any further payment for the CPCS Services, and (c) take all action required under Article 3.B of the General Terms of the Agreement. Thereafter, neither party shall have any further obligation to the other except that both parties shall continue to be bound by the provisions relating to confidentiality hereunder. If Payer fails to give notice to Emdeon of a rejection of the CPCS Services by the fifth (5^{th}) business day before the Projected Live Date, the CPCS Services shall be deemed accepted. The Projected Live Date or, where applicable, the date the CPCS Services are accepted by Payer after a notice of discrepancy under this Section 6.2 shall be deemed for all purposes of this Agreement as the "Acceptance Date". Notwithstanding the foregoing, if Payer has not "accepted" the CPCS Services and completed the Implementation Phase within one-hundred eighty (180) days of the CPCS Services Effective Date, Emdeon in its sole discretion may terminate this Agreement immediately upon written notice to Payer.

SECTION 7 - EMDEON OBLIGATIONS.

7.1. Emdeon shall perform the CPCS Services in accordance with the CPCS Specifications applicable to each such CPCS Service.

7.2. Upon receipt of each Payer data file containing check data, Emdeon shall review the lesser of: (a) the immediately preceding six million (6,000,000) checks issued by Emdeon on behalf of Payer or (b) Emdeon's entire database with respect to checks previously issued by Payer within the immediately preceding six (6) month period, in order to protect against the issuance of a duplicate check. Payer hereby acknowledges that Emdeon makes no representations whatsoever as to the existence of any protection against the issuance of a duplicate check beyond that stated in the immediately preceding sentence. **Further, Payer acknowledges that any change to the field lengths or specific character positions, for transit number, account number or check number or any transposition of the individual characters (including special MICR characters) within the transit number, account number or check number in the Legacy System + Erisco Facets System (collectively, the "Systems") data extract will disable Emdeon's duplicate check detection process, in which event Emdeon makes no representations whatsoever as to the existence of any protection against the issuance of a duplicate check.**

7.3. Emdeon shall deliver all printed Claims Communications into the United States Postal Service mail stream within two (2) business days of the receipt of their corresponding data files from Payer, provided the data files are successfully received, imported and in release status by 10:00 a.m. central time (the "Cut-off Time"). If the data files are successfully received, imported and in release status after the Cut-off Time, Emdeon shall deliver Payer's printed Claims Communications into the United States Postal Service mail stream within three (3) business days of receipt.

7.4. Upon request, Emdeon will provide its standard document design support services to Payer at no additional cost.

7.5. During the term of this CPCS Schedule, Emdeon will store and maintain all warehoused images on behalf of Payer for a period of at least ten (10) years, in accordance with Emdeon backup protocol.

7.6. Emdeon shall provide standardized reports for accounting, audit, or general purposes as identified in the CPCS Specifications.

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The nature and content of any additional customized reports shall be established by Payer and Emdeon during the Implementation Phase, and Emdeon reserves the right to bill Payer for the creation of any such reports at Emdeon's then current hourly rate.

7.7. Upon Payer's request or approval, Emdeon shall utilize, at Payer's expense, a special delivery service entity acceptable to Payer (i.e., Federal Express or UPS) to handle all overnight, second day, or special delivery requirements of Payer's printed Claims Communications.

7.8. Emdeon and Payer shall each designate a minimum of two (2) employees as contact personnel to handle day-to-day processing issues. The name, phone number, fax number and e-mail address (if applicable) of each contact person shall be included in a contact list (the "Contact List") to be created and maintained between the parties.

7.9. Emdeon shall ensure that the personnel designated in the Contact List shall be available during the Implementation Phase for trips to Payer's facility, if mutually deemed necessary, to discuss any implementation issues that may arise. Emdeon agrees to pay for all travel and lodging expenses for its personnel.

7.10. Notwithstanding anything else to the contrary contained herein, Emdeon shall have the right to analyze and use the mailing addresses and geographic information of Payer's members, insured, enrollees and customers as well as the mailing addresses and geographic information of Payer's providers to optimize the delivery of the CPCS Services.

7.11. Emdeon may use Payer's name, or any logo, trademark, service mark, or other identification only with Payer's prior written consent. Upon termination of this CPCS Schedule, all such uses shall cease.

7.12. Emdeon shall maintain all records and correspondence relating to Payer's use of the CPCS Services for a period which shall be the greater of that required by applicable law or two (2) years after the termination or expiration of this CPCS Schedule. Emdeon shall, and is hereby authorized by Payer to, make such records and correspondence available for examination, audit and inspection by any applicable regulatory agency.

7.13. Any mutually agreed upon programming services will be billed by Emdeon to Payer at the rate of one hundred-fifty dollars ($150.00) per hour.

SECTION 8 - PAYER OBLIGATIONS.

8.1. Payer shall provide Emdeon, on a daily basis or such other timeframe mutually agreed upon in writing by Emdeon and Payer, with data files, in a mutually agreed upon format, that contain information necessary for Emdeon to provide the CPCS Services.

8.2. If during the term of this CPCS Schedule Payer uses claims administration software other than **the Systems**, and the claims administration software has a module designed for Emdeon to facilitate the CPCS Services (a "Module"), Payer agrees to: (a) acquire and utilize the Module for its designated purpose, unless a pre-existing data transfer mechanism for Emdeon has been created and is in use, and (b) pay Emdeon's standard five thousand dollar ($5,000) transition fee ("Transition Fee"). If Payer uses claims administration software other than **the Systems** and no Module exists for data transfers as described herein, Payer agrees to: (x) assist Emdeon in the development of a data transfer mechanism, (y) compensate Emdeon at its then current hourly rate for its efforts in developing the data transfer mechanism upon such terms as Emdeon and Payer shall mutually agree in writing, and (z) pay to Emdeon the Transition Fee.

8.3. Prior to Emdeon commencing the CPCS Services, Payer agrees to provide Emdeon with all pertinent information concerning Payer and Payer's customers as it relates to the processing of Claims Communications. This information, including but not limited to electronic signatures, document routing information, customer and Payer logos, bank name, bank logos, bank account information, authorization forms and any special handling information (together with the information outlined in Section 8.1, "Payer Information"), as is required to provide the CPCS Services. Emdeon shall have no independent duty to verify or confirm any Payer Information provided by Payer to Emdeon and Emdeon shall not be responsible for any errors that occur as a result of incomplete, incorrect or inaccurate Payer Information provided by Payer to Emdeon.

8.4. Payer shall ensure that its personnel designated in the Contact List shall be available during the Implementation Phase (defined above) for trips to Emdeon's processing facility, if mutually deemed necessary, to discuss any implementation issues that may arise. Payer agrees to pay all travel and lodging expenses for its personnel.

8.5. On or prior to the Acceptance Date, Payer agrees to pay to Emdeon an amount equal to two (2) months worth of Payer's estimated postage costs (the "Postage Deposit"). The Postage Deposit shall be calculated by multiplying Payer's monthly postage cost for the last full month prior to the Acceptance Date by two (2), or, if there are no previous month's postage costs, such other amount that the parties may mutually agree. Emdeon shall place the Postage Deposit into an account maintained by Emdeon for daily postage disbursements ("Postage Account"). Payer agrees to maintain a positive balance in its Postage Account during the term of this CPCS Schedule. Payer also agrees to increase the Postage Deposit amount to reflect any increases in monthly printed Claims Communication volume. Notwithstanding anything else to contrary, if at any time during the term of this CPCS Schedule, Payer's Postage Account falls below zero dollars ($0), Emdeon may suspend the CPCS Services on five (5) business days prior written notice.

8.6. Payer shall use its commercially reasonable efforts to assist and enable Emdeon to carry out its duties under this CPCS Schedule.

8.7. Payer shall not provide any of its customers with Emdeon's phone number or address without the prior written approval of Emdeon.

8.8. Payer hereby authorizes Emdeon to make all of the 835s, PDF images of remittance advice documents, postable files and data

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index fields that Emdeon creates on behalf of Payer hereunder, available to the applicable healthcare provider through Emdeon's products and services, including Emdeon Payment Manager, Accupost, and Emdeon's EDI clearinghouse.

8.9. Payer acknowledges and agrees that Payer is solely responsible for filing, and agrees to file, any and all governmental forms (including Form 1099s) that may be required by applicable law or regulation in regards to any Claims Communication check or payment that Payer submits to Emdeon for processing hereunder.

8.10. Payer acknowledges and agrees that Payer is solely responsible for complying with all Move Update requirements that allow Payer to receive United States Postal Services (USPS) presort mail discounts.

8.11. Emdeon has created and maintains a register of healthcare providers (including pharmacies, physicians, hospitals, dentists, and other medical service related providers), vendors, bill paying services, commercial insurance companies, self-insurance organizations, managed care organizations, governmental agencies and other entities providing transaction submission services for providers (collectively "Providers") who have elected to replace the paper checks and/or paper remittance advice they currently receive from Emdeon with electronic counterparts. Payer hereby authorizes Emdeon to provide such Providers with electronic counterparts of their paper checks and/or paper remittance advice, which counterparts may include, but are not limited to, data files in standard formats (e.g. 835 ERAs and ACH transactions), data files in non-standard formats and human readable images (e.g. PDF images), all through Emdeon's products and services, including Payment Manager, Accupost, and Emdeon's EDI clearinghouse in lieu of printing such documents.

SECTION 9 - REPRESENTATIONS AND WARRANTIES.

9.1. Emdeon represents and warrants that the CPCS Services provided hereunder shall conform to the applicable CPCS Specifications in all material respects. In the event of a documented and reproducible flaw in the CPCS Services inconsistent with these warranties is discovered, Emdeon's sole responsibility shall be to use commercially reasonable efforts to correct such flaw in a timely manner. If such flaw is not resolved within thirty (30) days, Emdeon shall provide to Payer a report outlining the details of the flaw and the estimated time for resolution. These warranties do not apply to any claim resulting, in whole or in part, from a breach of Payer's obligations hereunder or from any error, inaccuracy, mistake or delay caused by incomplete, incorrect or inaccurate information provided by Payer to Emdeon.

9.2. In the event that Payer is a third party administrator acting on behalf of its clients (e.g. employer groups, indemnity plans or self insured plans) ("Payer Clients"), Payer represents and warrants: (i) it has the authority to act on behalf of the Payer Clients in regards to this CPCS Schedule, (ii) on behalf of Payer Clients, it shall administer the implementation, access and use of the CPCS Services in accordance with the terms of this CPCS Schedule, and (iii) it shall defend, indemnify, and hold harmless Emdeon from and against any and all claims, losses or liabilities (including reasonable attorneys fees and expenses) arising, directly or indirectly, from any misrepresentation by Payer with regard to the existence and scope of its agency relationship with any Payer Client, including, without limitation, losses or liabilities arising from any misrepresentation concerning its authority to bind any Payer Client to this CPCS Schedule.

IN WITNESS HEREOF, EMDEON AND PAYER, INTENDING TO BE LEGALLY BOUND, HAVE CAUSED THIS CPCS SCHEDULE TO BE EXECUTED BY THEIR AUTHORIZED REPRESENTATIVES AS OF THE CPCS SERVICES EFFECTIVE DATE SET FORTH BELOW.

ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, D/B/A ORANGE PREVENTION AND TREATMENT INTEGRATED MEDICAL ASSISTANCE D/B/A CALOPTIMA

"PAYER"

By: Michael Engelhard

Name: Michael Engelhard

Title: CFO

Date: 9/28/11

By: Richard Chambers

Name: Richard Chambers

Title: CEO

Date: 9/28/11

ENVOY LLC, an Emdeon company

By:

Name: Lowell Stokes

Title: Vice President, Deputy General Counsel

Date: OCT 18 2011

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EXHIBIT A

To Emdeon Claims Payment and Communication Services Schedule

Print Services Pricing

Emdeon Support Staff (Document design, changes, program updates):	No Charge
Implementation Fees:	
Print and Mail Services Implementation Fee:	**WAIVED**
WebAPI Services	$5,000.00
Domestic Postage:	At Cost
Foreign Postage:	The then current published USPS Global AirMail Letter Post Rates
Materials[1]**:**	
Secure Check Stock	$ 0.0209
White Paper Stock	$ 0.0099
Perforated White Paper (if required)	$ 0.0210
#10 Security Envelope	$ 0.0214
6X9 Envelope	$ 0.0350
9X12 Flat Envelope	$ 0.0990
1.5 inch corrugated box	$ 0.6450
2 inch corrugated box (if required)	$ 0.7450
3 inch corrugated box	$ 0.8950
4 inch corrugated box (if required)	$ 1.0400
4.5 inch corrugated box	$ 1.1650
Thermo Labels - Alternate Shipping	$ 0.2700
2 lb Mail Jacket (11X13.5) (if required)	$ 0.5300
1 lb Tyvek Envelope (if required)	$ 0.3100
#9 Business Reply Envelope (if required)	$ 0.0233
Emdeon Simplex Processing Fee:	$0.10/page
Additional Emdeon Duplex Processing Fee:	$0.05/page
Expedited USPS Fee (if used by Payer this is in addition to the applicable Emdeon Processing Fees):	$0.05/page
Intelligent Mail Service Fee:	$0.005 per envelope[2]
Online image storage and view:	$0.01/image
Online image written to DVD (if contract is terminated herein):	$0.0025/page
Client Access System:	**WAIVED**
Web API Hosting Fee:	$150.00 per month
Terrorist Watch Service:	$100.00 per month
Healthpayers USA:	50% of Savings[3]
Special Delivery Services (e.g., next day):	At Cost[4]

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1 In the event Emdeon experiences a cost increase on any of the Materials outlined above in an amount that is equal to or greater than fifteen percent (15%), Emdeon shall be entitled to pass through such increase immediately upon notice to Payer provided that, upon Payer's written request, Emdeon shall furnish Payer with written documentation evidencing such cost increase.

2 Emdeon reserves the right to pass along any Address Change Service fees that it may incur as a result of Payer's failure to update its addresses after receiving notification, from Emdeon or the USPS, of an updated address.

3 Savings shall be determined by Emdeon on a monthly basis and shall take into account savings achieved through postal consolidation with other clients.

4 These "at cost" charges are charged upon prior request and approval by Payer.

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Emdeon Claims Payment and Communication Services Specifications

Emdeon will perform the CPCS Services selected by Payer in accordance with the terms and conditions outlined in the Emdeon Business Services Payer Agreement and this Emdeon Claims Payment and Communication Services Specifications document.

I. EMDEON FILE TRANSMISSION PROCESS

A. FTP Process

Emdeon uses an FTP server allowing Payer to transmit data to Emdeon for processing. The FTP Process is defined below:

- Emdeon will provide a PGP-encryption key to Payer.
- Payer will PGP-encrypt all document files transmitted to Emdeon.
- Emdeon will provide FTP account information to Payer. This account is specific to Payer.
- Payer will acquire and utilize any commercially available FTP transfer program.
- Payer will transmit all document files to Emdeon via FTP.

B. Data Handling

Emdeon has several processes and procedures in place to ensure the integrity of Claims Communication data. The Data Handling process is defined below:

- Emdeon receives files from a Payer's claim processing system and then Emdeon performs verification of that file's uniqueness.
- The Emdeon FTP Server only allows for Zip or PGP files to be transferred. If the file is corrupted during transfer, the compressed files cannot be imported.
- The Emdeon System contains an index for each payer's check data built by concatenating "Check Number + Account Number + Transit Number". Emdeon maintains historic check data in the Emdeon system and the system audits for duplicate check numbers every time new data is sent to Emdeon. If a duplicate is found, the duplicate check record is rejected, and the Payer is notified immediately of the duplicate check.
- The Emdeon System automatically audits the entire MICR line, checking for valid characters on every check we receive. Emdeon places the MICR line based on the ANSI MICR specifications, and performs that function in a consistent manner for all checks created (1 set of rules within Emdeon System defines MICR line placement).
- Emdeon only maintains the MICR specs. The actual MICR line data is passed directly from the Payer's system through the data interface.
- The Emdeon System creates a summary check register based on the data received from Payer, which is emailed back to the client for verification. This is a "dual-control" function, because the Emdeon check register is created from "Printed Data", whereas the Payer's check register is created from "System Data".
- The Emdeon System automatically verifies delivery addresses against current postal data, and routes incomplete, undeliverable addresses back to Payer.
- The Emdeon System interfaces with Payer's claim system, and the interface allows Payer to flag individual claims for return to the Payer for additional oversight, review or processing.

II. PRINT AND MAIL SERVICE

A. Print Process

- Payer will transmit PGP-encrypted print files containing their Claims Communication data to Emdeon.
- Emdeon will decrypt the files, parse the file, and import the document data into the Emdeon System. During this process, a file receipt and a check register are generated and e-mailed to Payer.
- Prior to 10:00 a.m. Central time, Payer can access the Client Access System (defined below) to manage any successfully imported document. This management includes holds, releases, purges and re-routes.

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- At 10:00 a.m. Central time each business day, Emdeon will process the files eligible for processing since the last day's release. Emdeon will print the documents for mailing. Emdeon will also generate PDF images for all processed documents and make them available for on-line viewing within twenty-four (24) hours of processing.
- Payer may elect to have a production register distributed to them after the Emdeon processing. This file will contain information pertaining to the specific documents that were released for that day.

B. Insert Process

Emdeon uses a 2D barcode insertion process with full account sequencing, which allows all documents created by Emdeon to be tracked. The Insert Process is defined below:

- Machines log all insert transactions and categorize them as successful or unsuccessful (compromised).
- Since each user logs on to the machine to operate, all insert transactions are associated with the user.
- If any sheet is out of sequence or missing, the machine stops and the operator must research the discrepancy.
- If a duplicate print occurs (because the bar code is identical), the machine stops and the operator must intervene.

C. Automated Document Distribution and Oversight Controls

Automated Document Distribution and Oversight Controls are defined below:

- The Emdeon distribution rules (group rules) automate manual tasks with regard to the printing and distribution of documents for Payer.
- Emdeon automates all copy arrangements and distribution for Payer. Whenever Emdeon copies a check, the copy is generated on white paper and "Non-Negotiable" printed in the signature block(s).
- Emdeon shall establish audit controls for Payer with regard to high dollar checks. As an external process, this becomes a "dual control" scenario with Emdeon's audit parameters being the final check with regard to high dollar oversight situations. These high dollar checks are automatically routed to the designated party at Payer for review.
- ALL special handling performed by Emdeon for Payer is done and verified electronically within the Emdeon System. Error logs are created to notify Payer of missing, incorrect or incomplete information BEFORE anything is ever printed or distributed by Emdeon.

D. Manifest Mail Process

Emdeon's facility in Earth City, MO is a Mixed Weight Manifest Mail facility. The Mixed Weight Manifest Mail process is defined below:

- Emdeon sequences and trays all envelopes in zip code order across all payer mailings.
- United State Post Office (USPS) picks up trays from Emdeon on a daily basis.
- Due to its status as a Mixed Weight Manifest Mail facility, at no time is Emdeon required to go to a third party vendor for domestic USPS mail qualification or presort services. All domestic USPS mail generated by Emdeon is delivered into the postal system by Emdeon. No additional handling of the domestic USPS mail takes place and turnaround time can pick up from ½ to ¾ of a day on each end (send/deliver).
- Manifest Mail requires complete accuracy and compliance with USPS procedures. Mail trays are selectively audited by the USPS to ensure Emdeon's accuracy. This is an additional external check and balance for the Emdeon procedures.

III. CLIENT ACCESS SYSTEM (CAS)

The CAS is a tool that can be used by Payer to manage backend operations, by accessing data before and after the file transmission process. CAS allows clients to audit processes, change forms, change addresses, reroute distribution, send and view test files, manage errors and issues, and view documents and their distribution statistics. The following are features of CAS:

- Address Manager – Allows Payer access to manage return of address information on outbound documents.
- Employer Group Manager – Allows Payer to add or modify new groups and lines of business to current parameters.
- File Receipt Manager* – Allows Payer to see the status of files sent to Emdeon and view the contents of the files.
- Business and Distribution Rules Manager – Allows payer's access to manage group or line of business distribution and special handling rules.
- Document Manager*# – Allows Payer to manage documents that have been imported into the Emdeon system. Operations include:
  - Hold – Keeps documents from being delivered and allows them to remain in data format in the Emdeon System. Payer can hold an entire file, groups/lines of business within a file and individual documents.
  - Release – Releases files and documents that are on hold.
  - Pull – Prints and delivers documents back to the client for review.
  - Purge – Purges documents from the system.
  - Route – Allows the delivery address and delivery type to be changed on documents after being sent to Emdeon.
  - History – Provides a full audit trail of all transactions and who authorized them.
  - Search – Provides the ability to search for a particular document and view/print the PDF image of the document.
- Test File Manager – Allows the Payer to submit test files and receive PDF output of new or altered information inputted by Payer in the previously listed capabilities.
- Security Manager – Allows Payer to manage logon accounts and configuration of individual employee access rights.
- Error Manager* – Allows the Payer to access information on any file errors and necessary steps to correct files before importing into the Emdeon System.

* File Receipt Manager, Document Manager, and Error Manager are the only features that will be made available to the Payer in the initial release of the Client Access System. Payer will be given access to additional features of CAS as Payer becomes more familiar with the Emdeon System.

\# Prior to 10:00 a.m. Central time, Payer can use CAS to manage any successfully imported document. This management includes holds, releases, purges and re-routes.

IV. PDF IMAGE DELIVERY SERVICE

Emdeon's PDF Image Delivery Service provides Payer with a PDF image of its Claims Communication. The PDF Image Delivery Service is defined below:

- Emdeon will create a PDF image of Payer's Claims Communications utilizing the data supplied by Payer to Emdeon in the data file.
- Once created, Emdeon shall forward the PDF images, along with a corresponding PDF image data file index, to Payer at an agreed upon location.
- The PDF image data file index shall contain information that will allow Payer to locate a given PDF image within the PDF image file.

V. WEB API SERVICE

Emdeon's Web API enables payers, providers, and members to request their claim documents over the internet. Web API is defined below:

- Emdeon utilizes URL-encryption; which appends encoded parameters to the base URL provided by Emdeon. Emdeon Web API simplifies this parameter encoding through one COM method call.
- Payer will use the Emdeon Web API for any of the Payer's document types.

- Emdeon will provide documentation and consultation that will enable Payer to integrate Web API.

VI. HEALTHPAYERS USA SERVICE

Healthpayers USA is an Emdeon service that consists of seven (7) separate functions that are added to the Emdeon System to increase Emdeon's ability to optimize postage costs and mailing efficiencies. In order for Emdeon to perform such service on behalf of the Payer, the Payer will need to provide Emdeon with certain specific addressee information, including without limitation, addressee mailing address information, federal tax identification number ("TIN") information, paid claim information, and geographic information.

Healthpayers USA allows Emdeon clients to join together to lower postage and materials cost. Healthpayers USA is defined below:

1) **Cross Client Consolidation:**
   - Emdeon will consolidate Payer's Claims Communication with the documents of all other Emdeon clients that are using the Healthpayers USA service when all such documents are addressed to the same addressees.
   - Emdeon consolidates this mail by using addressee TIN or addressee name and mailing address to identify unique addressee matches.
   - Each day Emdeon will send one (1) envelope or package (a "Package") to each unique addressee on behalf of all Healthpayers USA users.
   - Emdeon will calculate Payer's postage costs by taking: (i) the number of pages in the Package that are attributable to Payer and dividing that number by the total number of pages going into the Package (collectively the "Multiplier"), and (ii) multiplying the Multiplier by the amount of postage that was used for the Package delivery. Emdeon will calculate Payer's materials cost for the Package by multiplying the Multiplier by the material's cost of the Package. Emdeon will calculate Payer's materials cost and processing fees for the Healthpayers USA cover sheet by multiplying the Multiplier by the material's cost of the coversheet and the Payer's processing fee, respectively. As an illustration, if the Payer was mailing a one page check/remit to Addressee A and three (3) other Emdeon clients were each also mailing 1 page check/remits to Addressee A, and all such clients (including Payer) were utilizing Healthpayers USA, Payer would be sending one (1) page out of a total of four (4) pages within such Package and the Payer would only be responsible for ¼th of the Package's postage and materials costs and ¼th of cover sheet's processing fees and material's cost. Nothing herein requires Emdeon to perform cross client consolidation for any Claims Communication containing incorrect or inaccurate TIN or mailing address information.

2) **Healthpayers USA Cover Sheet:**
   - Emdeon will insert a cover sheet into every cross client consolidated Package.
   - The cover sheet will describe the contents of each Package and the role of Emdeon as the consolidator/printer of the Claims Communications, as well as the provider of related electronic services.
   - The cover sheet will include Emdeon's return address.

3) **Return Mail Processing:**
   - All cross client consolidated mail that is deemed undeliverable by the USPS will be retuned to Emdeon.
   - To the extent reasonably possible, Emdeon will track, and re-route all returned Claims Communication within three (3) days of receipt by Emdeon.

4) **HPUSA Scheduler:**
   - If selected by Payer, HPUSA Scheduler allows Emdeon to determine which days of the week would maximize Healthpayers USA consolidation with other clients based on several factors including, line of business and geography, and to mail Payers documents on such days.

5) **Multi-Location Printing:**

- In the event that Emdeon constructs additional print and distribution facilities, Multi-Location Printing will allow Emdeon to print Payer's documents from the Emdeon facilities that will maximize postage savings through discounts that Emdeon may become eligible for or that it may negotiate with the USPS or other commercial carriers.
- Any savings generated from such discounts will be considered Healthpayers USA savings and Emdeon will be entitled to fifty percent (50%) of such savings (as determined by Emdeon) in addition to the applicable Processing Fees.

6) **Elimination of certain paper Claims Communications to certain Providers:**

- Emdeon has created and maintains a register of healthcare providers (including pharmacies, physicians, hospitals, dentists, and other medical service related providers), vendors, bill paying services, commercial insurance companies, self-insurance organizations, managed care organizations, governmental agencies and other entities providing transaction submission services for providers (collectively "Providers") who have elected to replace the paper checks and/or paper remittance advice they currently receive from Emdeon with electronic counterparts.
- Emdeon will provide such Providers with electronic counterparts of their paper checks and/or paper remittance advice, which counterparts may include, but are not limited to, data files in standard formats (e.g. 835 ERAs and ACH transactions), data files in non-standard formats and human readable images (e.g. PDF images), all through Emdeon's products and services, including ERA Manager.
- Emdeon will be entitled to collect the Emdeon Processing Fees for any paper Claim Communications that is converted to its electronic counterpart as well as any other applicable fees (e.g. ACH Transaction Fees or ERA Fees). In addition, any savings generated from delivering such documents electronically will be considered Healthpayers USA savings and Emdeon will be entitled to fifty percent (50%) of such savings (as determined by Emdeon).

7) **Elimination of certain paper Claims Communications to certain Members:**

- Emdeon has created and maintains a register of payer members, insureds, enrollees and customers (collectively "Members") who have elected to replace the paper checks and paper explanation of benefits ("EOBs") they currently receive from Emdeon with electronic counterparts.
- Emdeon will provide such Members with electronic counterparts of their paper checks and/or paper EOBs, which counterparts may include, but are not limited to, data files in standard formats (e.g. ACH transactions), data files in non-standard formats and human readable images (e.g. PDF images), all through Emdeon's products and services.
- Emdeon will be entitled to collect the Emdeon Processing Fees for any paper Claim Communications that is converted to its electronic counterpart as well as any other applicable fees (e.g. ACH Transaction Fees). In addition, any savings (as determined by Emdeon) generated from delivering such documents electronically will be considered Healthpayers USA savings and Emdeon will be entitled to fifty percent (50%) of such savings.

VII. eEOB SERVICE

- Payer shall provide Emdeon (in a manner specified by Emdeon) with a list of its Members (as defined above) who have elected to receive email notification that their EOB Claims Communications are available for online viewing ("eMembers"). Along with the list of its eMembers, Payer shall provide Emdeon with any other information necessary (as specified by Emdeon) for Emdeon to create such email notification.
- Utilizing the information provided by Payer, Emdeon shall create an email notification informing the eMembers that their EOB Claims Communications are available for viewing online. The email notification shall contain a hyperlink that will take the eMember to the Payer's website which will contain such eMember's EOB Claims Communication. This email notification shall be in lieu of mailing such eMembers EOB Claims Communication.

VIII. ePAYMENT SERVICE

A. Description of ePayment Service if Parties utilize Payer's Bank to submit ACH Transactions to Providers:

1. Establishing the Originating Deposit Financial Institution (ODFI)

a. Payer shall select a bank or banks that will serve as the Originating Depository Financial Institution (the "ODFI") for the ACH Transactions (as that term is defined below).

i. The ODFI must be a Federal Deposit Insurance Corporation – insured financial institution with an established account and service relationship with the Federal Reserve Banks of the U.S. Federal Reserve System, and capable of executing Fedwire and FedACH transactions.

ii. The ODFI must be able to conduct automated clearing house (ACH) electronic payment transactions in the standard NACHA format.

iii. "ACH Transaction" shall mean any individual payment to an Enabled Entity (as that term is defined below) for which Emdeon shall send payment instructions to the ODFI and for which payment is made by the ODFI pursuant to such instructions, regardless of whether the payment is combined by the ODFI with any other payment to the Enabled Entity, the Enabled Entity's bank, or any correspondent of the Enabled Entity's bank or the payment is made simultaneously with any other payment by the ODFI.

b. Payer shall establish one or more accounts with the selected ODFI to fund the ACH Transactions (any such account being referred to herein as a "Designated Account"). Payer shall inform Emdeon in writing of the identity of the ODFI and of each Designated Account. Payer shall be solely responsible for fully funding and maintaining each such Designated Account.

c. Payer shall be solely responsible to pay any and all fees associated with selecting, establishing and maintaining the ODFI and each Designated Account as well as for any and all fees imposed by the ODFI or other third party associated with any ACH Transaction and for any and all overdraft charges.

d. Payer shall direct the ODFI to: (i) authorize Emdeon to initiate debit and credit ACH Transactions from each Designated Account on behalf of Payer (such authorization being referred to as "Transaction Authorization"), and (ii) notify Emdeon's Senior Vice President - Operations in writing when the ODFI has accepted the Transaction Authorization.

e. Promptly after receiving notification of the Transaction Authorization, Emdeon will coordinate with the ODFI to designate a mutually agreeable file transmission method through which Emdeon can initiate ACH Transactions from each Designated Account.

f. Emdeon shall notify Payer via email once the ACH file transmission method has been selected and fully tested with the ODFI.

g. Payer acknowledges and agrees that Emdeon shall not be responsible or liable for any claims, losses or damages (including any errors or delays in an ACH Transaction) that are attributable to or are caused by the acts or omissions of the ODFI or Payer.

2. *Enabled and Designated Entities*

a. Emdeon maintains a register (the "Register") of Providers (as defined above) that are enabled to receive payments from a Designated Account via ACH Transactions as provided in Section III below. Each such Provider shall be referred to herein as an "Enabled Entity."

b. In the event that Payer desires for Emdeon to add a new Provider (a "Designated Entity") into Emdeon's Register, Payer shall identify such Designated Entity to Emdeon in writing, providing Emdeon with sufficient contact information to allow Emdeon to enroll such Designated Entity in the ePayment Services. Payer shall reasonably assist Emdeon in obtaining all the necessary information from such Designated Entity to enable Emdeon to enroll such Designated Entity in the ePayment Services. The parties acknowledge and agree that such Designated Entity shall become an "Enabled Entity" only after it has completed all of the necessary enrollment and registrations procedures specified by Emdeon.

c. Payer acknowledges and agrees that Emdeon shall not be responsible or liable for any claims, losses or damages arising from Emdeon's actions or omissions in reliance on information provided by an Enabled Entity.

3. *ePayment Services*

With respect to each Enabled Entity, Emdeon shall provide the ePayment Services in the following manner:

a. Payer shall submit its Claims Communications data to Emdeon for processing utilizing the data file format and delivery method specified by Emdeon (the "Data Feed").

b. Utilizing the information contained within the Payer's Data Feed, Emdeon shall identify any Enabled Entities who are to receive payments from Payer. Utilizing the information contained in Payer's Data Feed, Emdeon shall create an ACH Transaction instruction in the standard NACHA format for each payment destined to an Enabled Entity. Provided the Data Feed contains all the information necessary (as specified by Emdeon) for Emdeon to create such an ACH Transaction, Emdeon shall submit such ACH Transaction instruction to Payer's ODFI for processing within two (2) business days after Payer authorizes the release thereof through the Data Feed, the Client Access System, or as otherwise specified by Emdeon, whichever shall first occur.

c. Emdeon shall notify Payer of all ACH Transactions via the file receipt process or other processes specified by Emdeon.

d. With respect to each ACH Transaction, Emdeon shall promptly notify Payer of any errors associated with the ACH file generation or transmission process within two (2) business days of Emdeon's knowledge of such error(s). Such notifications shall be delivered to Payer through email and/or through posting on Emdeon's Client Access System. Payer shall then either re-submit the files which contained such errors or cooperate with Emdeon, the ODFI, the Enabled Entity, and the Enabled Entity's bank in a manual process to correct or compensate for such errors.

B. Any savings (as calculated by Emdeon) achieved through the use of the ePayment Services shall be included when determining Healthpayers USA savings.

IX. USPS MAIL TRACKING SERVICE

USPS Mail Tracking Service allows Payer to utilize the Client Access System to track Payer's first class mail #10 envelopes, 6x9 envelopes and flat envelopes as they are processed through the USPS system.

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X. ERA SERVICE

A. Description of ERA Services if Payer is generating the ERA

- Payer shall create an Electronic Remittance Advice ("ERA") for each ERA that it desires to have sent through Emdeon's EDI network. Payer shall create such ERAs in the standard X12 835 version 4010 A1 format, in accordance with the X12 ERA Implementation Guide, containing all the necessary data elements. Once created, Payer shall forward such ERAs to Emdeon. Emdeon shall then make such ERAs available (through its EDI network and through its other products and services, including Emdeon's ERA Manager) to "Receivers" (as such term is defined below) who are authorized by Emdeon to access such ERAs.

- Payer agrees that Emdeon shall not be responsible or liable for any damages, losses or claims that may arise from or are attributable to inaccuracies or errors in an ERA if such inaccuracies or errors arise from or attributable to Payer's failure to provide all of the necessary data or from incorrect data supplied by Payer or from Payer's failure to provide an ERA in the proper format.

- "Receivers" shall mean the entities, including, without limitation, direct receiving providers (including pharmacies, physicians, hospitals, dentists, and other medical service related providers), vendors, bill paying services, commercial insurance companies, self-insurance organizations, managed care organizations, governmental agencies and other entities providing transaction submission services for providers who are authorized by Emdeon to receive transactions through the EDI network.

B. Description of ERA Services if Emdeon is generating the ERA from Payer's data file

- Emdeon shall create ERA transactions for Payer from the data supplied by Payer utilizing the data file format and delivery method specified by Emdeon. Emdeon shall create the ERA in accordance with the ERA specifications published by Emdeon in effect, from time to time, including the ERA Data Map and the ERA Code Crosswalk (the "ERA Specifications"). Emdeon shall make such ERAs available (through its EDI network and through its other products and services, including Emdeon's ERA Manager) to "Receivers" (as such term is defined above) who are authorized by Emdeon to access such ERAs.

- Payer agrees to supply Emdeon with all of the data necessary to create an ERA transaction in accordance with the ERA Specifications. Payer agrees that Emdeon shall not be responsible or liable for any damages, losses or claims that may arise from or are attributable to inaccuracies or errors in an ERA if such inaccuracies or errors arise from or are attributable to Payer's failure to provide all of the necessary data or from incorrect data supplied by Payer. In addition, Payer agrees that Emdeon shall not be responsible or liable for any damages, losses or claims relating to any ERA transactions that was created in accordance with the ERA Specifications, including the ERA Data Map and ERA Code Crosswalk.

XI. TERRORIST WATCH SERVICE

The Terrorist Watch Service monitors Payer's payments to ensure payments are not being sent to individuals on the OFAC Blocked Persons List. The Terrorist Watch Service is defined below:

- Emdeon shall maintain a database table containing the names and addresses of known and suspected terrorists ("Suspected Individual Database"). Emdeon shall update the Suspected Individual Database at a minimum of once per month. The information used to create and update the Suspected Individual Database shall be derived exclusively from the official United States Government website, http://www.ustreas.gov/offices/eotffc/ofac (the "Government Website"). Emdeon makes no representations or warranties as to the accuracy or sufficiency of the information contained on the Government Website.

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- Emdeon shall analyze and compare all check documents sent by Payer to Emdeon for a match in the Suspected Individual Database. The matching logic will verify the name and address of the check document against the names and addresses listed Suspected Individual Database.
- Any check document identified as a match will be rerouted to Payer and coded with a special mail handling code of "TW".

XII. REPORTS

Emdeon provides Standard Reports via hardcopy, email, and CAS at no additional cost. Payer can also request Custom Reports for an additional charge to the Payer. Standard Reports are defined below.

Required Reports:

- Emdeon File Receipt Confirmation/Check Summary Report – via email.
- Emdeon Monthly Invoice – Itemized by group and delivered via hardcopy and email.
- Emdeon CAS provides a series of process and delivery audit reports.

XIII. HOLIDAYS

Emdeon's holidays are listed below. The Emdeon production and client services department are closed on these dates.

New Year's Day
Memorial Day
July 4th
Labor Day
Thanksgiving Day
Day after Thanksgiving
Christmas Day

If any of the Holidays falls on a weekend, the Friday before the Holiday or the Monday after the Holiday will be observed. Holiday observation dates can be provided upon request.

XIV. CONTACT LIST

[PAYER NAME] Contacts

Contact 1:	NAME _____	
	PHONE #	_____-_____-_____
	FAX#	_____-_____-_____
Contact 2:	NAME _____	
	PHONE #	_____-_____-_____
	FAX#	_____-_____-_____
Contact 3:	NAME _____	
	PHONE #	_____-_____-_____
	FAX#	_____-_____-_____

Emdeon Contacts

Contact 1:	NAME	Lynn McKeone
	PHONE #	314-785-4301
	FAX#	314-770-2654
	Email	lmckeone@emdeon.com

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Contact 2:	NAME	Pat Coughlin
	PHONE #	314-785-4300
	FAX#	314-770-2654
	Email	pcoughlin@emdeon.com
Contact 3:	NAME	Jeff Mouser
	PHONE #	314-785-4302
	FAX#	314-770-2654
	Email	jmouser@emdeon.com

XV. AUTHORIZATION FORM

Payer must provide written confirmation of its intent to go into live production by providing Emdeon, either via hard copy or e-mail, an authorization form that is substantially similar to the example below. The Emdeon Implementation Manager will initiate this process, once testing is completed.

By my signature affixed below, I certify that I have reviewed the results of the parallel tests conducted by Emdeon pursuant to that certain Emdeon Business Services Payer Agreement dated as of _____, 20__ and, as an authorized agent of [PAYER NAME], hereby authorize Emdeon to immediately commence the CPCS Services, as defined in the Emdeon Business Services Payer Agreement. The official start date shall be _____, 20__.

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ADDENDUM NO. 2 TO
CONTRACT MC 04123

BY AND BETWEEN

ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, DBA ORANGE PREVENTION & TREATMENT INTEGRATED MEDICAL ASSISTANCE, DBA CALOPTIMA
(CalOptima)

AND

ENVOY LLC
(Contractor)

ADDENDUM NO. 2 TO THIS CONTRACT is entered into as of this 25th day of January, 2017, with respect to the following facts:

A. CalOptima and Contractor (hereinafter collectively referred to as the "**Parties**") entered into the Emdeon Payer Agreement (Contract MC 04123) effective September 1, 2011, for Emdeon E-Services and Emdeon Claims Payment and Communication Services (hereinafter, "**Contract**").

B. Pursuant to –Section 3.H.8. - Amendment of the Contract, the Contract may be amended only in writing executed by the Parties.

C. The Parties now desire to amend the Contract.

NOW, THEREFORE, THE PARTIES AGREE AS FOLLOWS:

1. All capitalized terms used herein shall have the same meanings given them in the Agreement, unless the context specifically provides otherwise herein.

2. The parties acknowledge and agree that on January 1, 2016, Envoy LLC changed its name to Change Healthcare Solutions, LLC. Therefore, all references to "**Envoy LLC**" under the Agreement shall be changed to "**Change Healthcare Solutions, LLC**" and all references to the defined term "**Emdeon**" shall be changed to "**CHC**" or "**Change Healthcare.**"

3. **No Other Changes.** This Addendum No. 2 is by this reference made part of said Contract. Except as otherwise provided in this Addendum, all of the terms, conditions, and provisions of the Contract and prior addendums shall continue in full force and effect. In the event of any conflict or inconsistency between the provisions of this Addendum and any provisions of the Contract and prior addendums, if any, the provisions of this Addendum No. 2 shall in all respect govern and control. Unless otherwise specifically defined herein, terms used in this Addendum shall have the same meaning as ascribed to them in the Addendum. The execution and delivery of this Addendum shall have the same meaning as ascribed to them in the Contract. The execution and delivery of this Addendum shall not operate as a waiver of or, except as expressly set forth herein, an addendum of any right, power or remedy of either party in effect prior to the date hereof.

[SIGNATURES ON FOLLOWING PAGE]

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IN WITNESS THEREOF, these Parties have, by their duly authorized representatives, executed this Addendum No. 2 on the day and year last shown below.

"OCALOPTIMA"

Date: _____

By: ~~Chet Uma~~ Mark Finch
Its: ~~Chief Financial Officer~~ Procurement Manager

Date: _____

By: ~~Michael Schnader~~
Its: ~~Chief Executive Officer~~

Date: January 25, 2017

Change Healthcare Solutions, LLC

By: Daniel E. Cortez
Its: VP and Senior Managing Division Counsel

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ORIGINAL

DATA CLEARINGHOUSE AGREEMENT

This Data Clearinghouse Agreement (the "Agreement") is entered into as of July 1, 2004 (the "Effective Date") by and between CalOptima, a public agency in the State of California, ("CalOptima") and Office Ally, L.L.C., a California corporation having its principal place of business at 1107 S. Coast Highway, Laguna Beach, CA 92651 ("Vendor").

RECITALS

A. CalOptima desires to purchase and acquire from Vendor certain services (the "Services") relating to the creation of a clearinghouse for CalOptima's data, as more fully described in Exhibit A hereto.

B. Vendor desires to sell and provide such Services to CalOptima, all in accordance with the terms and conditions of this Agreement. Vendor has represented that it has the systems architecture, professional skills, and technological capabilities required to fulfill its obligations hereunder.

NOW, THEREFORE, in consideration of the foregoing Recitals (which are incorporated herein) and other good and valuable consideration, the parties agree as follows:

AGREEMENT

1. ARTICLE I – DOCUMENTS CONSTITUTING CONTRACT

This Agreement shall include, in addition to this document and its exhibits and attachments, all documents cited herein or incorporated by reference. The invalidity in whole or in part of any term or condition of the Agreement shall not affect the validity of other terms or conditions. CalOptima's failure to insist on any one or more instances upon Vendor's performance of such terms or conditions of this Agreement shall not be construed as a waiver or relinquishment of CalOptima's right to such performance or to future performance of such terms or conditions, and Vendor's obligation in respect thereto shall continue in full force and effect. In the event of any conflict of provisions among the documents constituting the Agreement, the provisions shall prevail in the following descending order of precedence: (1) the provisions of this Agreement, including all exhibits and attachments; and (2) all other documents cited herein or incorporated by reference.

2. SERVICES AND SPECIFICATIONS.

(a) Vendor agrees to perform those services and duties as set forth in Exhibit A; all other performance requirements included or incorporated by reference into this Agreement; and, to the extent it is not inconsistent with the above, the documentation

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delivered to CalOptima by Vendor hereunder (collectively, the "Specifications"). Vendor shall provide appropriate personnel to timely and professionally perform its obligations hereunder. CalOptima and Vendor may amend Exhibit A (or attach additional Exhibits A sequentially numbered as Exhibit A-1, Exhibit A-2, and so on) from time to time by mutual written agreement.

(b) Vendor shall use security measures in accordance with industry best practices to prevent unauthorized intrusions and access into its systems and data. Vendor, however, cannot guarantee or warrant that such intrusions and access will not occur despite its best efforts, unless such intrusions and access result from Vendor's negligence or willful misconduct.

(c) CalOptima assumes all responsibility for the data supplied by CalOptima to Vendor, and Vendor shall have no liability of any kind with regard to CalOptima's use of CalOptima's own data. Vendor will correct any material errors in the output it furnishes to CalOptima if the error results from defects in the programs or services provided by Vendor within fifteen (15) days of CalOptima's receipt of the first output that evidences the error.

3. ACCEPTANCE TESTING.

Prior to first productive use of the Services in CalOptima's day-to-day operations, Vendor shall notify CalOptima that the Services are ready to be tested for conformance to the Specifications. CalOptima will test or evaluate the Services to determine whether they conform in all material respects with the Specifications. Upon completion of review and testing, CalOptima shall promptly notify Vendor whether it has accepted the Services ("Accept"), or whether it has identified discrepancies with the Specifications ("Reject"). CalOptima may Accept or Reject the Services in its sole discretion. If CalOptima Rejects the Services, CalOptima shall provide a written list of items that must be corrected. On receipt of CalOptima's notice, Vendor shall immediately commence all reasonable efforts to complete, as quickly as possible, such necessary corrections, repairs and modifications to the Services as will permit them to be ready for retesting and review, but in no event shall such corrective measures exceed twenty (20) days. The testing and evaluation process shall resume, as set forth above. If CalOptima Accepts the Services, it shall issue a written "Acceptance Notice." The date of such Acceptance Notice shall be deemed the "Acceptance Date." If CalOptima determines that the Services, as revised, still do not comply in all material respects with the Specifications, CalOptima may either (1) afford Vendor the opportunity to repeat the correction and modification process as set forth above, or (2) depending on the nature and extent of the failure in CalOptima's sole judgment, terminate this Agreement in accordance with Section 5 (Term and Termination) as a non-curable default. The foregoing correction and modification procedure shall be repeated until the Services, based on CalOptima's good faith determination, conform to the Specifications, or CalOptima elects one of the termination options described above.

4. PRICES AND PAYMENT TERMS.

(a) Fee Schedule. CalOptima will pay Vendor in accordance with the fee schedule attached hereto as Exhibit B ("Fee Schedule"). Vendor will be solely responsible for payment of all sales, use, or other taxes assessed against or associated with the Services or any other service authorized by CalOptima under this Agreement.

(b) Compensation and Expense Reimbursement. Apart from any expenses expressly specified in the Fee Schedule as reimbursable, Vendor will be responsible for all costs and expenses incidental to the performance of Services for CalOptima hereunder, including but not limited to, all costs of licenses, bonds or taxes required of or imposed against Vendor and all other of Vendor's costs of doing business. In addition, no payments will be made for services rendered by Vendor other than the Services, unless such services are approved in advance in writing by CalOptima.

(c) Invoices. Vendor may invoice CalOptima on a monthly basis for chargeable services provided. The rates, as defined in Exhibit B, Fee Schedule, are acknowledged to include Vendor's base labor rates, overhead and profit. Work completed shall be documented on Vendor's invoice(s). Vendor shall also furnish such other information as may be requested by CalOptima to substantiate the validity of an invoice. At its sole discretion, CalOptima may decline to make full payment for any work and direct costs until such time as Vendor has documented, to CalOptima's satisfaction, that Vendor has fully completed the work required under this Agreement and Vendor's performance is accepted by CalOptima. CalOptima's payment in full for any work shall not constitute CalOptima's final acceptance of Vendor's work under this Agreement.

(d) Vendor shall submit invoices to CalOptima's Accounts Payable Office. Each invoice shall provide the description of work performed; the time period covered by the invoice and the amount of payment requested. CalOptima shall remit payment within thirty (30) days of receipt of each invoice, provided that CalOptima does not timely and reasonably dispute such invoice. CalOptima's dispute of specific charges on any part of an invoice does not relieve CalOptima of responsibility to pay the undisputed portion on the due date. Undisputed unpaid balances shall bear interest charges of one and one-half percent (1.5%) per month or fraction thereof.

5. TERM AND TERMINATION.

(a) Term. This Agreement will commence on the Effective Date and will remain in effect for an initial term of one (1) year(s) (the "Initial Term"), unless earlier terminated in accordance with the provisions of this Agreement. At the end of the Initial Term, CalOptima may renew this Agreement for three (3) successive periods of one (1) year (each a "Renewal Term") by written notice to Vendor not less than thirty (30) days prior to the end of the then-current term. If written notice is not provided, this Agreement shall terminate at the end of the then-current Renewal Term. As used herein, "Term" shall mean the Initial Term and any Renewal Terms.

(b) Termination for Unavailability of Funds.

In recognition that CalOptima is a governmental entity and its operations and budgets are determined on an annual basis, CalOptima shall have the right to terminate this Agreement as follows:

i. Right to Terminate. CalOptima may terminate this Agreement if it does not receive funding from the State of California for any fiscal year.

ii. Payment of Fees. If this Agreement is terminated pursuant to this Section 5 (Term and Termination), CalOptima agrees to promptly pay Vendor all fees and other charges due and payable as of the termination date.

iii. Reinstatement. If this Agreement is terminated pursuant to this Section 5 (Term and Termination) and funds are received by CalOptima from the State of California within one-hundred twenty (120) days of the date of termination, then CalOptima shall promptly notify Vendor in writing and CalOptima shall have the right to reinstate this Agreement for that period for which funds are received by CalOptima or the unexpired term of this Agreement as of the date of termination, whichever period is shorter in duration. Notwithstanding the foregoing, CalOptima may only reinstate this Agreement two (2) times during the Term of this Agreement.

(c) Termination for Convenience by CalOptima. CalOptima may terminate this Agreement without any breach by Vendor by providing written notice to Vendor sixty (60) days in advance of the effective date of termination. Upon such termination, CalOptima will be responsible for payment of undisputed fees for Services rendered prior to the effective date of such termination.

(d) Automatic Termination. This Agreement shall terminate automatically if CalOptima's Agreement with the State of California is terminated. This Agreement shall also automatically terminate if the Department of Health Services (DHS) withdraws its approval of waiver granted under Section 1915(b) of the Social Security Act for county-wide organization health systems.

(e) Termination for Cause. Either party may terminate this Agreement upon thirty (30) days written notice to the other party as a result of any of the following events:

i. A material breach of this Agreement, provided that such breach has not been cured by the expiration of such thirty (30) day period.

ii. Either party becomes insolvent, makes a general assignment for the benefit of creditors, seeks protection under any bankruptcy laws or consents to or acquires any trustee, receiver or the other person authorized to take over the business operations and/or assets of such party.

iii. Nonpayment of any undisputed invoice amount.

6. OUTSOURCING AND ASSIGNMENT.

(a) Vendor. Vendor's obligations are personal to Vendor, and Vendor acknowledges that CalOptima has entered this Agreement in reliance on Vendor's ability and agreement to perform its obligations accurately, competently and completely. Vendor may not outsource, assign, subcontract or delegate this Agreement nor any of its rights, duties or obligations under this Agreement without the express written consent of CalOptima. Any purported assignment or delegation in violation of this provision shall be void at the option of CalOptima. CalOptima's consent shall not be deemed an endorsement of such assignment or delegation and shall not relieve Vendor of any of its obligations or liabilities under this Agreement. Any such assignment, delegation or subcontracting, even if approved by CalOptima, will be at Vendor's own risk and expense.

(b) CalOptima. CalOptima reserves the right to assign its rights and obligations hereunder, as it deems appropriate with the consent of Vendor, which consent shall not be unreasonably withheld.

7. WARRANTIES; LIMITS OF LIABILITY.

(a) Standard of Performance. Vendor warrants to CalOptima that it will perform the Services in accordance with (i) the Specifications and (ii) in accordance with generally accepted professional standards for similar services in effect at the time of such performance. Without limiting the foregoing, Vendor will provide prompt and professional responses to all CalOptima requests.

(b) Intellectual Property Warranty. Vendor warrants that Vendor will not, in its provision of Services, infringe or misappropriate any patent, copyright, trade name, trade secret or other proprietary right (collectively "Intellectual Property Rights") of a third party. If any Service or part thereof furnished under this Agreement, becomes, or in CalOptima's or Vendor's reasonable opinion is likely to become, the subject of any claim arising from or alleging infringement of, or in the event of any adjudication that such Service or part thereof infringes on, any Intellectual Property Right of a third party, Vendor, at its own expense shall take the following actions in the listed order of preference:

i. secure for CalOptima the right to continue using the Service and/or part thereof;

ii. replace or modify the Service and/or part thereof to make it non-infringing; provided, however, that such modification or replacement shall not degrade the operation or performance of the Service; or

iii. refund all fees paid by CalOptima to Vendor hereunder.

(c) Rights to Perform. Vendor further represents and warrants, during the entire term of this Agreement, (i) that Vendor has and will have all rights, titles, licenses, permissions, and approvals necessary to perform its obligations hereunder, to provide the Services to CalOptima as contemplated by this Agreement and to grant CalOptima the rights granted herein, and (ii) there are no claims, demands or proceedings that have been instituted, or are pending or threatened, by any person against Vendor or, to Vendor's knowledge, any customer of Vendor alleging any matter contrary to the foregoing.

(d) Disabling Device. Vendor represents, warrants and agrees that Vendor will not knowingly cause any unplanned interruption of the operations of, or accessibility to the Services through any device, method or means including, without limitation, the use of any "virus," "lockup," "time bomb," or "key lock" device or program, or disabling code, which has the potential or capability of causing any unplanned interruption of the operations of, or accessibility of the Services, to CalOptima or any authorized user or which could alter, destroy, or inhibit the use of the Services, or any data contained therein or accessible thereby (collectively referred to for purposes of this Section as "Disabling Device(s)") which could block access to or prevent the use of the Services or data by CalOptima or any of CalOptima's or authorized users.

(e) Insurance. Vendor represents, warrants and agrees that it has in place, and will maintain in full force and effect throughout the Term, all insurance policies in accordance with Section 12 below and industry standards.

(f) Assignment of Warranties. To the extent permissible, Vendor hereby assigns and agrees to deliver to CalOptima all representations and warranties received by Vendor from Vendor's third party licensors or suppliers.

(g) Warranty Disclaimer. Except for the representations and warranties set forth in this Agreement (including the Exhibits attached hereto), neither party makes any warranties of any kind, whether express, implied or statutory, including any warranties of merchantability, noninfringement of third party rights or fitness for a particular purpose, which are hereby expressly disclaimed.

(h) Overall Liability. EXCEPT FOR VENDOR'S INDEMNIFICATION OBLIGATIONS HEREUNDER OR WITH RESPECT TO A BREACH OF SECTION 8 (CONFIDENTIAL INFORMATION), NEITHER PARTY'S TOTAL LIABILITY TO THE OTHER PARTY FOR ANY CLAIM ARISING OUT OF OR RELATING TO THIS AGREEMENT SHALL EXCEED THE GREATER OF (i) $50,000 OR (ii) THE AMOUNT OF ALL MONIES PAID BY CALOPTIMA TO VENDOR DURING THE

TWELVE MONTHS PRIOR TO THE DATE SUCH CLAIM AROSE, OR PROJECTION OF TWELVE MONTH PERIOD, IF THE EVENT RESULTING IN LIABILITY OCCURS BEFORE TWELVE MONTHS OF HISTORY EXISTS.

(i) Indirect Damages. EXCEPT FOR VENDOR'S INDEMNIFICATION OBLIGATIONS HEREUNDER OR WITH RESPECT TO A BREACH OF SECTION 8 (CONFIDENTIAL INFORMATION), NEITHER PARTY SHALL HAVE ANY LIABILITY TO THE OTHER OR ANY THIRD PARTY FOR ANY INCIDENTAL, INDIRECT, CONSEQUENTIAL, PUNITIVE, OR SPECIAL DAMAGES OF ANY KIND (INCLUDING LOST REVENUES OR PROFITS, LOSS OF BUSINESS, OR LOSS OF DATA) ARISING OUT OF OR IN CONNECTION WITH OR RELATED TO THIS AGREEMENT OR THE RIGHTS PROVIDED HEREUNDER SUFFERED BY A PARTY OR BY ANY ASSIGNEE, TRANSFEREE OF, OR THIRD PARTY CLAIMING RIGHTS DERIVED FROM A PARTY TO THIS AGREEMENT, EVEN IF INFORMED IN ADVANCE OF THE POSSIBILITY OF SUCH DAMAGES.

8. CONFIDENTIAL INFORMATION.

(a) Definition of Confidential Information. For purposes hereof, "Confidential Information" shall mean, collectively: (i) regardless of whether marked confidential or proprietary, any information relating to patients of CalOptima or any other health care provider, any information concerning research activities and plans, marketing or sales plans, pricing or pricing strategies, operational techniques, strategic plans, financial information, business opportunities, personnel information, research, development or know-how; (ii) any information designated by either party as "confidential" or "proprietary" or which, under the circumstances taken as a whole, would reasonably be deemed to be confidential; and (iii) the terms and conditions of this Agreement.

(b) Exclusions. Notwithstanding the foregoing, Confidential Information will not include any information or material to the extent any such information or material that:

i. is or becomes public information, unless such publication is a breach of this Agreement or a similar confidentiality or non-disclosure agreement;

ii. was already known to the disclosing party prior to being disclosed by or obtained from the other party as evidenced by written records kept in the ordinary course of business of or by proof of actual use by the disclosing party;

iii. has been or is hereafter rightfully received by the disclosing party from a third person (other than the other party) without restriction or disclosure and without breach of this Agreement; or

iv. has been independently developed by the disclosing party without reference to the other party's Confidential Information.

It will be presumed that any Confidential Information in a disclosing party's possession is not within exception (b) above, and the burden will be upon the disclosing party to prove otherwise by records and documentation.

(c) Treatment of Confidential Information. Each party recognizes the importance of the other's Confidential Information. In particular, each party recognizes and agrees that the Confidential Information of the other is critical to their respective businesses and that neither party would enter into this Agreement without assurance that such information and the value thereof will be protected as provided in this Section 8 and elsewhere in this Agreement. Accordingly, each party agrees as follows:

i. Each party will hold any and all Confidential Information it obtains in strictest confidence and will use and permit use of Confidential Information solely for the purposes of this Agreement.

ii. Each party may disclose or provide access to its responsible employees, and may make copies, of Confidential Information only to the extent reasonably necessary to carry out its duties hereunder.

iii. Each party currently has, and in the future will maintain in effect and enforce, rules and policies to protect against access to or use or disclosure of Confidential Information other than in accordance with this Agreement, including without limitation written instruction to and agreements with employees and agents to ensure that such employees and agents protect the confidentiality of Confidential Information. Each party expressly will instruct its employees and agents not to disclose Confidential Information to third parties, including without limitation customers, subcontractors or consultants, without the other's prior written consent.

iv. Each party, at its own expense, will take all steps, including without limitation the initiation and prosecution of actions at law or in equity, necessary or appropriate to prevent use or disclosure, and upon any unauthorized disclosure further unauthorized disclosure or use, of any Confidential Information received or obtained by it except as expressly permitted by the terms of this Agreement.

v. Each party will notify the other immediately of any unauthorized disclosure or use, and will cooperate with that party to protect all proprietary rights in and ownership of its Confidential Information.

(d) Compelled Disclosures. To the extent required by applicable law or by lawful order or requirement of a court or governmental authority having competent jurisdiction over the disclosing party, the disclosing party may disclose Confidential Information, in accordance with such law or order or requirement, subject to the following conditions: As soon as possible after becoming aware of such law, order or requirement and prior to disclosing Confidential Information, pursuant thereto, the disclosing party will so notify the other party in writing and, if possible, the disclosing party will provide the other party notice not less than five (5) business days prior to the required disclosure. The disclosing party will use reasonable efforts not to release Confidential Information, pending the outcome of any measures taken by the other party to contest, otherwise oppose or seek to limit such disclosure by the disclosing party and any subsequent disclosure or use of Confidential Information, that may result from such disclosure. The disclosing party will cooperate with the other party regarding such measures. Notwithstanding any such disclosure, the disclosing party will not affect its obligations hereunder with respect to Confidential Information so disclosed.

(e) Disclosures to Contractors. Subject to Section 6(a), above, Vendor may use independent contractors who are natural persons in fulfilling its duties under this Agreement provided that Vendor will be responsible and liable for such independent contractors and will obtain confidentiality agreements from such independent contractors. Such confidentiality agreements must contain: (i) provisions which require that the independent contractor comply with the terms and conditions of this Section 8; and (ii) language providing that CalOptima may enforce its rights against the independent contractor as an intended third party beneficiary of such agreement, even though CalOptima is not a party to such agreement, provided that CalOptima's right to exercise such rights will be conditioned on its having given Vendor reasonable prior written notice of CalOptima's intention to do so, and specific reasons for doing so, such that Vendor has a reasonable opportunity to resolve the issue that CalOptima has with such independent contractor. Vendor will provide CalOptima with copies of such confidentiality agreements upon request.

(f) Return of Confidential Information. Upon the disclosing party's written request or upon expiration or termination of this Agreement for any reason, the receiving party will promptly return or destroy, at the disclosing party's option, all originals and copies of all Confidential Information, all originals and copies of all summaries, records, descriptions, modifications, negatives, drawings, adoptions and other documents or materials, whether in writing or in machine-readable form, prepared by receiving party prepared under its direction or at its request from the Confidential Information.

(g) Non-Exclusive Equitable Remedy. Each party acknowledges and agrees that due to the unique nature of Confidential Information, there can be no adequate remedy at law for any breach of its obligations hereunder, that any such breach will result in irreparable harm to such party, and therefore, that upon any such breach or any threat thereof, each party will be entitled to appropriate equitable relief from a court of competent jurisdiction in addition to whatever remedies either of them might have with this Agreement and to be indemnified by the other party from any loss or harm, including, without limitation, lost profits and attorneys' fees, in connection with any breach or enforcement of such party's obligations hereunder or the unauthorized use or release of any such Confidential Information. Each party will notify the other in writing immediately upon the occurrence of any such unauthorized release or other breach. Any breach of this Section 8 will constitute a material breach of this Agreement and be grounds for immediate termination of this Agreement in the exclusive discretion of the non-breaching party.

(h) Security of Patient Information. Without limiting the foregoing, Vendor will maintain and enforce safety and physical security procedures with respect to its access and maintenance of any and all information relating to patients that are (i) at least equal to industry standards for such types of locations, (ii) in accordance with CalOptima's provided security requirements, and (iii) which are in compliance with all Federal, State and local laws, rule and regulations. The term, "applicable Federal, State, and local laws" above, specifically includes, without limitation, the following:

i. Applicable provisions (Sections 261-264) of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and all implementing regulations from the Department of Health and Human Services, whether such regulations are proposed or finally adopted (each set of proposed implementing regulations shall be considered replaced, for purposes of this Agreement, by their final implementing regulations at the time the final implementing regulations are published), including without limitation the implementing regulations entitled, "Standards for Privacy of Individually Identifiable Health Information" and "Security and Electronic Standards" (altogether, the "HIPAA Requirements");

ii. Applicable requirements of the Food and Drug Administration ("FDA"), including without limitation the requirements of 21 Code of Federal Regulations ("C.F.R.") Part 11 (entitled "Electronic Records; Electronic Signatures"); the "Guidance for Industry" published in April, 1999 by the FDA entitled, "Computerized Systems Used In Clinical Trials;" and any required FDA approval or certification any System Component; and

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iii. Applicable Hospital Conditions of Participation for the Medicare and Medicaid Programs that require protection of and security for health information and appropriate patient access to such information, including without limitation 42 C.F.R. Section 482.13 (d) (entitled "Standard: Confidentiality of Patient Records").

9. BUSINESS ASSOCIATE AGREEMENT

Vendor agrees to sign a Business Associate Agreement, which is attached hereto as Exhibit C and incorporated herein by this reference

10. INDEMNIFICATION.

(a) Indemnification. Vendor will indemnify and hold harmless CalOptima, its affiliates, successors and assigns and the directors, officers and employees and agents of any of them (each an "Indemnified Party"), from any claim, loss, damage, expense or liability arising out of (i) a breach by Vendor of Section 8 (Confidential Information); (ii) a claim that CalOptima's permitted use of the Services and Software infringes the patent, copyright, trade secret, or other rights of a third party; or (iii) arising out of or incurred by any such person due to the negligence or willful misconduct of Vendor or its directors, officers or employees, except to the extent arising out of or based on any negligent act or omission of CalOptima with respect to the subject matter of this Agreement.

(b) Indemnification Procedure. CalOptima will as soon as is reasonably practicable provide Vendor with prompt written notice of any claim for which indemnification is required, tender the defense of any such claim to Vendor, provide reasonable cooperation for such defense at Vendor's expense, and not settle without Vendor's prior written approval, not to be unreasonably withheld. CalOptima may participate in any such defense or settlement with counsel of its own choosing at its expense.

11. INDEPENDENT CONTRACTOR STATUS.

The parties acknowledge that neither Vendor nor Vendor's employees or agents are CalOptima employees for state or federal tax purposes or any other purpose. As neither Vendor nor Vendor's employees or agents are CalOptima's employee, Vendor is responsible for paying all required state and federal taxes or other amounts due as a result of the payment of compensation by CalOptima under this Agreement. In particular: (i) CalOptima will not withhold FICA from Vendor's payments; (ii) CalOptima will not make state or federal unemployment insurance contributions on behalf of Vendor, its employees or agents; (iii) CalOptima will not withhold state or federal income tax from the payments to Vendor; (iv) CalOptima will not make disability insurance contributions on behalf of Vendor, its employees or agents; and (v) CalOptima will not obtain workers' compensation insurance on behalf of Vendor, its employees or agents. However,

CalOptima may, at its sole discretion, report its payments to Vendor to appropriate state and federal government agencies.

12. INSURANCE REQUIREMENTS.

(a) Required Insurance Coverages. Vendor shall obtain, pay for, and maintain in full force and effect during the Term insurance as follows:

i. Workers' compensation and employers' liability insurance with limits to conform with the greater of the amount required by California law or one million dollars ($1,000,000) each accident, including occupational disease coverage;

ii. Commercial general liability insurance with limits not less than three million dollars ($3,000,000) combined single limit for bodily injury, death, and property damage, including personal injury, contractual liability, independent contractors, broad-form property damage, and products and completed operations coverage;

iii. Commercial automobile liability insurance with limits not less than one million dollars ($1,000,000) each occurrence combined single limit of liability for bodily injury, death, and property damage, including owned and non-owned and hired automobile coverages, as applicable; and

iv. Professional liability insurance (Errors and Omissions) with limits not less than three million dollars ($3,000,000) annual aggregate for all claims each policy year for computer programming and electronic data processing services.

(b) Claims Made Coverages. To the extent any insurance coverage required under this Section is purchased on a "claims-made" basis, such insurance shall cover all prior acts of Vendor during the Term, and such insurance shall be continuously maintained until at least three (3) years beyond the expiration or termination of the Term, or Vendor shall purchase "tail" coverage, effective upon termination of any such policy or upon termination or expiration of the Term, to provide coverage for at least one (1) year from the occurrence of either such event.

(c) Certificates Of Insurance. Certificates of Insurance evidencing all coverages described in this Section shall be furnished to CalOptima prior to the Effective Date.

(d) Cancellation Or Lapse Of Insurance. Vendor shall give thirty (30) days' prior written notice to CalOptima of cancellation, non-renewal, or material change in coverage, scope, or amount of any policy. Should Vendor fail to keep in effect at all times the insurance coverages required under this Section 12, CalOptima may, in addition

to and cumulative with any other remedies available at law, equity, or hereunder withhold payments to Vendor required under this Agreement in an amount sufficient to procure the insurance required herein.

13. VERIFICATION OF CALOPTIMA COSTS BY GOVERNMENT.

Until the expiration of eight (8) years after the furnishing of any service pursuant to this Contract, Vendor will make available, upon written request of the Secretary of Health and Human Services of the Comptroller General of the United States or any of their duly authorized representatives, or the California Department of Health Services, Department of Justice, or Bureau of Medical Fraud, copies of this Agreement and any books, documents, records, and other data of Vendor that are necessary to certify the nature and extent of costs incurred by CalOptima for such services. This provision shall also apply to any agreement between a subcontractor and an organization related to the subcontractor by control or common ownership.

14. GENERAL.

(a) Compliance With Applicable Law. Vendor warrants that, in the performance of this Agreement, it shall observe and comply with federal, state, and local laws in effect when this Agreement is signed or which may come into effect during the term of this Agreement.

(b) Governing Law. This Agreement will be governed by and construed in accordance with the laws of the State of California, without giving effect to principles of conflicts of law.

(c) CalOptima Designee. The Chief Executive Officer of CalOptima, or their designee, shall have the authority to act for and exercise any of the rights of CalOptima, as set forth in this Agreement, subsequent to and in accordance with the authority granted by the Board of Directors.

(d) Prohibited Interests. Vendor covenants that, for the term of this Agreement, no director, member, officer, or employee of CalOptima during his/her tenure has any interest, direct or indirect, in this Agreement or the proceeds thereof.

(e) Ownership Of Reports And Documents. The originals of all letters, documents, reports, software programs and other products and data produced for the purposes of this Agreement shall be delivered to, and become the property of CalOptima. Copies may be made for Vendor's records, but shall not be furnished to others without written authorization from CalOptima. Such deliverables shall become the sole property of CalOptima and all rights in copyright therein shall be retained by CalOptima.

(f) Notice of Labor Disputes. Whenever Vendor has knowledge that any actual or potential labor dispute may delay this Agreement, Vendor shall immediately notify and submit all relevant information to CalOptima. Vendor shall insert the

substance of this entire clause in any subcontract hereunder as to which a labor dispute may delay this Agreement.

(g) Unavoidable Delays. If the delivery of services under this Agreement should be unavoidably delayed, CalOptima, shall extend the time for completion of the Agreement for the determined number of days of excusable delay. A delay is unavoidable only if the delay was not reasonably expected to occur in connection with, or during Vendor's performance, and was not caused directly or substantially by acts, omissions, negligence, or mistakes of Vendor, Vendor's subcontractors, or their agents, and was substantial and in fact caused Vendor to miss delivery dates, and could not adequately have been guarded against by contractual or legal means. Delays beyond the control of Vendor or caused by CalOptima will be sufficient justification for delay of services, and Vendor shall be allowed a day-for-day extension.

Vendor shall notify CalOptima, as soon as Vendor has, or should have, knowledge that an event has occurred which will delay deliveries. Within five (5) working days, Vendor shall confirm such notice in writing, furnishing as much detail as is available.

Vendor agrees to supply, as soon as such data are available, any reasonable proofs that are required by CalOptima, to make a decision on any request for extension. CalOptima shall examine the request and any documents supplied by Vendor and shall determine if Vendor is entitled to an extension and the duration of such extension. CalOptima shall notify Vendor of this decision in writing. It is expressly understood and agreed that Vendor shall not be entitled to damages or compensation, and shall not be reimbursed for losses on account of delays resulting from any cause under this provision.

(h) Force Majuere. When satisfactory evidence of a cause beyond a party's control is presented to the other party, and nonperformance is unforeseeable, beyond the control, and not due to the fault of the party not performing, a party shall be excused from performing its obligations under this Agreement during the time and to the extent that it is prevented from performing by such cause, including, but not limited to, any incidence of fire, flood, acts of God, commandeering of material, products, plants or facilities by the federal, state or local government, or a material act or omission by the other party.

(i) No Liability Of County Of Orange. As required under Ordinance No. 3896 of the County of Orange, State of California, the parties hereto acknowledge and agree that the obligations of CalOptima under this Agreement are solely the obligations of CalOptima, and the County of Orange, State of California, shall have no obligation or liability therefor.

(j) Severability. The invalidity in whole or in part of any provision of this Agreement shall not affect the validity of other provisions.

(k) Nonexclusive Agreement. This Agreement is a nonexclusive agreement. CalOptima expressly reserves the right to contract with others for any of the products or services it may require.

(l) Waiver. CalOptima's failure to insist on performance of any provision of this Agreement, or to exercise any right herein conferred, will not be construed as a waiver of CalOptima's right to assert or rely on that provision or right, or any similar provision or right, in any later instance.

(m)Notices. All notices, consents and other communications required by or permitted to be given under this Agreement will be in writing and will be deemed to have been duly given if and when: (i) delivered personally; (ii) sent by confirmed facsimile transmission; (iii) mailed by first class certified mail, return receipt requested, postage prepaid; or (iv) sent by a nationally recognized express courier service, postage or delivery charges prepaid, and in all events will be deemed given upon receipt. All such notices, consents and communications will be sent to the addresses set forth below, or to such other address as may be designated by a party by giving written notice to the other party pursuant to this Section.

To CalOptima:
CalOptima
1120 West La Veta Avenue
Orange, CA 92868
Attention: Bill Farry
Chief Information Officer

To Vendor:
Office Ally
1107 S. Coast Hwy.
Laguna Beach, CA 92651
Attn: Brian P. O'Neill

(n) Advertising. Vendor shall acquire no right to use, and shall not use, without CalOptima's prior written consent, the terms or existence of this Agreement, the names, characters, artwork, designs, trade names, copyrighted materials, trademarks or service marks of CalOptima, its related or subsidiary companies, parent, employees, directors, shareholders, assigns, successors or licensees: (i) in any advertising, publicity, press release, client list, presentation or promotion; (ii) to express or to imply any endorsement of Vendor or Vendor's services; or (iii) in any manner other than expressly in accordance with this Agreement.

(o) Entire Agreement. This Agreement and its Exhibits constitute the entire agreement between the parties regarding its subject matter, and supersede any prior or contemporaneous representations, understandings and agreements, whether oral or

written regarding its subject matter. This Agreement may be modified or amended only by a writing signed by duly authorized representatives of both parties. In the event of any conflict between thee terms of this Agreement and any Exhibit, attachment, work order, purchase order or other document between the parties, the body of this Agreement shall prevail and govern, with precedents next given to the Exhibits attached hereto.

(p) Survival. The following provisions will survive termination of this Agreement: 7, 8, 10, 11, 12(b), 13 and 14.

(q) Legal Fees. If any enforcement action or equitable claim between the parties with respect to this Agreement, the prevailing party in such proceeding will be entitled to receive its reasonable attorneys' fees, expert witness fees and out-of-pocket costs incurred in connection with such proceeding, in addition to any other relief it may be awarded.

No action, regardless of form, arising out of this Agreement may be brought by either party more than two (2) years after the cause of action has occurred, except an action for nonpayment may be brought within two (2) years of the date of the last payment.

IN WITNESS WHEREOF, duly authorized representatives of the parties have executed this Agreement as of the Effective Date.

CalOptima

By: _____

Title: CFO

VENDOR

By: _____

Title: President/CEO

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EXHIBIT A

SCOPE OF SERVICES

1. Objective

   To allow providers to submit claims data electronically in multiple formats to Vendor who in turn will apply approved edits and data validation and translate data into an ANSI 837 data file for submission to CalOptima.

2. Go-Live Requirements:

   a. Vendor shall have the ability to accept multiple file formats from Providers for HCFA1500 and UB92 claims and then convert them to ANSI 837 (through Level 4 compliance per Claredi).
   b. Vendor to stay current with HIPAA / ANSI regulation addends and changes.
   c. As needed to reflect changes in Medi-Cal billing and payment practices, additional business edits to be implemented in line with an agreed to timeline.
   d. FTP file transmission to CalOptima's FTP secure site with PGP encryption
   e. Vendor shall submit to CalOptima a daily file for each form type. (HCFA 1500, UB92 – split between inpatient and outpatient file, develop process to take 25-1 inbound LTC file layouts and convert to 837 ANSI format).
   f. Vendor shall accommodate "start-up" activities with CalOptima as follows:
      - Along with CalOptima, develop a standard letter of notification to the Provider community regarding CalOptima's ability to accept claims data electronically.
      - Mail the notification letter to each Provider on the list of Providers supplied by CalOptima.
      - Develop the test script program to download file(s) to CalOptima.
      - Incorporate business rules as defined by CalOptima into existing software code including but not limited to provider validation, member eligibility validation and claims processing rules.
        - CalOptima will provide Vendor with a weekly Provider Master file to support validation / business rule logic.
        - Source data for membership validation to be determined by vendor and CalOptima. Options include State Membership BIC file or data file provided by CalOptima.
        - CalOptima will provide Vendor with a list of fields for each form type that is required. If the record is blanked or spaced, the record is rejected.

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g. Vendor to obtain approval from CalOptima for any changes to logic impacting production file no less than 24 hours prior to the change being implemented.

h. Vendor will coordinate a testing process of all upgrades to production logic prior to migration into production.

i. Vendor shall provide CalOptima a management report or file to report rejected record activity per provider and a total record count for each daily file for reconciliation purposes.

j. Vendor will be able to receive CalOptima claims from other Clearing House vendors, convert them to CalOptima standards, and include records into CalOptima's daily files.

k. Vendor shall be able to support aggressive outreach and support activities directly with Providers to improve EDI submissions rates.

l. Vendor shall contact providers and encourage them to send data electronically.

m. Vendor shall provide telephone support to CalOptima and its providers between the hours of 6:00 am (PST) and 6:00 pm (PST) at a minimum.

n. Vendor shall provide custom support visits to CalOptima's office, as necessary.

o. Vendor to provide a secure and reliable technical infrastructure to support Services. Changes to current infrastructure shall be communicated to CalOptima. Current infrastructure includes the following:

- The "host" where the servers are located has two layers of battery backup to go through before diesel-powered generators are engaged for power. All disk storage is backed up onto tape every night. All disk storage is stored redundantly for quick recovery in case of disk failure. Vendor to have emergency phone numbers and e-mail addresses for CalOptima use in case of system emergencies. Vendor's network and servers are simple, secure and stable. Update is better than 99.9%.
- The "host" network of servers is reduntantly connected to all three major Internet backbones (MCI, Sprint and UUNet). Each backbone connection is via direct T3 links, providing Vendor with over 130 Megabits per second of transfer available straight to the backbone.
- The servers are hosted in a world-class climate-controlled machine room with rigid temperature and humidity control. All power is filtered and emergency power is always available via battery backup systems and backup generators capable of providing continuous power indefinitely.

p. Vendor's web site is to be HIPAA compliant and compliant with any and all new government regulations.

- CalOptima allows Vendor to use the "CalOptima" name in their listing of current customers. Vendor to obtain prior approval from CalOptima for all other advertising.

EXHIBIT B

FEE SCHEDULE

1. Vendor shall be paid $0.25 cents for all claims transmitted to CalOptima (HCFA-1500, UB92, 25-1).
2. Vendor shall manually review all claims denied for eligibility reason if desired by submitting entity. The standard per claim fee ($0.25 cents) to be charged to CalOptima if and only if the member is determined as eligible and the record is therefore transmitted to CalOptima.
3. Vendor agrees to transmit claims electronically to CalOptima within 24 hours except when claims are received by Vendor after 5:00 p.m. on a Federal Holiday or a weekend, in which case, Vendor will transmit to CalOptima on the following business day. (HCFA-1500, UB92)
4. Vendor agrees to transmit claims LTC facility claims (typically 25-1 inbound file format) to CalOptima in line with a mutually agreeable timeframe.
5. Vendor shall be paid $0.25 cents for all attachments (without regard to the number of pages). CalOptima shall only pay for attachments if they are viewed by CalOptima.

EXHIBIT C

BUSINESS ASSOCIATE PROTECTED HEALTH INFORMATION DISCLOSURE AGREEMENT

This Business Associate Protected Health Information Disclosure Agreement ("Agreement') is entered into as of July 1, 2004, by and between CalOptima ("Plan") and Office Ally, L.L.C. ("Business Associate").

RECITALS

WHEREAS, the parties have executed an agreement(s) whereby Business Associate provides services to Plan, and Business Associate receives, has access to or creates Protected Health Information in order to provide those services ("Services Agreement(s)");

WHEREAS, Plan is subject to the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act of 1996, and regulations promulgated thereunder, including the Standards for Privacy of Individually Identifiable Health Information at 45 Code of Federal Regulations Parts 160 and 164 ("Privacy Regulations");

WHEREAS, the Privacy Regulations require Plan to enter into a contract with Business Associate in order to mandate certain protections for the privacy and security of Protected Health Information, and those Regulations prohibit the disclosure to or use of Protected Health Information by Business Associate if such a contract is not in place;

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:

DEFINITIONS

1.1 "Disclose" and "Disclosure" mean, with respect to Protected Health Information, the release, transfer, provision of access to, or divulging in any other manner of Protected Health Information outside Business Associate's internal operations or to other than its employees.

1.2 Individual means the person who is the subject of Protected Health Information and shall include a person who qualifies as a personal representative in accordance with 45 C.F.R. § 164.502(g).

1.3 "Protected Health Information" has the same meaning as the term "protected health information" in 45 C.F.R. § 164.501, limited to the information created or received by Business Associate from or on behalf of Plan. Protected Health Information includes information that (i) 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; (ii) identifies the Individual (or for which there is a reasonable basis for believing that the information can be used to identify the Individual); and (iii) is received by Business Associate from or on behalf of Plan, or is created by Business Associate, or is made accessible to Business Associate by Plan.

1.4 Required By Law means a mandate contained in law that compels an entity to make a Use or Disclosure of Protected Health Information 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 any 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.

1.5 "Services" has the same meaning as in the Services Agreement(s).

1.6 "Use" or "Uses" mean, with respect to Protected Health Information, the sharing, employment, application, utilization, examination or analysis of such Information within Business Associate's internal operations.

1.7 Terms used, but not otherwise defined, in this Agreement shall have the same meaning as those terms in the Privacy Regulations.

OBLIGATIONS OF BUSINESS ASSOCIATE

2.1 Permitted Uses and Disclosures of Protected Health Information. Business Associate:

(a) shall Use and Disclose Protected Health Information as necessary to perform the Services , and as provided in Sections 2.3, 2.4, 2.5, 2.6, 2.7, 2.8, 3.3 and 4.1 of this Agreement;

(b) shall Disclose Protected Health Information to Plan upon request;

(c) may, as necessary for the proper management and administration of its business or to carry out its legal responsibilities:

(i) Use Protected Health Information; and

(ii) Disclose Protected Health Information if the Disclosure is required by law.

Business Associate shall not Use or Disclose Protected Health Information for any other purpose.

2.2 Adequate Safeguards for Protected Health Information. Business Associate warrants that it shall implement and maintain appropriate safeguards to prevent the Use or Disclosure of Protected Health Information in any manner other than as permitted by this Agreement.

2.3 Reporting Non-Permitted Use or Disclosure. Business Associate shall report to Plan each Use or Disclosure that is made by Business Associate, its employees, representatives, agents or subcontractors but is not specifically permitted by this Agreement. The initial report shall be made by telephone call to Laura Blank, telephone number (714) 246-8499 (Plan's Privacy Officer) within five (5) business days from the time the Business Associate becomes aware of the non-permitted Use or Disclosure, followed by a full written report to the Privacy Officer no

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later than twenty (20) business days from the date the Business Associate becomes aware of the non-permitted Use or Disclosure. If Business Associate is unable to provide a full written report within the stated time frames, Business Associate may request an extension of up to ten (10) additional business days. Such requests shall be in written form (facsimile is acceptable), and submitted to Plan's Privacy Officer within the original twenty (20) business day deadline, and must contain an explanation for the basis of the requested extension. Plan retains the right to approve or deny such requested extensions; however Plan shall not unreasonably deny such requests.

2.4 Mitigation of Harmful Effect. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a Use or Disclosure of Protected Health Information by Business Associate in violation of the requirements of this Agreement.

2.5. Availability of Internal Practices, Books and Records to Government Agencies. Business Associate agrees to make its internal practices, books and records relating to the Use and Disclosure of Protected Health Information available to the Secretary of the federal Department of Health and Human Services for purposes of determining Plan's compliance with the Privacy Regulations. Business Associate shall immediately notify Plan of any requests made by the Secretary and provide Plan with copies of any documents produced in response to such request.

2.6 Access to Protected Health Information. Business Associate shall, to the extent Plan determines that any Protected Health Information constitutes a "designated record set" as defined by 45 C.F.R. § 164.501, make the Protected Health Information specified by Plan available to the Individual(s) identified by Plan as being entitled to access and copy that Protected Health Information. Business Associate shall provide such access for inspection of that Protected Health Information within thirty (30) calendar days after receipt of request from Plan. Business Associate shall also provide copies of that Protected Health Information within thirty (30) calendar days after receipt of request from Plan.

2.7 Amendment of Protected Health Information. Business Associate shall, to the extent Plan determines that any Protected Health Information constitutes a "designated record set" as defined by 45 C.F.R. § 164.501, make any amendments to Protected Health Information that are requested by Plan. Business Associate shall make such amendment within thirty (30) calendar days after receipt of request from Plan in order for Plan to meet the requirements under 45 C.F.R. § 164.526.

2.8 Accounting of Disclosures. Upon Plan's request, Business Associate shall provide to Plan an accounting of each Disclosure of Protected Health Information made by Business Associate or its employees, agents, representatives or subcontractors.

Any accounting provided by Business Associate under this Section 2.8 shall include:

(a) the date of the Disclosure;

(b) the name, and address if known, of the entity or person who received the Protected Health Information;

(c) a brief description of the Protected Health Information disclosed; and

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(d) a brief statement of the purpose of the Disclosure.

For each Disclosure that could require an accounting under this Section 2.8, Business Associate shall document the information specified in (a) through (d), 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). Business Associate shall not, however, be required to maintain such information for disclosures of Protected Health Information:

(a) to carry out treatment, payment, and health care operations on behalf of Plan, or that are incident to such disclosures;

(b) to individuals of protected health information about them; or

(c) pursuant to a written authorization given by or behalf of the individual.

Business Associate shall provide to Plan, within thirty (30) calendar days after receipt of request from Plan, information collected in accordance with this Section 2.8 to permit Plan to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. § 164.528.

TERM AND TERMINATION

3.1 Term. This Agreement shall remain in effect as long as any Services Agreement is in effect, including any such Services Agreement(s) entered into by the parties after the effective date of this Agreement. Business Associate's obligations under Sections 2.1 (as modified by Section 4.2), 2.3, 2.4, 2.5, 2.6, 2.7, 2.8, and 4.3 shall survive the termination or expiration of this Agreement.

3.2 Termination for Cause. In addition to and notwithstanding the termination provisions set forth in the Services Agreement(s), upon Plan's knowledge of a material breach by Business Associate, Plan shall either:

(a) Provide an opportunity for Business Associate to cure the breach or end the violation and terminate this Agreement if Business Associate does not cure the breach or end the violation within the time specified by Plan;

(b) Immediately terminate this Agreement and the Services Agreement(s) if Business Associate has breached a material term of this Agreement and cure is not possible; or

(c) If neither termination nor cure is feasible, Plan shall report the violation to the Secretary of the federal Department of Health and Human Services.

3.3 Disposition of Protected Health Information Upon Termination or Expiration.

(a) Except as provided in paragraph (b) of this section, upon termination for any reason of this Agreement and the Services Agreement(s), Business Associate shall return or destroy all Protected Health Information received from Plan, or created or received by Business Associate on behalf of Plan. This provision shall apply to Protected Health Information

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that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.

(b) In the event that Business Associate determines that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to Plan notification of the conditions that make it infeasible. If return or destruction is infeasible, Business Associate shall extend the protections of this Agreement to such Protected Health Information and limit further Uses and Disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

MISCELLANEOUS

4.1 Use of Subcontractors and Agents. Business Associate shall require each of its agents and subcontractors that receive Protected Health Information from Business Associate, or create Protected Health Information for Business Associate, on behalf of Plan, to execute a written agreement obligating the agent or subcontractor to comply with all the terms of this Agreement.

4.2 Regulatory References. A reference in this Agreement to a section in the Privacy Regulations means the section as in effect or as amended.

4.3 Interpretation. Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits Plan to comply with the Privacy Regulations.

4.4 Amendment. The parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Plan to comply with the requirements of the Privacy Regulations.

EXECUTION

Subject to the execution of the State Contract by CalOptima and the State, this Agreement shall become effective as of July 1, 2004 ("Effective Date").

In witness thereof, the parties have executed this Contract:

Business Associate

Brian P. O'Neill
Print Name

Signature

President/CEO
Title

6/30/04
Date

CalOptima

AMY PARK
Print Name

Signature

CFO
Title

7/6/04
Date

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ORIGINAL

AMENDMENT NO. 1 TO DATA CLEARINGHOUSE AGREEMENT

BETWEEN

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

AND

OFFICE ALLY, L.L.C.,

(VENDOR)

AMENDMENT NO. 1 TO THIS AGREEMENT is entered into as of the 1st day of July, 2005, with respect to the following facts:

A. CalOptima and VENDOR entered into a Data Clearinghouse Agreement on July 1, 2004; and

B. CalOptima and VENDOR agree to exercise the option in paragraph 5 of the Agreement to extend the Initial Term by one year, using the first of three Renewal Terms. The new termination date shall be changed to June 30, 2006;

C. CalOptima and VENDOR agree that there are two remaining Renewal Terms in the Agreement. The second Renewal Term, if exercised, shall be from July 1, 2006 through June 30, 2007. The third and final Renewal Term, if exercised, shall be from July 1, 2007 through June 30, 2008; and

D. CalOptima and VENDOR agree to incorporate language required by the Center for Medicare and Medicaid Services (CMS) for CalOptima's new Medicare Advantage Program under a new Section 14 as follows:

14. MEDICARE ADVANTAGE PROGRAM.

(a) In addition to compliance with the provisions of Section 15(a) below, VENDOR expressly warrants that VENDOR and VENDOR'S subcontractors, if any, shall comply with all applicable Medicare laws, regulations, and CMS instructions, including but not limited to all Medicare laws applicable to marketing. VENDOR further agrees and

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acknowledges that this provision will be included in any and all agreements with VENDOR'S subcontractors.

(b) For any medical records or other health and enrollment information VENDOR maintains with respect to Medicare enrollees, VENDOR shall establish procedures to:

i. Abide by all Federal and State laws regarding confidentiality and disclosure of medical records and other health and enrollment information. VENDOR shall safeguard the privacy of any information that identifies a particular enrollee and shall have procedures that specify (a) the purpose or purposes the information will be used within VENDOR'S organization; and (b) to whom and for what purpose VENDOR will disclose the information.

ii. Ensure that the medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas.

iii. Maintain the records and information in an accurate and timely manner.

iv. Ensure timely access by enrollees to the records and information that pertain to them.

(c) VENDOR shall comply with the reporting requirements provided in Title 42 of the Code of Federal Regulations, Section 422.516 as well as the encounter data submission requirements of 42 CFR section 422.257. Notwithstanding the preceding sentence, the parties hereto expressly agree and acknowledge that the provisions of 42 CFR 422.516 and 42 CFR 422.257 are not applicable to this Agreement.

(d) In addition to the termination provisions of Section 5 of this Agreement, VENDOR agrees and acknowledges that CalOptima may terminate the Agreement if CMS or CalOptima determines that VENDOR has not satisfactorily performed its obligations under the Agreement. Under such circumstances, CalOptima may pay VENDOR its allowable costs

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incurred to the date of termination. Thereafter, VENDOR shall have no further claims against CalOptima for matters pertaining to this Agreement.

(e) While CalOptima maintains ultimate responsibility for adhering to and complying with all terms and conditions of its Agreement with CMS, VENDOR shall comply with all such requirements at the direction of CalOptima.

(f) CalOptima shall review, approve, and audit on an ongoing basis, the credentialing of medical professionals, if any, associated with VENDOR and VENDOR'S performance of this Agreement.

(g) Notwithstanding the delegation by CalOptima to VENDOR the selection of providers, contractors, or subcontractors, CalOptima expressly retains the right to approve, suspend, or terminate any such arrangement.

Notwithstanding the written delegation by CalOptima to VENDOR of any other activities under this Agreement, CalOptima maintains ultimate responsibility for adhering to and complying with all terms and conditions of its Agreement with CMS, and expressly retains the right to approve, suspend, or terminate any such arrangement with VENDOR. With all such delegated activities, CalOptima shall monitor VENDOR'S performance on an ongoing basis to ensure compliance with all applicable CalOptima and CMS requirements."

E. Renumber Section 14, GENERAL, as a new Section 15.

F. SIGNATURES -- This Amendment No. 1 to the Agreement shall be made effective upon execution by both parties. IN WITNESS WHEREOF, the parties hereto have caused this Amendment No. 1 to the Agreement to be executed on the date first above written.

~~Office Ally, L.L.C.~~	CalOptima
By: _____	By: _____ 8/25/05
Brian P. O'Neill	~~Amy Park~~ Dr. Greg Buchert
President/Chief Executive Officer	Operating Chief ~~Financial~~ Officer

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ORIGINAL

AMENDMENT NO. 2 TO DATA CLEARINGHOUSE AGREEMENT

BETWEEN

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

AND

OFFICE ALLY, L.L.C.,

(VENDOR)

AMENDMENT NO. 2 TO THIS AGREEMENT is entered into as of the 1st day of July, 2006, with respect to the following facts:

A. CalOptima and VENDOR entered into a Data Clearinghouse Agreement on July 1, 2004;

B. CalOptima and VENDOR exercised the first of three one year Renewal Terms on July 1, 2005;

C. CalOptima and VENDOR agree to exercise the second Renewal Term for July 1, 2006 through June 30, 2007. The new termination date shall be changed to June 30, 2007;

D. CalOptima and VENDOR agree that there is one remaining Renewal Term in the Agreement. The third Renewal Term, if exercised, shall be from July 1, 2007 through June 30, 2008;

E. SIGNATURES -- This Amendment No. 2 to the Agreement shall be made effective upon execution by both parties. IN WITNESS WHEREOF, the parties hereto have caused this Amendment No. 2 to the Agreement to be executed on the date first above written.

Office Ally, L.L.C.	CalOptima
By: _____	By: _____
Brian P. O'Neill	Keith Quinlivan
President/Chief Executive Officer	Chief Financial Officer

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AMENDMENT NO. 3 TO DATA CLEARINGHOUSE AGREEMENT

BETWEEN

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

AND

OFFICE ALLY, L.L.C.,

(VENDOR)

AMENDMENT NO. 3 TO THIS AGREEMENT is entered into as of the 26th day of June, 2007, with respect to the following facts:

A. CalOptima and VENDOR entered into a Data Clearinghouse Agreement on July 1, 2004;

B. CalOptima and VENDOR agree to exercise the third and final Renewal Term and extend such Term to June 30, 2008;

C. SIGNATURES -- This Amendment No. 3 to the Agreement shall be made effective upon execution by both parties. IN WITNESS WHEREOF, the parties hereto have caused this Amendment No. 3 to the Agreement to be executed on the date first above written.

Office Ally, L.L.C.	CalOptima
By:	By: for 7/25/07
Brian P. O'Neill	Keith Quinlivan
President/Chief Executive Officer	Chief Financial Officer

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AMENDMENT NO. 4 TO DATA CLEARINGHOUSE AGREEMENT

BETWEEN

ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, DBA ORANGE

PREVENTION AND TREATMENT INTEGRATED MEDICAL ASSISTANCE,

DBA CALOPTIMA

AND

OFFICE ALLY, LLC

(VENDOR)

AMENDMENT NO. 4 TO THIS AGREEMENT is entered into as of the 26th day of June, 2008, with respect to the following facts:

A. CalOptima and VENDOR entered into a Contract entitled "Data Clearinghouse Agreement" on July 1, 2004 to edit and validate claims for submission to CalOptima; and

B. CalOptima and VENDOR agree to maintain the current fee schedule and to use Contract No. MC 03299 as a Purchase Order number to bill for the clearinghouse services performed effective July 1, 2008; and

C. CalOptima and VENDOR agree to extend the terms of the Agreement under Contract No. MC 03299 to the 30th day of June, 2009.

SIGNATURES -- This Amendment No. 4 to the Contract shall be made effective upon execution by both parties. IN WITNESS WHEREOF, the parties hereto have caused this Amendment No. 4 to the Contract to be executed on the date first above written.

Office Ally, LLC

By: _____

Brian P. O'Neill

President/Chief Executive Officer

CalOptima

By: _____

Michael Engelhard

Chief Financial Officer

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AMENDMENT NO. 5 TO MC 03299 DATA CLEARINGHOUSE AGREEMENT

BETWEEN

ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, DBA ORANGE

PREVENTION AND TREATMENT INTEGRATED MEDICAL ASSISTANCE,

DBA CALOPTIMA

AND

OFFICE ALLY, LLC

(VENDOR)

AMENDMENT NO. 5 TO THIS AGREEMENT is entered into as of the 6th day of November, 2008, with respect to the following facts:

A. CalOptima and VENDOR entered into a Contract entitled "Data Clearinghouse Agreement" on July 1, 2004 to edit and validate claims for submission to CalOptima; and

B. CalOptima and VENDOR agree to modify the Scope of Work to contract MC 03299 to include electronic delivery of the PM160 document. The PM160 document is defined as the document that captures the pediatric preventative service that is shared with the state in the Child Health and Disability Prevention (CHDP) program. CalOptima agrees to pay VENDOR $0.25 per PM160 delivered electronically to CalOptima. All other terms and conditions remain otherwise unchanged.

SIGNATURES -- This Amendment No. 5 to the Contract shall be made effective upon execution by both parties. IN WITNESS WHEREOF, the parties hereto have caused this Amendment No. 5 to the Contract to be executed on the date first above written.

Office Ally, LLC

By: _____

Brian P. O'Neill

President/Chief Executive Officer

CalOptima

By: _____

Rita Vitagliano

Director of Finance and Procurement

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AMENDMENT NO. 6 TO MC 03299 DATA CLEARINGHOUSE AGREEMENT

BETWEEN

ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, DBA ORANGE

PREVENTION AND TREATMENT INTEGRATED MEDICAL ASSISTANCE,

DBA CALOPTIMA

AND

OFFICE ALLY, LLC

(VENDOR)

AMENDMENT NO. 6 TO THIS AGREEMENT is entered into as of the 16th day of February, 2009, with respect to the following facts:

A. CalOptima and VENDOR entered into a Contract entitled "Data Clearinghouse Agreement" on July 1, 2004 to edit and validate claims for submission to CalOptima; and

B. CalOptima and VENDOR agree to extend the terms of the Agreement to June 30, 2010.

SIGNATURES -- This Amendment No. 6 to the Contract shall be made effective upon execution by both parties. IN WITNESS WHEREOF, the parties hereto have caused this Amendment No. 6 to the Contract to be executed on the date first above written.

Office Ally, LLC

By: _____

Brian P. O'Neill

President/Chief Executive Officer

CalOptima

By: Richard Chambers

Richard Chambers

Chief Executive Officer

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AMENDMENT NO. 7 TO MC 03299 DATA CLEARINGHOUSE AGREEMENT

BETWEEN

ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, DBA ORANGE

PREVENTION AND TREATMENT INTEGRATED MEDICAL ASSISTANCE,

DBA CALOPTIMA

AND

OFFICE ALLY, LLC

(VENDOR)

AMENDMENT NO. 7 TO THIS AGREEMENT is entered into as of the 2nd day of June, 2010, with respect to the following facts:

A. CalOptima and VENDOR entered into a Contract entitled "Data Clearinghouse Agreement" on July 1, 2004 to edit and validate claims for submission to CalOptima; and

B. CalOptima and VENDOR agree to modify the payment terms of Amendment 5 Section B to reduce the price of the PM 160 R11 from $.25 to $.15. All other prices shall remain the same; and

C. VENDOR agrees to provide an SAS 70 Type II equivalent report ensuring internal controls are in place protecting PHI connected with electronic transmission of claims data; and

D. CalOptima and VENDOR agree to extend the terms of the Agreement to June 30, 2011.

SIGNATURES -- This Amendment No. 7 to the Contract shall be made effective upon execution by both parties. IN WITNESS WHEREOF, the parties hereto have caused this Amendment No. 7 to the Contract to be executed on the date first above written.

Office Ally, LLC

By: _____

Brian P. O'Neill

President/Chief Executive Officer

CalOptima

By: Richard Chambers

Richard Chambers

Chief Executive Officer

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AMENDMENT NO. 8 TO MC 03299 DATA CLEARINGHOUSE AGREEMENT

BETWEEN

ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, DBA ORANGE

PREVENTION AND TREATMENT INTEGRATED MEDICAL ASSISTANCE,

DBA CALOPTIMA

AND

OFFICE ALLY, LLC

(VENDOR)

AMENDMENT NO. 8 TO THIS AGREEMENT is entered into as of the 18th day of June, 2011, with respect to the following facts:

A. CalOptima and VENDOR entered into a Contract entitled "Data Clearinghouse Agreement" on July 1, 2004 to edit and validate claims for submission to CalOptima; and

B. CalOptima and VENDOR agree to extend the terms of the Agreement to June 30, 2012.

SIGNATURES -- This Amendment No. 8 to the Contract shall be made effective upon execution by both parties. IN WITNESS WHEREOF, the parties hereto have caused this Amendment No. 8 to the Contract to be executed on the date first above written.

Office Ally, LLC

By: _____

Brian O'Neill

President / CEO

CalOptima

By: _____

Richard Chambers

Chief Executive Officer

CalOptima

By: _____

Michael Engelhard

Chief Financial Officer

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RE: attachments

Perikly, Jaime

Sent: Friday, June 17, 2011 3:59 PM

To: Aleshire, Ryan

One year.

From: Aleshire, Ryan
Sent: Friday, June 17, 2011 3:59 PM
To: Perikly, Jaime
Subject: RE: attachments

Yes, that would be fine. How long should the contract be extended?

Regards,

Ryan Aleshire
Sr. Buyer
CalOptima
Phone: (714) 246 8714
eFax: (714) 571 2499

From: Perikly, Jaime
Sent: Friday, June 17, 2011 3:58 PM
To: Aleshire, Ryan
Subject: RE: attachments

Ryan,

Can we just draft an extension amendment like the most recent one that expires at the end of the month for now? We will need to redo the scope, but there is much more missing that needs to be added. In the interest of time, I think it is best to keep it as is since they are not having any major issues at the moment.

Your thoughts?

From: Aleshire, Ryan
Sent: Friday, June 17, 2011 3:52 PM
To: Perikly, Jaime
Subject: RE: attachments

See attached.

Regards,

Ryan Aleshire
Sr. Buyer
CalOptima
Phone: (714) 246 8714
eFax: (714) 571 2499

From: Perikly, Jaime
Sent: Friday, June 17, 2011 3:45 PM
To: Aleshire, Ryan
Subject: FW: attachments

Do you have the full copy of the contract in its entirety? I want to be sure that we have some specific language in there about the pricing and service expectations before I finish up this amendment.

Thanks!

From: Laurie Kirkland [mailto:laurie.kirkland@officeally.com]
Sent: Friday, June 17, 2011 3:39 PM
To: Perikly, Jaime
Cc: Brannon, Sabrina; Aleshire, Ryan
Subject: RE: attachments

Jamie,

Since this is a scanned pdf it doesn't look like I can copy and paste anything from it.

Laurie

From: Perikly, Jaime [mailto:jperikly@caloptima.org]
Sent: Friday, June 17, 2011 3:26 PM
To: 'Laurie Kirkland'
Cc: Brannon, Sabrina; Aleshire, Ryan
Subject: RE: attachments

Laurie,

Thanks for checking. I am handling the new amendment for this year. Can you copy and paste from last year and forward to me ASAP?

Jaime Perikly, PMP
Director, eBusiness and Project Management Office
CalOptima
Telephone: (714) 246-8813
Fax: (714) 571-2472
E-mail: jperikly@caloptima.org

From: Laurie Kirkland [mailto:laurie.kirkland@officeally.com]
Sent: Friday, June 17, 2011 3:23 PM
To: Perikly, Jaime
Subject: RE: attachments

Hi Jamie,

I was looking for our original contract and it must have been misplaced during our move- but it should have had attachments included on it. I left a message with Marcia because I wanted to see if she remembers implementing with us – someone over there did before 2008. Anyway we charge $0.20 for all attachments that go with one claim. We must not have ever charged you for them either. Sabrina has asked me to create the yearly contract with you, do you want me to copy and paste from last year or will you supply that to me?

Laurie

From: Perikly, Jaime [mailto:jperikly@caloptima.org]
Sent: Monday, June 13, 2011 2:32 PM
To: 'Laurie Kirkland'
Subject: FW: attachments

Laurie,

Can you please provide for me the costs for the attachments? There is nothing in the existing agreement that spells out what the costs were. Also, I do not think we ever requested or approved the allowance of the attachments and worked out the process. Can you please advise?

Can you give me more details on the PM160 demo account that created?

Thanks!

Jaime Perikly, PMP
Director, eBusiness and Project Management Office
CalOptima
Telephone: (714) 246-8813
Fax: (714) 571-2472
E-mail: jperikly@caloptima.org

From: Kodama, Janine

Sent: Friday, June 10, 2011 8:58 AM
To: Perikly, Jaime
Subject: FW: attachments

Hi Jaime, can you assist Laurie below. Not sure what she's referring regarding PM160 demo. There was a 2nd phase we were waiting for to enhance the PM160 process but never received additional information. If you have additional questions, please let me know. Thanks.

Thanks,

Janine Kodama
Coding Quality Manager, Coding Initiatives
CalOptima
Email: jkodama@caloptima.org
Phone: (714) 246-8440
Fax: (714) 481-6506

From: Laurie Kirkland [mailto:laurie.kirkland@officeally.com]
Sent: Friday, June 10, 2011 8:30 AM
To: Kodama, Janine
Subject: attachments

Hi Janine,

I was wondering if you have decided what to do about the attachments we are still posting to you but you are not picking up. I spoke to one of your providers that mentioned she is sending claims electronically to you through us but then she is going to CMS Mgmt online and uploading her reports and she typically is hearing that the 2 are not syncing up.
Should we be shutting off the attachment option for you? We can also deliver them via SFTP if you prefer.

On another subject – any idea where the PM 160 stands? We gave you access to a demo account with all the new updates in early May but never heard back.

Laurie Kirkland
Office Ally
Director of Business Development
866-575-4120 ext 215

(20110610) _____

The message was checked by ESET NOD32 Antivirus.

http://www.eset.com

_____ Information from ESET NOD32 Antivirus, version of virus signature database 6196 (20110610) _____

The message was checked by ESET NOD32 Antivirus.

http://www.eset.com

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_____ Information from ESET NOD32 Antivirus, version of virus signature database 6204 (20110613) _____

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http://www.eset.com

_____ Information from ESET NOD32 Antivirus, version of virus signature database 6218 (20110617) _____

The message was checked by ESET NOD32 Antivirus.

http://www.eset.com

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AMENDMENT NO. 9 TO MC 03299 DATA CLEARINGHOUSE AGREEMENT

BETWEEN

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

AND

OFFICE ALLY, LLC

(VENDOR)

AMENDMENT NO. 9 TO THIS AGREEMENT is entered into as of the 26th day of June, 2012, with respect to the following facts:

A. CalOptima and VENDOR entered into a Contract entitled "Data Clearinghouse Agreement" on July 1, 2004 to edit and validate claims for submission to CalOptima; and

B. CalOptima entered into Amendments 1 though 8 between July 1, 2005 and June 18, 2011.

NOW, THEREFORE, THE PARTIES AGREE AS FOLLOWS:

1. CalOptima and VENDOR agree to extend the terms of the Agreement to June 30, 2013.

SIGNATURES -- This Amendment No. 9 to the Contract shall be made effective upon execution by both parties. IN **WITNESS WHEREOF, the parties** hereto have caused this Amendment No. 9 to the Contract to be executed on the **date first above written.**

Office Ally, LLC

By: _____

Brian O'Neill

President/Chief Executive Officer

CalOptima

By: _____

Michael Engelhard

Interim Chief Executive Officer

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AMENDMENT NO. 10 TO MC 03299 DATA CLEARINGHOUSE AGREEMENT

BETWEEN

ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, DBA ORANGE

PREVENTION AND TREATMENT INTEGRATED MEDICAL ASSISTANCE,

DBA CALOPTIMA

AND

OFFICE ALLY, LLC

(VENDOR)

AMENDMENT NO. 10 TO THIS AGREEMENT is entered into as of the 11th day of June, 2013, with respect to the following facts:

A. CalOptima and VENDOR entered into a Contract entitled "Data Clearinghouse Agreement" on July 1, 2004 to edit and validate claims for submission to CalOptima; and

NOW, THEREFORE, THE PARTIES AGREE AS FOLLOWS:

1. CalOptima and VENDOR agree to extend the terms of the Agreement to December 31, 2016.

SIGNATURES -- This Amendment No. 10 to the Contract shall be made effective upon execution by both parties. IN WITNESS WHEREOF, the parties hereto have caused this Amendment No. 10 to the Contract to be executed on the date first above written.

Office Ally, LLC

By: _____

Brian O'Neill

President/Chief Executive Officer

CalOptima

By: _____

Patti McFarland

Chief Financial Officer

By: _____

Michael Schrader

Chief Executive Officer

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CalOptima
A Public Agency
Better. Together.

Orange, CA 92868
(714) 246-8400

Purchase Order No	17-10226
PO Date	8/25/2016
Delivery Date	8/24/2017
Buyer	Kim Marquez
FOB	BEST METHOD
Shipping Point	Orange
Payment Terms	Net 30 Days
Shipping Method	Best Method
Page	1

Vendor: Office Ally, LLC
8415 Datapoint Drive
Suite 900
San Antonio TX 78229

Phone: (866) 575-4120 Ext. 00(
Fax: (000) 000-0000 Ext. 00(

Ship To: CalOptima - MediCal
Mike Herman/PO 17-10226
505 City Parkway West
Orange CA 92868

^ Changed Since The Previous Revision

Number	Qty	Item U/M	Stock Number	Description	Unit Price	Extended Price
1	1	Each	SER-061-512	Clearinghouse Set Up Fee For implementation of hosting of 270/271 and 276/277 Transactions. Timeframe 1-2 weeks. Per Contract MC 03299, Amendment #11. One time fee.	$4,500.00	$4,500.00
2	12	Each	SER-060-262	EDI Clearinghouse Services Monthly fee of $1,200 per month for hosting 270/271 and 276/277 transactions. Effective 8/25/2016 for first 12 months. Per Contract MC 03299 Amendment No. 11.	$1,200.00	$14,400.00

Req #: 19105/amillspaugh

Verbal additions, deletions, or modifications of any kind to this purchase order shall be considered unauthorized and invalid. Do not accept verbal modifications from any employee, agent, or implied or apparent agent of CalOptima. Valid modifications to this purchase order shall be in the form of a written notice signed by an authorized member of the CalOptima Procurement staff.

Invoices received in excess of the total amount of this purchase order shall be considered unauthorized and, as such, may not be paid. Terms and conditions appearing on the reverse side are hereby incorporated.

PO NUMBER MUST APPEAR ON PACKING SLIP.
TO ASSIST WITH RECEIPT OF GOODS AND ENSURE PAYMENT OF VENDOR INVOICE(S), ALL ITEMS BEING DELIVERED DIRECTLY TO CALOPTIMA FROM THE MANUFACTURER MUST INDICATE CALOPTIMA'S PURCHASE ORDER NUMBER ON THE PACKING SLIP.

Subtotal	$18,900.00
Trade Discount	$0.00
Freight	$0.00
Miscellaneous	$0.00
8.00% Sales Tax	$0.00
Order Total	$18,900.00

See Contract for Signature
Authorized Signature Date

AMENDMENT NO. 11 TO CONTRACT MC 03299
DATA CLEARINGHOUSE AGREEMENT

BY AND BETWEEN

ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY,
dba ORANGE PREVENTION AND TREATMENT ITEGRATED MEDICAL ASSISTANCE, dba
(CalOptima)

AND

OFFICE ALLY, INC
(VENDOR)

AMENDMENT NO. 11 TO THIS CONTRACT is entered into as of this 25th day of August, 2016, with respect to the following facts:

A. CalOptima and Office Ally (hereinafter collectively referred to as "the Parties") entered into Contract MC 03299 on July 1, 2004, under which agreed to provide Data Clearinghouse Services (hereinafter, "Contract").

B. Pursuant to Section 14 (o), the Contract may be amended only in writing executed by the Parties.

C. The Parties now desire to amend the Contract by modifying Exhibit A to include additional services, and Exhibit B to include additional fees.

NOW, THEREFORE, THE PARTIES AGREE AS FOLLOWS:

1. All capitalized terms used herein shall have the same meanings given them in the Agreement, unless the context specifically provides otherwise herein.

2. CalOptima and Office Ally agree to modify Exhibit A - Scope of Services to include a new hosted service for 270/271 and 276/277 transactions. This is to include the initial set up and ongoing monthly service. Office Ally will host this data by way of a set of eligibility and claims "flat files" from CalOptima and respond to provider system real-time inquires and responses with HIPAA ANSI x12 EDI transactions 270/271 Eligibility and 276/277 Claims.

3. CalOptima and Office Ally agree to modify Exhibit B - Fee Schedule to include an initial Setup fee of $4,500.00 for the 270/271 and 276/277 hosting service. CalOptima and Office Ally also agree to a monthly fee of $1,200.00 for, unlimited, hosting and responding to inquiries via these 270/271 and 276/277 transactions.

4. No Other Changes. This Amendment No. 11 is by this reference made part of said Contract. Except as otherwise provided in this Amendment, all of the terms, conditions, and provisions of the Contract and prior amendments shall continue in full force and effect. In the event of any conflict or inconsistency between the provisions of this Amendment and any provisions of the Contract and prior amendments, if any, the provisions of this Amendment No. 11 shall in all respect govern and control. Unless otherwise specifically defined herein, terms used in this Amendment shall have the same meaning as ascribed to them in the Agreement. The execution and delivery of this Amendment shall have the same meaning as ascribed to them in the Contract. The execution and delivery of this Amendment shall not operate as a waiver of or, except as expressly set forth herein, an amendment of any right, power or remedy of either party in effect prior to the date hereof.

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IN WITNESS THEREOF, these Parties have, by their duly authorized representatives, executed this Amendment No. 11 on the day and year last shown below.

"CALOPTIMA"

Date: 8-31-16

By: Ken Wong
Its: Director of Budget and Procurement

Date: 8/29/2016

"VENDOR"

By: BRIAN P O'NEILL
Its: PRESIDENT/CFO
[Chairman, President or Vice President]

By: Gloria Chung
Its: COO
[Secretary or CFO]

If VENDOR is a corporation, two officer signatures or Corporate Resolution or Corporate Seal is required.

AMENDMENT NO. 12 TO
CONTRACT MC 03299
Data Clearinghouse Agreement

BY AND BETWEEN

ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, dba ORANGE PREVENTION AND TREATMENT INTEGRATED MEDICAL ASSISTANCE
dba
(CalOptima)

AND

OFFICE ALLY, INC.
(VENDOR)

AMENDMENT NO. 12 TO THIS CONTRACT is entered into as of this 22ND day of September, 2016, with respect to the following facts:

A. CalOptima and Vendor (hereinafter collectively referred to as "the Parties") entered into Contract MC 03299 on July 1, 2004, under which agreed to edit and validate claims for submission to CalOptima (hereinafter, "Contract").

B. Pursuant to Section 14 (o) of the Contract, the Contract may be amended only in writing executed by the Parties.

C. The Parties now desire to amend the Contract by extending the contract term.

NOW, THEREFORE, THE PARTIES AGREE AS FOLLOWS:

1. All capitalized terms used herein shall have the same meanings given them in the Agreement, unless the context specifically provides otherwise herein.

2. The Term of the Contract and all Amendments to the Contract are hereby extended through December 31, 2020.

3. **No Other Changes.** This Amendment No. 12 is by this reference made part of said Contract. Except as otherwise provided in this Amendment, all of the terms, conditions, and provisions of the Contract and prior amendments shall continue in full force and effect. In the event of any conflict or inconsistency between the provisions of this Amendment and any provisions of the Contract and prior amendments, if any, the provisions of this Amendment No. 12 shall in all respect govern and control. Unless otherwise specifically defined herein, terms used in this Amendment shall have the same meaning as ascribed to them in the Agreement. The execution and delivery of this Amendment shall have the same meaning as ascribed to them in the Contract. The execution and delivery of this Amendment shall not operate as a waiver of or, except as expressly set forth herein, an amendment of any right, power or remedy of either party in effect prior to the date hereof.

[SIGNATURES ON FOLLOWING PAGE]

IN WITNESS THEREOF, these Parties have, by their duly authorized representatives, executed this Amendment No. 12 on the day and year last shown below.

"CALOPTIMA"

Date: 10-7-16

By: Michael Schrader
Its: Chief Executive Officer

By: ~~Chief Admin~~ Ladan Khamseh
Its: ~~CFO~~ CAO

Date: 10/4/2016

"VENDOR"

By: BRIAN P O'NEIL
Its: President/CFO
[Chairman, President or Vice President]

By: Gloria C. Chung
Its: C.C.O.
[Secretary or CFO]

If VENDOR is a corporation, two officer signatures or Corporate Resolution or Corporate Seal is required.

CalOptima Health Board Action Agenda Referral

Action To Be Taken December 1, 2022
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar
9. Approve New CalOptima Health Claims Administration Policy FF.1014p

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

Recommended Action
Approve claims administration policy FF.1014p: Payment for Covered Services Rendered to a Member Enrolled in a Health Network.

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

The purpose of new policy FF.1014p is to outline payment methodologies for member services covered by CalOptima Health's delegated health networks. This policy includes and addresses provisions related to financial responsibility for post-stabilization services. This policy also addresses mandatory terms imposed on health networks due to applicable statutory, regulatory, and/or contractual requirements.

Specifically, Policy FF.1014p outlines Medi-Cal payment methodologies for a provider or practitioner that provides covered services to a member in which the health network is financially responsible in accordance with the division of financial responsibility.

Fiscal Impact
The recommended action has no additional fiscal impact. The Fiscal Year 2022-23 Operating Budget medical expense forecast assumed the payment methodologies for Medi-Cal covered services included in this policy.

Rationale for Recommendation
CalOptima Health staff recommends that the Board approve and adopt policy FF.1014p to ensure CalOptima Health's continuing commitment to conducting its operations in compliance with all applicable state and federal laws and regulations.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

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Attachments

1. FF.1014p: Payment for Covered Services Rendered to a Member Enrolled in a Health Network (Redlined and Clean)
2. APL 08-008: Reimbursement for Non-Contracted Hospital Emergency Inpatient Services
3. APL 08-010: Hospital Payment for Medi-Cal Post-Stabilization Services
4. APL 17-020 (Revised): American Indian Health Programs
5. APL 18-019: Family Planning Services Policy for Self-Administered Hormonal Contraceptives
6. APL 18-022: Access Requirements for Freestanding Birth Centers and the Provision of Midwife Services
7. APL 19-008: Rate Changes for Emergency and Post-Stabilization Services Provided by Out-of-Network Border Hospitals Under the Diagnostic Related Group Payment Methodology: Outcome of Federal Court Litigation Rejecting a Challenge to State Plan Amendment 15-020
8. APL 21-008: Tribal Federally Qualified Health Center Providers

/s/ Michael Hunn *11/23/2022*
Authorized Signature **Date**

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Policy:	FF.1014p
Title:	**Payment for Covered Services Rendered to a Member Enrolled in a Health Network**
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	
Effective Date:	TBD
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy outlines Health Network payment methodologies for a Provider or Practitioner that provides Covered Services to a Member. This policy shall only apply to Covered Services in which the Health Network is financially responsible in accordance with the Division of Financial Responsibility (DOFR).

II. POLICY

A. Non-contracted hospitals, non-contracted Practitioners, and non-contracted Ancillary Service Providers shall not be eligible to participate in any Health Network incentive payment programs.

B. A Practitioner or Provider shall not bill a Member for any portion of a Covered Service, as set forth in Title 22 of the California Code of Regulations, Section 51002.

C. The Health Network shall recover or reimburse overpayments in accordance with FF.2001: Claims Processing for Covered Services for which CalOptima Heath is Financially Responsible.

III. PROCEDURE

A. Hospital Payment: Subject to all applicable Health Network claims and utilization management policies, a Health Network shall reimburse a hospital that provides Covered Services to a Member, as follows:

1. Contracted Hospital: Health Network reimbursement to a Contracted Hospital for Covered Services provided to a Member, shall be based on the Health Network contract with the Hospital.

2. Non-Contracted Hospital: Health Network reimbursement to a non-contracted hospital for Covered Services provided to a member, that has received appropriate authorization, unless exempt from such authorization, in accordance with the Health Network's policy.

   a. Outpatient Emergency and Non-Emergency Services: Health Network shall reimburse non-contracted outpatient Covered Services provided to a Member of the Health Network, at the same amount paid by the California Department of Health Care Services (DHCS) for the

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same services rendered to a Medi-Cal beneficiary in the Medi-Cal Fee-for-Service (FFS) program, in accordance with Section 14091.3(c)(1) of the California Welfare and Institutions Code and Section 1932(b)(2)(D) of the Social Security Act.

b. Emergency Inpatient Services: A Health Network shall reimburse non-contracted emergency inpatient Covered Services provided to a Member of the Health Network using the All Patient Refined Diagnosis Related Groups (APR-DRG) rates, in accordance with Section 14105.28 of the California Welfare and Institutions Code.

c. Non-Emergency Inpatient Services: In the absence of any negotiated rate agreed to, in writing, between Health Networks and a hospital, a Health Network shall reimburse a hospital using the APR-DRG rates, in accordance with Section 14105.28 of the California Welfare and Institutions Code. Prior Authorization is required for all non-emergency inpatient services.

d. Out of State Hospitals: a Health Network shall reimburse a hospital located outside of California using the APR-DRG rates, in accordance with Section 14105.28 of the California Welfare and Institutions Code.

i. Border Hospital: A Health Network shall apply the State Plan Amendment (SPA) 15-020 changes established in the Medi-Cal FFS system to the DRG-based rates paid to out-of-network Border Hospitals for acute care hospital inpatient emergency and post-stabilization services, Health Network may pay a lower negotiated rate agreed to by the hospital.

3. Non-Emergency Non-Authorized Services: A Health Network shall not reimburse a hospital for any services that are subject to authorization requirements, in accordance with the Health Network's policy.

4. If a Member changes Health Networks, for purposes of this policy, during an inpatient stay, the Health Network that authorized the admission shall retain the financial responsibility for the entire stay.

B. Practitioner Payment: For purposes of this policy, a Practitioner does not include those Providers who render services to Members that are not a benefit included in Covered Services provided by the CalOptima Heath Medi-Cal program. Subject to all applicable Health Network policies, a Health Network shall reimburse a Practitioner providing Covered Services to a Member as follows:

1. Contracted Practitioner: Health Network shall reimburse a Contracted Practitioner based on the terms and conditions of the contract between such Contracted Practitioner and Health Network.

2. Non-contracted Practitioner: Health Network reimbursement to a non-contracted Practitioner for Covered Services provided to a Member, shall be based on the following:

a. Emergency Services: Health Network shall reimburse a non-contracted Practitioner that provides emergency Covered Services to a Member of the Health Network, at one hundred percent (100%) of the CalOptima Heath Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

b. Non-Emergency Services: Health Network shall reimburse a non-contracted Practitioner for Covered Services rendered to a Member of the Health Network, for Covered Services for which the Health Network is financially responsible.

C. If a non-contracted birthing center is used for non-contracted Certified Nurse Midwife and licensed midwife services as permitted within each practitioner's scope of practice, the Health Network shall reimburse facility and professional services at one hundred percent (100%) of the Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

D. Federally Qualified Health Center (FQHC) Payment: Subject to all applicable Health Network claims and utilization management policies, a Health Network shall reimburse an FQHC that provides Covered Services to a Member of the Health Network, for Covered Services for which CalOptima Heath is financially responsible, as follows:

1. Contracted FQHC: A Health Network shall reimburse a Contracted FQHC based on the terms and conditions of the contract between such FQHC and Health Network. A Health Network's contracted rates for an FQHC shall not be less than the Health Networks contracted rates to any other Provider or Practitioner for the same scope of services.

2. Non-contracted FQHC: The Health Network shall reimburse a non-contracted FQHC for Covered Services rendered to a Member of the Health Network, for Covered Services for which the Health Network is financially responsible at one hundred percent (100%) of the Medi-Cal Fee Schedule but in no case less than the same amount paid by DHCS for the same services rendered to a Medi-Cal beneficiary in the Medi-Cal FFS program.

a. Health Network shall reimburse a non-contracted FQHC based on the Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS) for each procedure rendered, and not the FQHC's all-inclusive rate.

E. American Indian Health Service Program Payment: Subject to all applicable Health Network claims and utilization management policies, a Health Network shall reimburse an Indian Health Service Facility that provides Covered Services to a Member enrolled in a Health Network, for Covered Services for which the Health Network is financially responsible as follows:

1. Contracted American Indian Health Service Program:

a. If the American Indian Health Service Program is a Rural Health Clinic or qualifies as an FQHC, the Health Network shall reimburse the program at the program's interim per visit rate as established by DHCS, or through an alternate reimbursement methodology approved in writing by DHCS.

b. If the American Indian Health Service Program is a Rural Health Clinic or FQHC, and the Health Network and the program have agreed to an at-risk rate and the program has waived its rights to cost-based reimbursement under its contract with the Health Network, the Health Network shall reimburse the program at the negotiated rate.

c. If the American Indian Health Service Program is entitled to be reimbursed as an American Indian Health Service Provider by the federal government at a rate other than the rate described in (a) above, the Health Network shall reimburse the program at the American Indian Health Service payment rate.

2. Non-contracted American Indian Health Service Program: The Health Network shall reimburse a non-contracted American Indian Health Service Program at the approved Medi-Cal per visit rate for that facility.

3. Effective for dates of service on or after January 1, 2018, a Health Network shall reimburse contracted and non-contracted American Indian Health Service Programs at the current and applicable Office of Management and Budget (OMB) encounter rate, published in the Federal Register. These rates shall apply when services are provided to Members who are qualified to receive services from an American Indian Health Services Program, as set forth in Supplement 6, Attachment 4.19-B of the California Medicaid State Plan.

4. A Health Network shall ensure that the following criteria are met for receipt of payments:

   a. The American Indian Health Service Program Provider must be identified by DHCS;

   b. Except as provided in Section III.E.5. of this Policy, and as set forth in California Medicaid State Plan Supplemental 6. Attachment 4.19-B, only one rate payment per day, per category, shall be allowed within the following three (3) categories. This allows for a maximum of three (3) payments per day, one (1) from each category:

      i. Medical health visit;

      ii. Mental health visit; and

      iii. Ambulatory visit.

5. Tribal FQHC: Effective January 1, 2021, the Health Network shall reimburse a Tribal FQHC Provider, including an Indian Health Care Provider enrolled as an Indian Health Services Memorandum of Agreement (IHS-MOA) clinic that elected to participate in Medi-Cal as a Tribal FQHC Provider in accordance with the Alternate Payment Methodology (APM) and the following reimbursement requirements:

   a. For Medi-Cal beneficiaries with full Medicare coverage or Medicare Part B only, irrespective of Medicare Part D coverage, the required payment is the difference between the "APM Rate (Excluding Medicare)" and 80 percent (80%) of the Medicare FQHC prospective payment system rate.

   b. For Medi-Cal beneficiaries that do not have Medicare Coverage or have Medicare Part A only, irrespective of Medicare Part D coverage, the required payment is the "APM Rate (Excluding Medicare)."

   c. The Health Network shall ensure that the following criteria are met for receipt of payments:

      i. The Tribal FQHC Provider must be identified by DHCS;

      ii. Service must be a Covered Service included in CalOptima Heath's contract with DHCS;

      iii. As set forth in DHCS All Plan Letter 21-008: Tribal Federally Qualified Health Center Providers and California State Plan Amendment to Attachment 4.19-B, CA-20-0044, a Tribal FQHC Provider shall be reimbursed at the applicable rate for up to three (3)

visits per day, per Member in any combination of different visits in the following visit categories:

1) Medical health visit;

2) Mental health visit; and

3) Ambulatory visit.

6. Certain Covered Services shall be reimbursed outside of the OMB or APM rate, including Non-Medical Transportation, Non-Emergency Medical Transportation, and pharmacy services.

F. Ancillary Service Provider Payment: Subject to all applicable Health Network claims and utilization management policies, Health Network shall reimburse an Ancillary Service Provider for Covered Services rendered to a Member for Covered Services for which Health Network is financially responsible as follows:

1. Health Network shall reimburse a contracted Ancillary Service Provider based on the terms and conditions of the contract between such contracted Ancillary Service Provider and Health Network.

2. Health Network shall reimburse a non-contracted Ancillary Service Provider for Covered Services rendered to a Member, at the Provider rate.

G. Financial Responsibility for Medically Necessary Post-Stabilization Services: Subject to compliance with all applicable Health Network claims and utilization management policies, including but not limited to, authorization, medical records, coding and billing requirements, Health Network financial responsibility for Medically Necessary Post-Stabilization Services provided to a Member are as follows:

1. Contracted Provider: Health Network is financially responsible for Medically Necessary Post-Stabilization Services rendered to a Member by Contracted Providers in accordance with their contract unless the contracting provider and contractor have agreed in writing to an alternate payment schedule.

2. Non-Contracted Provider:

a. A Heath Network is financially responsible for Medically Necessary Post-Stabilization Services provided by a non-contracted Provider to a Member that are:

i. Pre-approved by the Health Network, as applicable.

b. A Health Network is financially responsible for Medically Necessary Post-Stabilization Services provided by a non-contracted Provider to a Member that are not pre-approved by the Health Network, as applicable, but administered to maintain, improve, or resolve the Member's stabilized condition if:

i. The Health Network, as applicable, does not respond within thirty (30) minutes after receipt of a written request for Prior Authorization for Medically Necessary Post-Stabilization Services.

ii. The Health Network, as applicable, cannot be contacted; or

iii. A representative of the Health Network, as applicable, and the treating physician cannot reach an agreement concerning the Member's care

c. A Health Network shall pay for all Medically Necessary health care services provided to a Member which are necessary to maintain the Member's stabilized condition up to the time that the Health Network, as applicable, effectuates the Member's transfer or the Member is discharged.

d. A Health Network's financial responsibility for Medically Necessary Post-Stabilization Services not pre-approved ends when:

i. The Health Network plan physician, as applicable, with privileges at the treating hospital assumes responsibility for the Member's care;

ii. The Health Network plan physician assumes responsibility for the Member's care through transfer;

iii. A representative of the Health Network, as applicable, and the treating physician reach an agreement concerning the Member's care; or

iv. The Member is discharged.

e. Denial and Transfer: In the event that the Health Network denies a Prior Authorization request for Post-Stabilization Services from a non-contracted Provider, and transfers the Member to a contracted Provider, payment shall be made for Medically Necessary services furnished to the Member to maintain his or her stabilized condition up to the time that the Member's transfer is effectuated.

f. No Prior Authorization Request: If a non-contracted Provider does not seek a Prior Authorization request for Post-Stabilization Services from the Health Network, then the Health Network is only financially responsible for Emergency Services rendered, and not for Post-Stabilization Services.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Heath Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Heath Policy FF.2001: Claims Processing for Covered Services for which CalOptima Heath is Financially Responsible
C. California Health and Safety Code (HSC), §1797.1
D. California Welfare and Institutions Code (WIC), §14105.28
E. Department of Health Care Services (DHCS) Letter of July 20, 2020: Post-Stabilization Authorization Payment Disputes
F. Department of Health Care Services (DHCS) Policy Letter (PL) 96-09: Sexually Transmitted Disease Services in Medi-Cal Managed Care
G. Department of Health Care Services (DHCS) Policy Letter (PL) 13-004: Rates for Emergency and Post-Stabilization Acute Inpatient Services Provided by Out-Of-Network General Acute Care Hospitals Based On Diagnosis Related Groups Effective July 1, 2013

H. Department of Health Care Services (DHCS) All Plan Letter (APL) 08-008: Reimbursement for Non-Contracted Hospital Emergency Inpatient Services
I. Department of Health Care Services (DHCS) All Plan Letter (APL) 08-010: Hospital Payment for Medi-Cal Post-Stabilization Services
J. Department of Health Care Services (DHCS) All Plan Letter (APL) 17-020 (Revised): American Indian Health Programs
K. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-019: Family Planning Services Policy for Self-Administered Hormonal Contraceptives
L. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-022: Access Requirements for Freestanding Birth Centers and the Provision of Midwife Services
M. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-008: Rate Changes for Emergency and Post-Stabilization Services Provided by Out-of-Network Border Hospitals Under the Diagnostic Related Group Payment Methodology: Outcome of Federal Court Litigation Rejecting a Challenge to State Plan Amendment 15-020
N. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-008: Tribal Federally Qualified Health Center Providers
O. Manual of Current Procedural Terminology (CPT®), American Medical Association
P. Social Security Act, §1932(b)(2)(D)
Q. Title 22, California Code of Regulations (CCR), §§51002, 55000 and 55140(a)
R. Title 28, California Code of Regulations (CCR), §1300.71.4
S. Title 42, Code of Federal Regulations (CFR), §422.113(c)
T. Title 42, United States Code (USC), §1396u-2(h)(2)(C)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
09/14/2022	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
TBD	Regular Meeting of the CalOptima Heath Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	TBD	FF.1014	Payment for Covered Services Rendered to a Member Enrolled in a Health Network	Medi-Cal

IX. GLOSSARY

Term	Definition
American Indian Health Services Program	Programs operated by Indian Health Care providers with funds from the IHS under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.
Ancillary Services	All Covered Services that are not physician services, hospital services, or long-term care services.
Border Hospital	Those hospitals located outside the State of California that are within 55 miles' driving distance from the nearest physical location at which a road crosses the California border as defined by the U.S. Geological Survey.
Certified Nurse Midwife	A registered nurse certified under Article 2.5, Chapter 6 of the California Business and Professions Code with additional training as a midwife who is certified to deliver infants and provide prenatal and postpartum care, newborn care, and some routine care of woman.
Certified Nurse Practitioner	A registered nurse certified under Article 2.5, Chapter 6 of the California Business and Professions Code who possesses additional preparation and skills in physical diagnosis, psycho-social assessment, and management of health-illness needs in primary health care, and who has been prepared in a program that conforms to board standards as specified in Title 16 California Code of Regulations, Section 1484.
Child Health and Disability Prevention (CHDP) Program	California's Early Periodic Screening, Detection, and Treatment (EPSDT) program as defined in the Health and Safety Code, Section 12402.5 et seq. and Title 17 of the California Code of Regulations, Sections 6842 through 6852, that provides certain preventive services for children eligible for Medi-Cal. For CalOptima Heath Members, the CHDP Program is incorporated into CalOptima Heath's Pediatric Preventive Services Program.

Term	Definition
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program, to the extent those services are included as Covered Services under CalOptima Heath'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 Heath Board of Directors, which shall be covered for Members notwithstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Division of Financial Responsibility (DOFR)	A matrix that identifies how Health Network identifies the responsible parties for components of medical services associated with the provision of Covered Services. The responsible parties include, but are not limited to, Physician, Hospital, Health Network and the County of Orange.
Emergency Services	Covered Services furnished by Provider qualified to furnish those health services needed to evaluate or stabilize an Emergency Medical Condition.

Term	Definition
Family Planning Services	Covered Services that are provided to individuals of childbearing age to enable them to determine the number and spacing of their children, and to help reduce the incidence of maternal and infant deaths and diseases by promoting the health and education of potential parents. Family Planning includes, but is not limited to: 1. Medical and surgical services performed by or under the direct supervision of a licensed Physician for the purpose of Family Planning; 2. Laboratory and radiology procedures, drugs and devices prescribed by a license Physician and/or are associated with Family Planning procedures; 3. Patient visits for the purpose of Family Planning; 4. Family Planning counseling services provided during regular patient visit; 5. IUD and IUCD insertions, or any other invasive contraceptive procedures or devices; 6. Tubal ligations; 7. Vasectomies; 8. Contraceptive drugs or devices; and 9. Treatment for the complications resulting from previous Family Planning procedures. Family Planning does not include services for the treatment of infertility or reversal of sterilization.
Federally Qualified Health Center	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.
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 Heath to provide Covered Services to Members assigned to that Health Network.
Indian Health Care Provider (IHCP)	As set forth in 42 CFR § 438.14 (a), a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in Section 4 of the Indian Health Care Improvement Act (25 USC § 1603).
Medically Necessary or Medical Necessity	Reasonable and necessary Covered Services to protect life, to prevent illness or disability, alleviate severe pain through the diagnosis or treatment of disease, illness, or injury achieve age-appropriate growth and development, and attain, or regain functional capacity. For Medi-Cal Members receiving managed long-term services and supports (MLTSS), Medical Necessity is determined in accordance with Member's current needs assessment and consistent with person-centered planning. When determining Medical Necessity of Covered Services for Medi-Cal Members under the age of 21, Medical Necessity is expanded to include the standards set forth in 42 U.S.C. section 1396d(r) and California Welfare and Institutions Code section 14132(v).

Term	Definition
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 Heath program.
Non-Emergency Services	Services provided by Providers that do not constitute an appropriate medical screening examination or stabilizing examination and treatment.
Post-Stabilization Services	Covered Services that are provided after a Member is stabilized following an Emergency Medical Condition in order to maintain the stabilized condition or, under the circumstances described in 42 CFR § 438.114(e) to improve or resolve the Member's condition. The attending emergency physician, or the Provider treating the Member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge and that determination is binding on Health Network for a Member enrolled in the Health Network for which Health Network is financially responsible for the Covered Services in accordance with the Division of Financial Responsibility.
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), Licensed Midwife, 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.
Prior Authorization	A formal process requiring a health care Provider to obtain advance approval to provide specific services or procedures.
Provider	For purposes of this policy, a person or institution that furnishes Covered Services to Members.
Qualified Family Planning Provider	A qualified provider is a provider who is licensed to furnish family planning services within their scope of practice, is an enrolled Medi-Cal provider, and is willing to furnish family planning services to an enrollee as specified in Title 22, California Code of Regulations, Section 51200.
Rural Health Clinic	An organized outpatient clinic or hospital outpatient department located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services.
Tribal Federally Qualified Health Center Provider or Tribal FHQC Provider	An Indian Health Care Provider operating under the authority of the Tribal Indian Self-Determination and Education Assistance Act and participating in Medi-Cal as a Tribal FQHC (using CMS criteria). California State Plan Amendment (SPA) 20-0044 establishes Tribal FQHCs provider type in Medi-Cal.

DHCS
SANDRA SHEWRY
Director

State of California—Health and Human Services Agency
Department of Health Care Services

ARNOLD SCHWARZENEGGER
Governor

DATE: October 2, 2008

MMCD All Plan Letter 08-008

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: REIMBURSEMENT FOR NON-CONTRACTED HOSPITAL EMERGENCY INPATIENT SERVICES

This All Plan Letter (APL) serves to provide information to Medi-Cal managed care plans regarding Welfare and Institutions (W&I) Code Section 14091.3, recently enacted in Section 42 of Assembly Bill 1183 (Chapter 758, Statutes of 2008). W&I Code section 14091.3 was enacted in part to comply with Section 6085 of the Federal Deficit Reduction Act (DRA) of 2005 (Pub. L. 109-171), also known as the "Rogers Amendment." Section 6085 limits the amount Medicaid managed care plans shall pay non-contracted hospitals for emergency services.

For purposes of this letter, "non-contracted" means a general acute care hospital, including hospitals that contract with the Department of Health Care Services (DHCS) under the Medi-Cal Selective Provider Contracting Program (SPCP), that does not have in effect a contract for general acute care inpatient services with a Medi-Cal managed care health plan. It is important to note that this letter is not related to, nor is it intended to be used as a guideline for, the reimbursement of non-contracted post-stabilization services following an admission for emergency inpatient services, which is addressed in subdivision (c)(3) of W&I Code Section 14091.3, but not subject to this APL. A separate letter on post-stabilization will be forthcoming.

Section 6085 of the DRA created a new section 1932(b)(2)(D) of the Social Security Act (SSA) and was federally mandated to be put into effect by states as of January 1, 2007. W&I Code Section 14091.3 finalizes implementation of that federal mandate by State statute. Section 14091.3 requires that non-contracted hospitals, both SPCP and non-SPCP participating hospitals, shall accept as payment in full the amounts published by DHCS for emergency general acute care inpatient services. Further, Section 14091.3, subdivision (d) mandates that final reimbursement rates for purposes of DRA Section 6085 become effective once published by DHCS and shall apply to all emergency inpatient services provided by non-contracted hospitals since January 1, 2007, the effective date of DRA Section 6085. This APL shall serve as publication of those final rates by DHCS.

On March 16, 2007, the Medi-Cal Managed Care Division sent out APL 07-003, Federal Deficit Reduction Act of 2005 (Reimbursement for non-contracted emergency services providers), in which the health plans were notified of the provisions set forth in Section 6085 and put on notice that final per diem reimbursement rates for emergency inpatient services would be forthcoming. That APL encouraged managed care plans to reimburse non-contracted hospitals for emergency inpatient services, both SPCP hospitals and non-SPCP hospitals, according to the average SPCP rate for the geographic region in which the provider is located, referred to as the Standard Consolidated Statistical Area (Average Rate), for the last year reported by the California Medical Assistance Commission (CMAC), and as published in the most recent CMAC Annual Report to the Legislature.

APL 07-003 further stated that once the final rates for reimbursement for emergency inpatient services were published, Medi-Cal managed care plans may be required to undergo a reconciliation process to ensure that all non-contracted hospitals who were paid on a temporary or transitional basis the Average Rate for emergency inpatient services are ultimately reimbursed in accordance with DHCS finalized emergency inpatient rates.

As stated in APL 07-003, this APL provides the final rates for reimbursement for the period January 1, 2007 to June 30, 2008 and for the period July 1, 2008 to June 30, 2009, as noted in the tables below. Rates for subsequent years will be provided prior to July 1 of each year.

The average regional per diem SPCP contract rates in the following tables are derived from unweighted average SPCP contract per diem rates that are publicly available on June 1 of each year and trended forward based on the annual increases in the regional average SPCP contract rates, as published in the CMAC Annual Report to the Legislature. As required by Government Code Section 6254(q) and SPCP contract terms, SPCP rates are confidential for 4 years and managed care plans or their contractors cannot require or compel an SPCP hospital to disclose or otherwise reveal its confidential SPCP rate information.

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Rogers Amendment rates for the applicable periods are as follows:

Rogers Amendment CMAC Regional Average Rates for Non-Contracted Hospital Emergency Inpatient Services Rate Period: 1/1/07 to 6/30/08		
	Average	
	Non Tertiary	Tertiary
Other	$1,291	$1,779
San Francisco / Bay Area	$1,594	$2,468
Southern California	$1,158	$1,804

Rogers Amendment CMAC Regional Average Rates for Non-Contracted Hospital Emergency Inpatient Services Rate Period: 7/1/08 to 6/30/09		
	Average	
	Non Tertiary	Tertiary
Other	$1,411	$1,944
San Francisco / Bay Area	$1,771	$2,742
Southern California	$1,283	$1,998

Other = All California counties other than those listed below

San Francisco / Bay Area = Counties of Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Santa Cruz, Solano and Sonoma

Southern California = Counties of Los Angeles, Orange, Riverside, San Bernardino and Ventura

W&I Code section 14166.245 defines a tertiary hospital as a Children's Hospital specified in W&I Code section 10727, or as a hospital that has been designated as a Level I or Level II trauma center by the Emergency Medical Services Authority established pursuant to Health and Safety Code section 1797.1.

Also, pursuant to Section 14091.3(d), health plans are required to make reconciliations and adjustments for all non-contracted hospital payments made since January 1, 2007 that were not based upon the rates published in this APL and, if applicable, provide supplemental payments to hospitals as necessary to make all such payments conform with the rates published in this APL. All supplemental payments must be made within

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60 working days from the date of this letter in order to avoid interest charges pursuant to Title 28, California Code of Regulations, Section 1300.71.

Finally, Section 14091.3(e)(3) requires Medi-Cal managed care health plans to provide DHCS with data and documentation, including contracts with providers and hospitals, as deemed necessary by DHCS in order to evaluate the impact of this process. The statute also requires DHCS to report to the Legislature on the progress of the implementation and the impact made by this process. DHCS will follow up separately with Medi-Cal managed care health plans to identify the documentation needed to fulfill this legislative reporting requirement.

If you have questions about the information in this letter, please contact Vickie Orlich, Chief of the Policy and Financial Management Branch, at (916) 449-5083 or via email at Vickie.Orlich@dhcs.ca.gov.

Sincerely,

Vanessa M. Baird, MPPA, Chief
Medi-Cal Managed Care Division

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DHCS
SANDRA SHEWRY
Director

State of California—Health and Human Services Agency
Department of Health Care Services

ARNOLD SCHWARZENEGGER
Governor

DATE: November 10, 2008

MMCD All Plan Letter 08-010

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: HOSPITAL PAYMENT FOR MEDI-CAL POST-STABILIZATION SERVICES

This All Plan Letter (APL) serves to provide information to Medi-Cal managed care plans regarding Welfare and Institutions (W&I) Code Sections 14091.3 and 14166.245, recently enacted in Sections 42 and 57, respectively, of Assembly Bill 1183 (Chapter 758, Statutes of 2008).

W&I Code Section 14091.3(c)(3) is based upon federal regulations and requires that all general acute care hospitals, including hospitals that contract with the Department of Health Services (DHCS) under the Medi-Cal Selective Provider Contracting Program (SPCP), that do not have in effect a contract for inpatient services with a Medi-Cal managed care plan, for post-stabilization services following an emergency admission that are furnished to a beneficiary enrolled in the plan, shall accept as payment in full for post-stabilization services the hospital's Medi-Cal Fee-For-Service (FFS) payment amounts for general acute care inpatient services set forth in W&I Code Section 14166.245.

W&I Code Section 14166.245 establishes such FFS payment amounts, which for the purposes of Section 14091.3(c)(3) shall also apply to SPCP and non-SPCP hospitals, as the ***lesser*** of the following two payment amounts for that particular hospital: (1) founded on the hospital's cost based interim percentage rate reduced by 10 percent, or (2) the hospital's applicable regional average per diem rate for tertiary or non-tertiary hospitals, reduced by 5 percent. For the hospitals that do not qualify as small and rural hospitals, but are exempt from the ***lesser*** of the two payment amounts as provided in W&I Code Section 14166.245(b)(2)(B), the payment amount shall be (1) above. For hospitals that do qualify as small and rural hospitals, the payment amounts shall be (1) above without the 10 percent reduction, as provided in W&I Section 14166.245(g).

Please note that the payment amounts set forth in the paragraph immediately above are applicable to payments for post-stabilization services only, and are not applicable to payments for emergency inpatient services pursuant to the Rogers Amendment.

Medi-Cal Managed Care Division
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Emergency inpatient services payment amounts for hospitals that do not have in effect a contract for inpatient services with a Medi-Cal managed care plan do not take into account the exemptions provided for in W&I Code section 14166.245 with respect to small and rural hospitals and specified hospitals in open health facility planning areas; however, such exemptions do apply to payments for post-stabilization services following an emergency admission.

The hospital's particular cost based interim percentage rate can be obtained from DHCS' Audits and Investigations Division, Audit Review and Analysis Section, at (916) 650-6696. The regional average per diem rates for tertiary and non-tertiary hospitals, reduced by 5 percent are as follows:

Region	Tertiary Status	Rate
San Francisco Bay Area	Non-tertiary	$ 1,682
San Francisco Bay Area	Tertiary	$ 2,605
Southern California	Non-tertiary	$ 1,219
Southern California	Tertiary	$ 1,898
Other	Non-Tertiary	$ 1,340
Other	Tertiary	$ 1,847

San Francisco Bay Area =	Counties of Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Santa Cruz, Solano, and Sonoma
Southern California =	Counties of Los Angeles, Orange, Riverside, San Bernardino, and Ventura
Other Areas =	All other counties or Combined Statistical Areas

The average regional per diem SPCP contract rates in the table above are derived from unweighted average SPCP contract per diem rates that are publicly available on June 1 of each year and trended forward based on the annual increases in the regional average SPCP contract rates, as published in the CMAC Annual Report to the Legislature, reduced by 5 percent. As required by Government Code Section 6254(q) and SPCP contract terms, SPCP rates are confidential for 4 years and managed care

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plans or their contractors cannot require or compel an SPCP hospital to disclose or otherwise reveal its confidential SPCP rate information.

As required by Section 14091.3(c)(3), DHCS has obtained the necessary approval from the Centers for Medicare and Medicaid Services (CMS) for contract language providing for the implementation of payment amounts for post-stabilization services following an emergency admission. Therefore, DHCS is implementing the payment amounts Medi-Cal managed care plans are required to reimburse non-contracting hospitals by Section 14091.3 effective for dates of service beginning November 1, 2008.

Medi-Cal managed care contracts will be amended effective November 1, 2008, to include the contract language that has been approved by CMS. The payment amounts required by Section 14091.3, however, will be effective as of November 1, 2008, regardless of whether the managed care plan's contract has been amended to include the approved language, which shall read as follows:

> *"Effective November 1, 2008, consistent with 42 CFR 438.114(e), 422.113(c)(2), and 422.214 Contractor is financially responsible for payment for post-stabilization services following an emergency admission at the hospital's Medi-Cal Fee-for-Service (FFS) payment amounts for general acute care inpatient services rendered by a non-contracting Medi-Cal certified hospital, unless a lower rate is agreed to in a writing signed by the hospital. For the purposes of this Subprovision __, the Medi-Cal FFS payment amounts for dates of service when the post-stabilization services were rendered shall be the Medi-Cal FFS payment amounts established in W&I Code Section 14166.245, which for the purposes of this Subprovision __ shall apply to all general acute care hospitals, including hospitals contracting with the State under the Medi-Cal Selective Provider Contracting Program (W & I Section 14081 et. seq.), less any associated direct or indirect medical education payments to the extent applicable. Payment made by Contractor to a hospital that accurately reflects the payment amounts required by this Sub provision shall constitute payment in full under this Subprovision __, and shall not be subject to subsequent adjustments or reconciliations by Contractor, except as provided by Medicaid and Medi-Cal law and regulations. A hospital's tentative and final cost settlement processes required by 22 CCR 51536 shall not have any effect on payments made by Contractor pursuant to this Subprovision __."*

DHCS and the California Medical Assistance Commission will be providing managed care plans with contract amendments that include this language as soon as possible.

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If you have questions about the information in this letter, please contact your contract manager.

Sincerely,

Vanessa M. Baird, MPPA, Chief
Medi-Cal Managed Care Division

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State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: January 19, 2018

ALL PLAN LETTER 17-020 *(REVISED)*

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: AMERICAN INDIAN HEALTH PROGRAMS

PURPOSE:

The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with information regarding reimbursement for American Indian Health Programs (Exhibit A, Attachment 8 of the MCP's contract). The Department of Health Care Services (DHCS) has developed a change in policy regarding reimbursement of American Indian Health Programs providing services to Medi-Cal managed care beneficiaries. *Revised text is found in italics.*

BACKGROUND:

Under federal law, California must ensure that American Indian Health Programs are paid the applicable encounter *rate* published annually in the Federal Register by the Indian Health Service (the Office of Management and Budget (OMB) encounter *rate*), and if there is any difference between the amount paid by an MCP and the applicable OMB encounter rate, the State is required to make an additional payment pursuant to Title 42 of the United States Code (USC) Section 1396u-2(h)(2)(C)(ii)[1] and Title 42 of the Code of Federal Regulations (CFR) Sections 438.14(c)(2) and (3).[2]

Historically, the State satisfied this requirement by tracking the amounts American Indian Health Programs received from MCPs for eligible services and by making subsequent payments necessary to meet the applicable OMB encounter rate.

[1] 42 USC Section 1396u-2(h)(2)(C)(ii) is available at: http://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title42-section1396u-2&num=0&edition=prelim

[2] 42 CFR Sections 438.14(c)(2) and (3) are available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=38cdce7f77ce8077ee8d0d1b41735ffa&mc=true&node=pt42.4.438&rgn=div5#se42.4.438_114

Under the policy change addressed in this APL, the State will now require that MCPs *make the necessary payments* to American Indian Health Programs *so that they receive the applicable OMB encounter rate* for eligible services provided on or after January 1, 2018.

POLICY:

Effective January 1, 2018, MCPs are required to *make the payments described below, so that* American Indian Health Programs for eligible services provided on or after January 1, 2018, at the applicable OMB encounter rate, published in the Federal Register by the Indian Health Service.

MCPs are reminded of their obligations to attempt to contract with American Indian Health Programs, prompt payment requirements, and the allowance for non-contracted American Indian Health Programs access, where applicable.

Office of Management and Budget Encounter Rate and Services:

Where the OMB encounter *rate applies, American Indian Health Programs must be paid as follows:*

1) *For* Medi-Cal beneficiaries with full Medicare coverage or Medicare Part B only, the *required payment is the difference between* the "Outpatient Per Visit Rate (Excluding Medicare)" *listed in the Federal Register and 80 percent of the Medicare Federally Qualified Health Center (FQHC) prospective payment system (PPS) rate, as set forth in 42 USC 1395w-4(e)(6)(A)(ii). See Attachment 2 for the specific Dual rate.*

2) *For* Medi-Cal *beneficiaries that do* not have Medicare *Coverage* or *have* Medicare Part A only*, the required payment is the "Outpatient Per Visit Rate (Excluding Medicare)". See Attachment 2 for the specific Non-Dual rate.*

The service types—medical visits, ambulatory visits, and mental health visits— for which the OMB encounter *rate applies* are set forth in the California Medicaid State Plan Supplement 6, Attachment 4.19-B.[3] The service types reimbursed at the OMB

[3] The *relevant State Plan Amendment* is available at: http://www.dhcs.ca.gov/formsandpubs/laws/Documents/Supplement6toAttachment4.19-B-REVISEDMAY.pdf

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encounter rate are further detailed in the Provider Manual.[4] To the extent that the Provider Manual conflicts with this APL, the requirements of this APL shall apply. Exceptions to MCP covered services that shall continue to be reimbursed outside the OMB encounter rate are: Non-Medical Transportation, Non-Emergency Medical Transportation, and Pharmacy.

Additionally, this policy does not extend the responsibility of the MCP to provide for eligible OMB encounter services that are outside the responsibility of the MCP currently. For example, MCPs will not be responsible for reimbursing the clinics for any dental services provided. The American Indian Health Programs will continue to follow their current billing practices for services outside the MCP's responsibility.

The OMB encounter rates are historically published with a retroactive effective date. MCPs are required to pay the most current applicable *payments as described in this APL (see Attachment 2)* during the calendar year for which the rate applies, and as an interim rate in a subsequent calendar year if an updated OMB rate has not been published. Plans shall ensure interim payments are reconciled to the applicable updated OMB rate for that calendar year in accordance with contractual prompt payment requirements.

Reimbursement Requirements:

MCPs shall ensure that the following criteria are met for receipt of *payments as described in this APL*:

- The American Indian Health Program provider must be identified by DHCS (see Attachment).
- Service must be a covered benefit included in the MCP's contract with DHCS.
- As set forth in California Medicaid State Plan Supplement 6, Attachment 4.19-B, only one OMB encounter rate payment per day, per category, shall be allowed within the following three categories. This allows for a maximum of three OMB encounter payments per day, one from each category:

[4] The Provider Manual sections related to IHS are available at: http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/indhealth_o01o03.doc

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- Medical Health Visit (Encounter) – A medical visit is a face-to-face encounter occurring at a clinic or center between a American Indian Health Program recipient and physician, physician assistant, nurse practitioner, nurse midwife or visiting nurse in certain circumstances.

- Mental Health Visit (Encounter) – A mental health visit is a face-to-face encounter between an American Indian Health Program recipient and a psychiatrist, clinical psychologist, clinical social worker, or other health professional for therapeutic mental health services.

- Ambulatory Visit (Encounter) – An ambulatory visit is a face-to-face encounter between an American Indian Health Program recipient and a health care professional other than a physician or mid-level practitioner which is included in California's Medi-Cal State Plan.

Monitoring of Subcontractors and Delegated Entities:

MCPs remain ultimately responsible for meeting the American Indian Service Programs reimbursement requirements, and must ensure that their delegated entities and subcontractors comply with all applicable State and federal laws and regulations, contractual requirements, and other requirements set forth in DHCS guidance and All Plan Letters (APLs). MCPs must communicate these requirements to all delegated entities and subcontractors in a timely manner to ensure compliance.

If you have any questions regarding this APL, and/or requests for an approved list of American Indian Service Programs, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

Attachments

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State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: November 21, 2018

ALL PLAN LETTER 18-019
SUPERSEDES ALL PLAN LETTER 16-003

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: FAMILY PLANNING SERVICES POLICY FOR SELF-ADMINISTERED HORMONAL CONTRACEPTIVES

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide clarification for Medi-Cal Managed Care Plans (MCPs) and their delegates regarding requirements for coverage of self-administered hormonal contraceptive supplies for family planning. This APL supersedes APL 16-003.

BACKGROUND:
Pursuant to federal law[1] and the Department of Health Care Services (DHCS) Medi-Cal managed care contract,[2] MCPs must not restrict a member's choice of provider for family planning services. Accordingly, MCP members have the right to access family planning services through any qualified family planning provider, including out-of-network providers, without prior authorization. A qualified provider is a provider who is licensed to furnish family planning services within their scope of practice, is an enrolled Medi-Cal provider,[3] and is willing to furnish family planning services to a member.

Senate Bill (SB) 999 (Pavley, Chapter 499, Statutes of 2016)[4] amended Business and Professions Code (BPC) Section 4064.5, Health and Safety Code (HSC) Section 1367.25, and Welfare and Institutions Code (WIC) Section 14000.01 pertaining to coverage of United States Food and Drug Administration (FDA) -approved, self-administered hormonal contraceptives. DHCS policy reflects these changes.

[1] Title 42 United States Code, Sections 1396a(a)23(B) and 1396d(a)(4)(C), available at: http://uscode.house.gov/
[2] Exhibit A, Attachment 9, Access and Availability. Medi-Cal Managed Care Boilerplate contracts are available at: http://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx
[3] Title 22, California Code of Regulations, Section 51200, is available at: https://govt.westlaw.com/calregs/Search/Index
[4] SB 999 is available at: http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB999

Managed Care Quality and Monitoring Division
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POLICY:
Pursuant to state law, MCPs must cover up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives when dispensed or furnished at one time by a provider or pharmacist or at a location licensed or authorized to dispense drugs or supplies.[5] This means MCPs must reimburse for a 12-month supply of oral contraceptive pills, hormone-containing contraceptive transdermal patches, or hormone-containing contraceptive vaginal rings when dispensed at one time at a member's request by a qualified family planning provider or pharmacist, including out-of-network providers. The Medi-Cal Provider Manual specifies appropriate 12-month supply quantities of these self-administered hormonal contraceptives for continuous cycle users.[6]

A physician, physician assistant, certified nurse midwife, nurse practitioner, and pharmacist are all authorized to dispense medication. When furnished by a pharmacist, self-administered hormonal contraceptives must be dispensed in accordance with a protocol approved by the California State Board of Pharmacy and the Medical Board of California.[7] A registered nurse who has completed required training pursuant to BPC Section 2725.2(b) may also dispense contraceptives when Evaluation and Management procedure 99201, 99211, or 99212 is performed and billed with modifier 'TD.'[8]

Absent clinical contraindications, MCPs must not impose utilization controls limiting the supply of FDA-approved, self-administered hormonal contraceptives dispensed or furnished by a provider, pharmacist, or other authorized location to an amount that is less than a 12-month supply.[9] In addition, MCPs must not impose utilization controls that are more restrictive than those described in the Medi-Cal Provider Manual.[10]

MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and any DHCS-issued guidance, including applicable APLs and Policy Letters.

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[5] See HSC Section 1367.25(d)(1). HSC Section 1367.25 is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1367.25.&lawCode=HSC
[6] See the Contraceptives heading within the Family Planning section of the Medi-Cal Provider Manual at: http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/famplanning_m00o03.doc.
[7] See BPC Section 4064.5(f)(2). BPC Section 4064.5 is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=4064.5.&lawCode=BPC
[8] See the Contraceptives heading within the Family Planning section of the Medi-Cal Provider Manual.
[9] HSC Section 1367.25(d)(4).
[10] See the Contraceptives heading within the Family Planning section of the Medi-Cal Provider Manual.

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If you have any questions regarding this APL, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

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State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: December 19, 2018

ALL PLAN LETTER 18-022
SUPERSEDES ALL PLAN LETTER 16-017

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: ACCESS REQUIREMENTS FOR FREESTANDING BIRTH CENTERS AND THE PROVISION OF MIDWIFE SERVICES

PURPOSE:
The purpose of this All Plan Letter (APL) is to clarify the requirements for Medi-Cal managed care health plans (MCPs) regarding their responsibilities to provide members with access to freestanding birth centers (FBCs) as well as to services provided by Certified Nurse Midwives (CNMs) and Licensed Midwives (LMs). This APL supersedes APL 16-017.[1]

BACKGROUND:
The Department of Health Care Services (DHCS) policy pertaining to FBCs, CNMs, and LMs, as contained in this APL, is supported by federal and state law, official guidance from the federal Centers for Medicare & Medicaid Services (CMS), and the California State Plan.

Freestanding Birth Centers
Federal law mandates coverage of FBC services and requires separate payments to providers administering prenatal labor and delivery or postpartum care in an FBC.[2] CMS guidance clarifies that the FBC benefit category is considered both a service and a setting for services.[3] Federal law defines an FBC[4] as a health facility –

(i) that is not a hospital;
(ii) where childbirth is planned to occur away from the pregnant woman's residence;

[1] A listing of APLs by number is available at: http://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.
[2] See Title 42 United States Code [USC] Sections 1396d (a)(28), 1396d (l)(3)(A), and 1396d (l)(3)(C). Title 42 USC Section 1396d is available at: http://uscode.house.gov/view.xhtml?req=(title:42%20section:1396d%20edition:prelim)%20OR%20(granuleid:USC-prelim-title42-section1396d)&f=treesort&edition=prelim&num=0&jumpTo=true
[3] See CMS State Health Official letter (SHO) #16-006, which is available at: https://www.medicaid.gov/federal-policy-guidance/downloads/smd16006.pdf.
[4] See Title 42 USC Section 1396d (l)(3)(B).

(iii) that is licensed or otherwise approved by the state to provide prenatal labor and delivery or postpartum care and other ambulatory services that are included in the plan; and

(iv) that complies with such other requirements relating to the health and safety of individuals furnished services by the facility as the state shall establish.

California State Plan Amendment (SPA) 11-022 added FBCs – also referred to in the SPA as Alternative Birth Centers (ABCs) – to the State Plan, as federally mandated.[5] SPA 11-022 did not change the scope of services at ABCs or the requirement that ABCs be certified as Comprehensive Perinatal Services Program providers.[6] The DHCS Provider Manual contains additional information about ABC services.[7]

Certified Nurse Midwives and Licensed Midwives

Federal law mandates coverage of services furnished by CNMs, as legally authorized by the state,[8] and California law requires coverage of both CNMs and LMs.[9] The California State Plan authorizes CNMs and LMs as providers of all services permitted within the scope of the practitioner's license.[10]

While CNMs and LMs are both authorized under state law to provide prenatal, intrapartum, and postpartum care, including family planning care for the mother and immediate care for the newborn, there are some differences between the two provider types with regard to licensing and supervision requirements, as well as the circumstances under which care may be provided.[11] For instance, a CNM is licensed as a registered nurse and certified as a nurse midwife by the California Board of Registered Nursing,[12]

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[5] SPA 11-022 is available at: http://www.dhcs.ca.gov/formsandpubs/laws/Documents/Recent%20Amendment%20SPA%2011-022.pdf

[6] See Welfare Institutions Code (WIC) Section 14148.8, which is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14148.8.&lawCode=WIC.

[7] The DHCS Provider Manual section on ABCs is available at: http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/altern_m00o03.doc.

[8] See 42 USC Section 1396d (a)(17).

[9] See WIC Sections 14132.4 and 14132.39 at: http://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=WIC&division=9.&title=&part=3.&chapter=7.&article=4.

[10] The California State Plan, Section 3 – Services, is available at: http://www.dhcs.ca.gov/formsandpubs/laws/Pages/Section3.aspx. See Limitations on Attachment 3.1-A.

[11] See Business and Professions Code (BPC) Sections 2746 – 2746.8 for CNMs and BPC Sections 2505 – 2523 for LMs. In particular, see BPC Sections 2746.5 (CNMs) and 2507 (LMs). BPC is available at: http://leginfo.legislature.ca.gov/faces/codes_displayexpandedbranch.xhtml?tocCode=BPC&division=2.&title=&part=&chapter=&article=.

[12] Additional information about CNMs can be found on the California Board of Registered Nursing website at: https://www.rn.ca.gov/practice/index.shtml

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while an LM is licensed as a midwife by the Medical Board of California.[13] Under state law, CNMs are permitted to "attend cases of normal childbirth," whereas LMs are permitted to "attend cases of normal pregnancy and childbirth, as defined" and must adhere to a detailed set of restrictions and requirements when a patient's condition deviates from the legal definition of normal.[14] The DHCS Provider Manual details supervision, billing, and enrollment requirements, along with covered services, for each provider type.[15]

POLICY:
MCPs are required to provide their members with access to FBC services. In accordance with federal and state network adequacy requirements, each MCP must include a minimum of one FBC in its provider network, to the extent that FBCs are available in the MCP's contracted service area.[16] If the MCP is unable to provide access to FBC services in-network, the MCP must reimburse out-of-network FBCs for services provided to its members, in accordance with the MCP contract.

MCPs are also required to provide their members with access to both CNMs and LMs as providers of services permitted within each practitioner's scope of practice. In accordance with federal and state network adequacy requirements, each MCP must include a minimum of one CNM and one LM in its provider network, to the extent that CNMs and LMs are available in the MCP's contracted service area.[17] If the MCP is unable to provide access to these provider types in-network, the MCP must reimburse out-of-network CNMs and LMs at no less than the applicable Medi-Cal fee-for-service (FFS) rate, in accordance with the MCP contract, for services provided to its members.

MCPs must document efforts to include each of the above provider types in their provider networks. MCPs are not required to contract with an FBC, a CNM, or an LM if any of the following circumstances apply:

1) The provider is unwilling to accept the higher of the MCP's contract rates or the Medi-Cal FFS rates.

[13] Additional information about LMs can be found on the Medical Board of California's website at: http://www.mbc.ca.gov/Licensees/Midwives/
[14] See BPC Section 2507 at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=2507.&lawCode=BPC
[15] See the DHCS Provider Manual section on Non-Physician Medical Practitioners at: http://files.medi-cal.ca.govpublications/masters-mtp/part2/nonph_m00o03o11.doc
[16] See SHO #16-006. Also, for details on requirements pertaining to network adequacy, see APL 18-005, "Network Certification Requirements."
[17] See APL 18-005, "Network Certification Requirements."

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2) The provider does not meet the MCP's applicable professional standards or has disqualifying quality of care issues (i.e., the MCP has documented concerns with the provider's quality of care).[18]

At a minimum, , MCPs must ensure that staff assisting members through telephone inquiries inform members of their right to obtain services from out-of-network FBCs, CNMs, and LMs when access to these provider types is not available in-network. If DHCS identifies deficiencies in an MCP's network, DHCS may require the MCP to submit documentation of its ability to provide members with information about out-of-network access.[19]

MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters. These requirements must be communicated by each MCP to all delegated entities and subcontractors.

If you have any questions regarding this APL, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

[18] For details on professional standards and quality deficiencies, see APL 17-019, "Provider Credentialing/ Recredentialing and Screening/Enrollment."
[19] These requirements are further outlined in the Network Certification Requirements APL.

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State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: June 18, 2019

ALL PLAN LETTER 19-008
SUPERSEDES ALL PLAN LETTER 16-016

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: RATE CHANGES FOR EMERGENCY AND POST-STABILIZATION SERVICES PROVIDED BY OUT-OF-NETWORK BORDER HOSPITALS UNDER THE DIAGNOSIS RELATED GROUP PAYMENT METHODOLOGY: OUTCOME OF FEDERAL COURT LITIGATION REJECTING A CHALLENGE TO STATE PLAN AMENDMENT 15-020.

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care health plans (MCPs) on changes in the Diagnosis Related Group (DRG) payment methodology used to establish reimbursement rates paid to out-of-network border hospitals, as defined in the State Plan, for acute care hospital inpatient services in the Medi-Cal Fee-for-Service (FFS) system. Additionally, this APL provides notice to MCPs that the Federal Court rejected a challenge to the validity of the changes in the DRG payment methodology under State Plan Amendment (SPA) 15-020. With the lawsuit now resolved, DRG payment rates remain effective as approved under SPA 15-020 and MCPs must continue to comply with SPA 15-020.[1]

BACKGROUND:
Pursuant to state law, the Department of Health Care Services (DHCS) implemented a payment methodology based on DRGs, that reflects the costs and staffing levels associated with quality of care for patients in all general acute care hospitals in state and out of state, including Medicare critical access general acute care hospitals, but excluding public hospitals, psychiatric hospitals, and rehabilitation hospitals, which include alcohol and drug rehabilitation hospitals.[2] The DRG reimbursement methodology replaced the previous payment method for all private hospitals with admissions on or after July 1, 2013, and for non-designated public hospitals with admissions on or after January 1, 2014.

[1] SPA 15-020 is located at: https://www.dhcs.ca.gov/provgovpart/Documents/DRG/CA-SPA-15-020-FP-AL-179-PP.pdf.
[2] Welfare and Institutions Code Section 14105.28 is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14105.28.

In APL 13-004, DHCS notified MCPs of both the DRG methodology and how that methodology was to be applied to pay out-of-network hospitals for emergency and post-stabilization hospital inpatient services beginning July 1, 2013.[3]

On September 29, 2015, the Centers for Medicare and Medicaid Services (CMS) approved SPA 15-020, which authorized changes to the DRG methodology as applied to the FFS rates that DHCS pays to out-of-network border hospitals for patient admissions on or after July 1, 2015. The term border hospitals is defined in the State Plan, pursuant to SPA 15-020, as those hospitals located outside the State of California that are within 55 miles driving distance from the nearest physical location at which a road crosses the California border as defined by the U.S. Geological Survey.

On December 7, 2016, DHCS issued APL 16-016 requiring MCPs to apply the SPA 15-020 changes established in the Medi-Cal FFS system to DRG-based rates the MCP pays to out-of-network border hospitals for acute care hospital inpatient emergency and post-stabilization services with respect to admissions on or after July 1, 2015.

POLICY:
SPA 15-020 changes applicable to FFS DRG rates paid to border hospitals are as follows:

1. A hospital-specific wage index is used to adjust the labor portion of the base price. SPA 15-020 provides that the hospital-specific wage index for a border hospital is the same wage index that the Medicare program applies to that hospital.

2. The higher “remote rural” base price applies to border hospitals that meet the definition of a “Remote Rural Border Hospital” as defined in SPA 15-020.

3. The cost-to-charge ratio used to determine eligibility for outlier payments varies depending on whether a border hospital is located in Arizona, Nevada, or Oregon.

SPA 15-020 also provides that the 1.75 neonatal intensive care unit (NICU) surgery policy adjustor for neonate hospital admissions applies to any border hospital that the California Children’s Services (CCS) program has approved as a Regional NICU or Community NICU that meets CCS neonatal surgery standards. As of the date of this APL, no border hospitals have submitted an application to CCS for approval. However, if and when the CCS program approves a border hospital as qualifying for the NICU

[3] APLs are available at the following link:
https://www.dhcs.ca.gov/formsandpubs/Pages/MgdCarePlanPolicyLtrs.aspx.

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surgery policy adjustor, the DRG website will be updated to show that the hospital is a Designated NICU, and when it became entitled to the NICU surgery policy adjustor.

The DRG webpage offers specific pricing information, including year-specific pricing factors applicable to all border hospitals under SPA 15-020.[4]

Conclusion of Federal Court Litigation: *Asante*, *et al.* v. *DHCS*
APL 16-016 advised MCPs of pending federal court litigation that impacted the Medi-Cal FFS DRG rates that DHCS paid the 19 plaintiff border hospitals in *Asante, et al. v. DHCS* (Case No. 14-cv-03226-EMC). The APL also advised MCPs that the United States District Court for the Northern District of California entered final judgement for plaintiffs on October 12, 2016. This ruling required further modification to the FFS DRG rates that DHCS paid the 19 plaintiff border hospitals under SPA 15-020 for admissions on or after December 21, 2015. Specifically, the district court ordered that the California rural floor wage index be used to adjust the labor portion of the base price for the 19 plaintiff border hospitals, and ordered that three of the plaintiff border hospitals that did not qualify as a remote rural hospital under SPA 15-020 receive the remote rural base price. APL 16-016 advised that MCPs were not required to take any action at that time based on the terms of the *Asante* judgment. The APL also indicated that MCPs would be notified whether the *Asante* judgment was affirmed on appeal.

The *Asante* judgement was not affirmed on appeal. Instead, on April 2, 2018, the United States Court of Appeals for the Ninth Circuit reversed the district's court ruling. (*Asante v. California Department of Health Care Services* (9th Cir. 2018) 886 F.3d 795.) The Ninth Circuit denied the plaintiffs' petition for rehearing, and on August 1, 2018, the district court granted DHCS' request for entry of final judgement in its favor. The *Asante* litigation is now concluded.

In light of the outcome in litigation, MCPs are not required to modify payments paid to the 19 plaintiff border hospitals for admissions on or after December 21, 2015, beyond what is required under SPA 15-020 and as herein. In accordance with DHCS policy and MCP contracts with DHCS, MCPs must continue to apply the SPA 15-020 changes established in the Medi-Cal FFS system to the DRG-based rates they pay to out-of-network border hospitals for acute care hospital inpatient emergency and post-stabilization services with respect to admissions on or after July 1, 2015, as stated herein. However, as stated in APL 13-004 , MCPs may pay a lower negotiated rate agreed to by the hospital.

[4] The DRG webpage is located at the following link: https://www.dhcs.ca.gov/provgovpart/Pages/DRG.aspx.

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MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters. These requirements must be communicated by each MCP to all delegated entities and subcontractors.

More information about the DRG program is available on the DRG webpage. If you have any questions regarding this APL, please contact the Safety Net Financing Division through the DRG general mailbox at DRG@dhcs.ca.gov.

Sincerely,

Original Signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

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State of California—Health and Human Services Agency
Department of Health Care Services

WILL LIGHTBOURNE
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: May 12, 2021

ALL PLAN LETTER 21-008

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: TRIBAL FEDERALLY QUALIFIED HEALTH CENTER PROVIDERS

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with information regarding the implementation of the Tribal Federally Qualified Health Center (Tribal FQHC) provider type in Medi-Cal with an effective date of January 1, 2021. This APL also provides guidance regarding reimbursement requirements for Tribal FQHC provider types.

BACKGROUND:
The Centers for Medicare and Medicaid Services (CMS) allows Indian Health Care Providers (IHCP) operating under the authority of the Tribal Indian Self-Determination and Education Assistance Act to participate in Medi-Cal as one of several clinic provider types, including but not limited to:[1]

- Indian Health Services Memorandum of Agreement (IHS-MOA) clinic;
- FQHC (using Health Resources Services Administration criteria);
- Tribal FQHC (using CMS criteria); and
- Community clinic.

California must assure that IHCPs are reimbursed in accordance with federal law.[2] The rules for each specific provider type, including payment rates, covered services, billable providers, allowances for the number of reimbursable visits per day, and service sites are set forth in California's Medicaid State Plan. IHCP may operate as only one of the provider types listed above. For instance, IHCPs cannot be both an IHS-MOA and a Tribal FQHC.

[1] See 25 United States Code (U.S.C.) Chapter 46 (Public Law 93-638). The U.S.C. is searchable at the following link: https://uscode.house.gov/browse.xhtml.
[2] See 42 U.S.C. section 1396u-2(h)(2)(C) and 42 Code of Federal Regulations (C.F.R.) section 438.14(c). 42 C.F.R. 438.14(c) is available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=4f517849d06685b38053c59d244f961a&mc=true&node=pt42.4.438&rgn=div5.

CMS recognizes the Tribal FQHC as a new clinic provider type with corresponding service site parameters. IHCPs participating in Medi-Cal as IHS-MOA provider types may elect to enroll as a Tribal FQHC in accordance with State Plan Amendment (SPA) 20-0044, which sets forth the reimbursement methodology for Tribal FQHCs.[3,4]

POLICY:
Effective January 1, 2021, MCPs are required to make payments to Tribal FQHC providers for eligible services provided on or after the implementation date, in accordance with the Alternate Payment Methodology (APM) and reimbursement requirements described below.[5] MCP contracts with Tribal FQHCs must include all covered and eligible services available at the Tribal FQHC with the exception of dental services, which are not managed care reimbursable services. MCPs may not limit their contracts to a specific set of those services. MCPs are reminded of their obligations to attempt to contract with IHCPs, to comply with prompt payment requirements, and the allowance for non-contracted Tribal FQHC provider access, where applicable.

Alternate Payment Methodology
MCPs must reimburse IHCPs that are currently enrolled as IHS-MOA clinic providers that elect to participate in Medi-Cal as Tribal FQHCs utilizing an APM.

Where the APM applies, MCPs must pay Tribal FQHC providers as follows for each visit:

1) For Medi-Cal beneficiaries with full Medicare coverage or Medicare Part B only, irrespective of Medicare Part D coverage, the required payment is the difference between the "APM Rate (Excluding Medicare)" and 80 percent of the Medicare FQHC prospective payment system rate.[6]

2) For Medi-Cal beneficiaries that do not have Medicare Coverage or have Medicare Part A only, irrespective of Medicare Part D coverage, the required payment is the "APM Rate (Excluding Medicare)".[7]

[3] SPA 20-0044 can be accessed at the following link: https://www.dhcs.ca.gov/Documents/SPA-20-0044-Approval.pdf
[4] See Attachment 2 for a list of IHCPs that are enrolled in Medi-Cal as Tribal FQHCs. Attachment 2 will be added to this APL at a later date.
[5] See Attachment 1 for applicable APM.
[6] See 42 U.S.C. § 1395w-4(e)(6)(A)(ii).
[7] See Attachment 1 for the specific Non-Dual rate.

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Tribal FQHCs must be reimbursed at the applicable rate for up to three visits per day in any combination of different visits in the following visit categories: medical, mental health, and ambulatory. For example, Tribal FQHCs can be reimbursed for:

- A combination of three (3) different medical visits with a primary care physician, nurse practitioner, and a specialist;
- A combination of three (3) different mental health visits with a psychiatrist, psychologist, and a licensed clinical social worker;
- A combination of three (3) different ambulatory visits for audiology, physical therapy, and optometry services.

The visit categories, service types, and billable providers that are allowed reimbursement at the APM are further detailed in the Medi-Cal Provider Manual.[8] To the extent that the Medi-Cal Provider Manual conflicts with this APL, the requirements of this APL shall apply.

Alternate Payment Methodology Exclusions

Please note that certain MCP covered services will continue to be reimbursed outside the APM, including Non-Medical Transportation, Non-Emergency Medical Transportation, and Pharmacy.

This policy does not require MCPs to provide services that are carved-out of the MCP's contract with DHCS. For example, MCPs will not be responsible for reimbursing Tribal FQHCs for dental services not otherwise covered by the MCP contract.

Tribal FQHC providers must follow DHCS' FQHC established billing practices for services outside the MCP's responsibility.[9]

Reimbursement Requirements

In order for Tribal FQHCs to be eligible for APM reimbursement by MCPs pursuant to this APL, services must be covered benefits under the MCP's contract with DHCS and must not exceed the allowable limit of up to three (3) visits per day, per member, in any combination of medical, mental health, and ambulatory visits. Services provided offsite by Tribal providers and non-Tribal providers that are contractors of the Tribal FQHC are reimbursable in accordance with the APM.

APM rates will be effective for a calendar year, and may have a retroactive effective date. Therefore, MCPs are required to pay the most current applicable payments as described

[8] See the Medi-Cal Provider Manual. A link to the Medi-Cal Provider Manual will be added to this APL at a later date.
[9] For guidance, see the Medi-Cal Provider Manual. A link to the Medi-Cal Provider Manual will be added to this APL at a later date.

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in this APL during the calendar year for which the rate applies and as an interim rate in a subsequent calendar year if an updated APM has not been published.[10] MCPs must ensure that interim payments are reconciled to the applicable updated rate for that calendar year in accordance with contractual prompt payment requirements. MCPs will receive reimbursement for services paid to Tribal FQHCs through the submission of the Consolidated Supplemental File.[11]

If the requirements contained in this APL, including any updates or revisions to this APL, necessitate a change in an MCP's policies and procedures (P&Ps), the MCP must submit its updated P&Ps to its Managed Care Operations Division (MCOD) contract manager within 90 days of the release of this APL. If an MCP determines that no changes to its P&Ps are necessary, the MCP must submit an e-mail confirmation to its MCOD contract manager within 90 days of the release of this APL, stating that the MCP's P&Ps have been reviewed and no changes are necessary. The e-mail confirmation must include the title of this APL as well as the applicable APL release date in the subject line.

MCPs are responsible for ensuring that their subcontractors and network providers comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters.[12] These requirements must be communicated by each MCP to all subcontractors and network providers.

If you have any questions regarding this APL, please contact your MCOD Contract Manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

[10] See Attachment 1 for current applicable payments.
[11] Submission of the Consolidated Supplemental File is similar to the MCP payment process established under APL 17-020.
[12] For more information on Subcontractors and Network Providers, including the definition and requirements applicable, see APL 19-001, and any subsequent APLs on this topic. APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

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CalOptima Health Board Action Agenda Referral

Action To Be Taken December 1, 2022
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

10. Approve Updates to CalOptima Health Policy EE.1106: Health Network and CalOptima Health Community Network Minimum and Maximum Member Enrollment

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 923-8834
Michael Gomez, Executive Director, Network Operations, (714) 347-3292

Recommended Action

Approve recommended updates to CalOptima Health Policy EE.1106: Health Network and CalOptima Health Community Network Minimum and Maximum Member Enrollment.

Background and Discussion

CalOptima Health performs an annual review of its policies and procedures to ensure they are aligned with current federal and state regulations, contractual obligations, and reflect current CalOptima Health operational procedures.

Policy EE.1106: Health Network and CalOptima Community Health Network Minimum and Maximum Member Enrollment sets forth minimum enrollment requirements for delegated health networks and for CalOptima Health Community Health Network (CCN), sets maximum enrollment limits for each, and describes CalOptima Health's actions when health networks or CCN enrollment falls outside of these requirements and limits.

Staff recommend the following substantive updates to policy EE.1106 related to maximum enrollment:

- The current policy sets the maximum enrollment for health networks at (1/3) of health network eligible members. The proposed update details criteria for health networks that only enroll a subset of members. For such health networks, the maximum is one-third (1/3) of the health network eligible members in the subset.
- The update defines the calculation of the maximum enrollment for physician hospital consortia health networks that share the same primary hospital based on enrollment across all such health networks.
- The update also defines the calculation of the maximum enrollment for health networks that share the same officers, directors, general partners, or co-owners, based on the enrollment across all such health networks.

Other substantive updates to EE.1106 include clarifying language that better defines existing processes and aligning the policy with other CalOptima Health policies related to monitoring, oversight, and escalation.

Staff propose to make these updates effective January 1, 2023.

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Fiscal Impact

The recommended action to revise CalOptima Health Policy EE.1106 is operational in nature and has no additional fiscal impact beyond what was included in the Fiscal Year 2022-23 Operating Budget.

Rationale for Recommendation

Updates to EE.1106: Health Network and CalOptima Health Community Network Minimum and Maximum Member Enrollment will clarify and update language to reflect updated operational practices.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. CalOptima Health Policy EE.1106: Health Network and CalOptima Health Community Network Minimum and Maximum Member Enrollment (redline and clean versions)

/s/ Michael Hunn *11/23/2022*
Authorized Signature **Date**

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Policy:	EE.1106
Title:	**Health Network and CalOptima Health Community Network Minimum and Maximum Member Enrollment**
Department:	Health Network ~~Management~~Provider Relations
Section:	Not Applicable
CEO Approval:	
Effective Date:	03/01/1996
Revised Date:	09/01/2022
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy establishes minimum and maximum Member enrollment for a Health Network~~, Primary Hospital, Primary Physician Group,~~ and CalOptima Health Community Network (CCN).

II. POLICY

A. Minimum enrollment

1. To ensure the viability of Health Networks, support administrative efficiencies, and stabilize CalOptima Health's delivery system, Health Networks must maintain a minimum enrollment of five thousand (5,000) Medi-Cal Members.

~~1.~~ The minimum enrollment requirement shall apply to ~~a~~new Health ~~Network and CCN thirty-six (36) months~~Networks after the initial ~~Member enrollment date.~~

2. ~~After the initial~~ thirty-six (36) months of Member enrollment~~, a Health Network shall maintain a Member enrollment of at least five thousand (5,000) Members for the remainder of the term of the Contract for Health Care Services~~.

3. If a Health Network fails to maintain an average Member enrollment over three (3) consecutive months of at least five- thousand (5,000) Members, CalOptima Health may terminate the Contract for Health Care Services in accordance with the terms of that contract.

B. Maximum enrollment

1. Except as otherwise provided in Section II.B.3.b. of this ~~policy~~Policy:

~~a. Combined~~ Member enrollment in a ~~Primary Hospital or Primary Physician Group~~ Health Network shall not exceed one- third (1/3) of all Members eligible for Health Network enrollment.

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~~b.~~a. Member enrollment in a Health Network that only enrolls a subset of Members shall not exceed one third (1/3) of all ~~Members eligible for~~ Health Network ~~enrollment.~~Eligible Members within that subset.

b. Member enrollment across Physician Hospital Consortium (PHC) Health Networks sharing the same Primary Hospital shall not exceed one-third (1/3) of all Health Network Eligible Members. Section II.B.1.a shall apply in determining Health Network Eligible Members.

c. Member enrollment across Health Networks sharing the same Officer(s), Director(s), General Partner(s) and/or Co-Owner(s), as specified in Attachment B (Disclosure Form) of the Health Network's Amended and Restated Contract for Health Care Services, shall not exceed one-third (1/3) of all Health Network Eligible Members.

~~c.~~d. Combined Member enrollment in CalOptima Health Community Network (CCN), shall not exceed ten percent (10%) of all ~~Members eligible for~~ Health Network ~~enrollment~~Eligible Members.

~~2. If a Health Network, Primary Hospital, or Primary Physician Group reaches one-hundred percent (100%) of the maximum enrollment limit for three (3) consecutive months, such Health Network, Primary Hospital, or Primary Physician Group shall not be eligible to contract with CalOptima as part of an additional Health Network.~~

~~3. Subject to the provisions of this policy, CalOptima shall continue to enroll Members in a Health Network, or CCN, until the Health Network, CCN, Primary Hospital, or Primary Physician Group reaches one-hundred percent (100%) of the maximum enrollment limit for three (3) consecutive months.~~

If combined Member enrollment across PHC Health Networks sharing the same Primary Hospital

~~a.~~2. ~~If a Health Network~~ reaches one-hundred percent (100%) of the maximum enrollment limit for three (3) consecutive months, ~~CalOptima shall cease all auto assignment of Members to the Health Network effective the first (1st) calendar day of the immediately following month~~the Primary Hospital affiliated with the PHC Health Network(s) shall not be eligible to contract with CalOptima Health as part of an additional Health Network.

~~b.~~3. ~~If a Primary Hospital~~Subject to the provisions of this Policy, CalOptima Health shall continue to auto-assign Members to a Health Network or ~~Primary Physician Group~~CCN based on CalOptima Health's auto-assignment logic, as outlined in CalOptima Health Policy AA.1207a: CalOptima Health Auto-Assignment, until the Health Network or CCN reaches one-hundred percent (100%) of the maximum enrollment limit for three (3) consecutive months~~,~~ and CalOptima ~~shall cease all~~Health's Compliance Committee approves freezing auto-assignment ~~of Members to each~~ for the Health Network ~~comprised of such Primary Hospital~~ or ~~Primary Physician Group effective the first (1st) calendar day of the immediately following month.~~CCN.

~~c.~~a. ~~-~~If a Health Network or CCN reaches one-hundred percent (100%) of the maximum enrollment ~~limit~~as defined in this policy for three (3) consecutive months, CalOptima ~~shall~~Health may cease ~~all~~ auto~~-~~assignment of Members to ~~CCN effective the first (1st) calendar day of the immediately following month.~~the Health Network or CCN in accordance with Section III.C. and III.D. of this Policy.

~~d.~~b. Notwithstanding the ~~provisions~~freezing of auto-assignment under this section, CalOptima Health shall continue to enroll a Member in a Health Network~~,~~ or CCN~~,~~ if:

i. The Member selects the Health Network or CCN in accordance with CalOptima Health Policy DD.2008: Health Network and CalOptima Health Community Network Selection Process;

ii. The Member has Family Linked Members currently enrolled in the Health Network or CCN;

iii. The Member is re-enrolled in the Health Network~~,~~ or CCN~~,~~ after experiencing a lapse of Medi-Cal eligibility less than three-hundred-sixty-five (365) calendar days in accordance with CalOptima Health Policy DD.2008: Health Network and CalOptima Health Community Network Selection Process;

iv. The Member otherwise meets criteria for enrollment into CCN, in accordance with CalOptima Health Policy DD.2006: Enrollment In/Eligibility with CalOptima Health Direct~~.~~;

v. CalOptima Health auto~~-~~assigns the Member to the Health Network or CCN based on auto~~-~~assignment allocation to a Community Clinic as set forth in CalOptima Health Policy AA.1207a: CalOptima Health Auto~~-~~Assignment; or

vi. ~~CalOptima's~~CalOptima Health's Chief Medical Officer (CMO) or Designee determines that it is in the Member's best interest to enroll in the Health Network or CCN.

C. Health Network Enrollment Changes

1. CCN ~~and~~, a Health Network, and ~~its~~ Contracted Providers~~,~~ shall not advise, urge, or otherwise encourage Members to change Health Networks as a direct result ~~from~~of the Member's medical history or health status.

2. CCN ~~and~~or a Health Network shall be responsible for all Members who ~~either~~ select or are otherwise ~~auto~~ assigned to ~~the~~CCN or a Health Network, and are strictly prohibited from discriminating against Members based on:

a. Diagnosis;

b. Medical or claims history;

c. Age;

d. Mental or physical disability;

e. Genetic information;

f. Source of payment;

g. Sexual orientation;

h. Marital status;

i. Creed;

j. Religion;

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k. Sex/Gender identity;

l. Race;

m. Color;

n. Ancestry; and

o. National origin.

3. CalOptima Health shall process alleged acts of discrimination in accordance with CalOptima Health Policy HH.1104: Complaints of Discrimination.

D. ~~CalOptima's~~CalOptima Health's Board of Directors shall have the right to selectively waive a Health Network's or CCN's minimum and maximum enrollment, or limit a Health Network's or CCN's enrollment, if it determines that such action is in the best interest of Members.

III. PROCEDURE

~~A. Minimum and Maximum Enrollment~~

~~1.~~A. ~~CalOptima's~~CalOptima Health's Health Network Relations Department shall monitor ~~a~~monthly Health Network~~,~~ and CCN ~~Primary Hospital, and Primary Physician Group~~Member enrollment for compliance with the minimum and maximum ~~enrollments~~enrollment limits set forth in this policy.

1. Monitoring results shall be reported monthly to the Audit & Oversight Committee (AOC) and/or CalOptima Health's Audit & Oversight (External) Department.

~~2.~~B. If a Health Network fails to maintain an average enrollment over three (3) consecutive months of at least five~~-~~ thousand (5,000) Members after the initial thirty-six (36) months~~,~~ of ~~the~~ initial Member enrollment:

~~a.~~1. ~~CalOptima's~~CalOptima Health's Health Network Relations Department shall notify the ~~CalOptima's Compliance~~Audit & Oversight Committee~~;~~ (AOC) of the Health Network's failure to maintain minimum Member enrollment as required in this Policy and propose options to the AOC for remediation and resolution of non-compliance with this requirement, up to and including contract termination, as authorized by CalOptima Health's Board of Directors.

2. CalOptima Health Network Operations and the AOC shall bring the approved recommendation for action to the CalOptima Health Compliance Committee for review and approval.

~~b.~~3. Upon approval of a recommended action from ~~CalOptima's~~CalOptima Health's Compliance Committee, ~~CalOptima's~~CalOptima Health's Regulatory Affairs & Compliance Department will review the Health Network's non-compliance and issue a notice in accordance with CalOptima Health Policies HH.2005~~A~~: Corrective Action Plan and HH.2002~~A~~: Sanctions.

~~3.~~C. If a Health Network~~, CCN, Primary Hospital, or Primary Physician Group~~ reaches one~~-~~ hundred percent (100%) of the maximum enrollment limit for three (3) consecutive months:

1. ~~CalOptima's~~CalOptima Health's Health Network Relations Department shall notify the AOC of the Health Network meeting the maximum Member enrollment limit as set forth in this Policy

and propose options to the AOC for remediation and resolution of non-compliance with this requirement, including auto-assignment freeze, as authorized by CalOptima Health's Board of Directors.

a.2. Upon approval~~CalOptima's~~, the AOC shall bring the approved recommendation for action to CalOptima Health's Compliance Committee~~;~~ for review and approval.

~~2.~~ Upon approval from ~~CalOptima's Compliance Committee, CalOptima's Network Management Department shall notify the Health Network, CCN, Primary Hospital, or Primary Physician Group that such Health Network, CCN, Primary Hospital, or Primary Physician Group is not eligible to contract with CalOptima for any other Health Network;~~ CalOptima Health's

c.3. ~~Upon approval from CalOptima's~~ Compliance Committee, and except as provided in Section II.B.3.~~c~~d. of this ~~policy~~Policy, CalOptima Health shall cease Member auto-assignment to the Health Network and shall make appropriate adjustments to the auto-assignment allocation ~~as~~ set forth in CalOptima Health Policy AA.1207a: CalOptima Health Auto-Assignment~~; and~~.

4. ~~CalOptima's~~CalOptima Health's Health Network Relations Department shall notify the Health Network as soon as practicable of the suspension of auto-assignment as a result of the Health Network's meeting the maximum enrollment limit as set forth in this Policy.

a. If ~~,~~the Health Network is a PHC Health Network, CalOptima Health's Health Network Relations Department shall notify the Health Network(s)' Primary Hospital~~, Primary Physician Group, or~~ it is not eligible to contract with CalOptima Health under a PHC agreement with any additional Health Network based on the terms of this Policy.

~~d.~~D. If CCN reaches one hundred percent (100%) of the maximum enrollment limit~~.~~ for three (3) consecutive months:

1. ~~If~~ CalOptima Health's Health Network Relations Department shall notify the Provider Relations Department.

2. CalOptima Health's Provider Relations Department shall notify the AOC of CCN meeting the maximum member enrollment set forth in this policy and propose options to the AOC for remediation and resolution of non-compliance with this requirement, including auto-assignment freeze, as authorized by CalOptima Health's Board of Directors.

3. CalOptima Health Network Operations and the AOC shall bring the approved recommendation for action to CalOptima Health's Compliance Committee for review and approval.

4. Upon approval from CalOptima Health's Compliance Committee, and except as provided in Section II.B.3.b. of this Policy, CalOptima Health shall cease Member auto-assignment to CCN and shall make appropriate adjustments to the auto-assignment allocation as set forth in CalOptima Health Policy AA.1207a: CalOptima Health Auto-Assignment.

~~4.~~E.If Member enrollment in a Health Network~~, CCN, Primary Hospital,~~ or ~~Primary Physician Group~~CCN falls below the maximum enrollment limit for three (3) consecutive months, CalOptima Health shall reinstate Member auto-assignment to the Health Network or CCN.

~~5.~~1. CalOptima Health's Health Network Relations Department shall notify the Health Network as soon as practicable of the reinstating of auto-assignment as a result of the Health Network's enrollment falling below the maximum enrollment limit for three (3) consecutive months.

~~I.~~IV. ATTACHMENT(S)

Not Applicable

~~II.~~V. REFERENCE(S)

A. CalOptima Health Contract for Health Care Services
B. CalOptima Health Policy AA.1207a: CalOptima Health Auto-Assignment
C. CalOptima Health Policy DD.2006: Enrollment In/Eligibility with CalOptima Health Direct
D. CalOptima Health Policy DD.2008: Health Network and CalOptima Health Community Network Selection Process
E. CalOptima Health Policy HH.1104: Complaints of Discrimination
F. CalOptima Health Policy HH.2002: Sanctions
G. CalOptima Health Policy HH.2005: Corrective Action Plan

~~III.~~VI. REGULATORY AGENCY APPROVAL(S)

Date	**Regulatory Agency**
01/23/2015	Department of Health Care Services
03/29/2016	Department of Health Care Services

~~IV.~~VII. BOARD ACTION(S)

Date	**Meeting**
03/12/1996	Regular Meeting of the CalOptima Health Board of Directors
01/05/1999	Regular Meeting of the CalOptima Health Board of Directors
05/07/2002	Regular Meeting of the CalOptima Health Board of Directors
08/30/2006	Regular Meeting of the CalOptima Health Board of Directors
03/06/2014	Regular Meeting of the CalOptima Health Board of Directors
08/04/2016	Regular Meeting of the CalOptima Health Board of Directors
	Regular Meeting of the CalOptima Health Board of Directors

~~V.~~VIII. REVISION HISTORY

Action	**Date**	**Policy**	**Policy Title**	**Program(s)**
Effective	03/01/1996	EE.1106	Health Network Minimum and Maximum Member Enrollment	Medi-Cal
Revised	03/07/1996	EE.1106	Health Network Minimum and Maximum Member Enrollment	Medi-Cal
Revised	01/01/2007	EE.1106	Health Network Minimum and Maximum Member Enrollment	Medi-Cal
Revised	12/01/2011	EE.1106	Health Network Minimum and Maximum Member Enrollment	Medi-Cal
Revised	09/01/2014	EE.1106	Health Network Minimum and Maximum Member Enrollment	Medi-Cal

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Action	Date	Policy	Policy Title	Program(s)
Revised	02/01/2016	EE.1106	Health Network and CalOptima Health Community Network Minimum and Maximum Member Enrollment	Medi-Cal
Revised	08/04/2016	EE.1106	Health Network and CalOptima Health Community Network Minimum and Maximum Member Enrollment	Medi-Cal
Revised	08/01/2017	EE.1106	Health Network and CalOptima Health Community Network Minimum and Maximum Member Enrollment	Medi-Cal
Revised	09/01/2022	EE.1106	Health Network and CalOptima Health Community Network Minimum and Maximum Member Enrollment	Medi-Cal

~~VI.~~IX. GLOSSARY

Term	Definition
CalOptima Health Community Network (CCN)	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.
Community ~~Health Center~~Clinic	Also known as Community ~~Clinic~~Health Center—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; and 3. Ability to function as a Primary Care Provider (PCP).
Contracted Provider	A Provider who is obligated by written contract to provide Covered Services to Members on behalf of CalOptima Health, its contracted Health Networks or Physician Medical Groups.
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.
Family Linked Member	A Member who shares a county case number, as assigned by the County of Orange Social Services Agency, with another Member who is in his or her family and who resides in the same household.
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 (CCN).
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.
Primary Hospital	A hospital contracted with CalOptima Health on a capitated and delegated basis as the hospital partner of a Physician Hospital Consortium (PHC).
Primary Physician Group	A physician group contracted with CalOptima Health on a capitated and delegated basis as the physician partner of a Physician Hospital Consortium (PHC).

Policy:	EE.1106
Title:	**Health Network and CalOptima Health Community Network Minimum and Maximum Member Enrollment**
Department:	Health Network Provider Relations
Section:	Not Applicable
CEO Approval:	
Effective Date:	03/01/1996
Revised Date:	09/01/2022
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy establishes minimum and maximum Member enrollment for a Health Network and CalOptima Health Community Network (CCN).

II. POLICY

A. Minimum enrollment

1. To ensure the viability of Health Networks, support administrative efficiencies, and stabilize CalOptima Health's delivery system, Health Networks must maintain a minimum enrollment of five thousand (5,000) Medi-Cal Members.

2. The minimum enrollment requirement shall apply to new Health Networks after the initial thirty-six (36) months of Member enrollment.

3. If a Health Network fails to maintain an average Member enrollment over three (3) consecutive months of at least five thousand (5,000) Members, CalOptima Health may terminate the Contract for Health Care Services in accordance with the terms of that contract.

B. Maximum enrollment

1. Except as otherwise provided in Section II.B.3.b. of this Policy:

   a. Member enrollment in a Health Network shall not exceed one third (1/3) of all Members eligible for Health Network enrollment. Member enrollment in a Health Network that only enrolls a subset of Members shall not exceed one third (1/3) of all Health Network Eligible Members within that subset.

   b. Member enrollment across Physician Hospital Consortium (PHC) Health Networks sharing the same Primary Hospital shall not exceed one-third (1/3) of all Health Network Eligible Members. Section II.B.1.a shall apply in determining Health Network Eligible Members.

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c. Member enrollment across Health Networks sharing the same Officer(s), Director(s), General Partner(s) and/or Co-Owner(s), as specified in Attachment B (Disclosure Form) of the Health Network's Amended and Restated Contract for Health Care Services, shall not exceed one-third (1/3) of all Health Network Eligible Members.

d. Combined Member enrollment in CalOptima Health Community Network (CCN), shall not exceed ten percent (10%) of all Health Network Eligible Members.

2. If combined Member enrollment across PHC Health Networks sharing the same Primary Hospital reaches one-hundred percent (100%) of the maximum enrollment limit for three (3) consecutive months, the Primary Hospital affiliated with the PHC Health Network(s) shall not be eligible to contract with CalOptima Health as part of an additional Health Network.

3. Subject to the provisions of this Policy, CalOptima Health shall continue to auto-assign Members to a Health Network or CCN based on CalOptima Health's auto-assignment logic, as outlined in CalOptima Health Policy AA.1207a: CalOptima Health Auto-Assignment, until the Health Network or CCN reaches one-hundred percent (100%) of the maximum enrollment limit for three (3) consecutive months and CalOptima Health's Compliance Committee approves freezing auto-assignment for the Health Network or CCN.

a. If a Health Network or CCN reaches one-hundred percent (100%) of the maximum enrollment as defined in this policy for three (3) consecutive months, CalOptima Health may cease auto-assignment of Members to the Health Network or CCN in accordance with Section III.C. and III.D. of this Policy.

b. Notwithstanding the freezing of auto-assignment under this section, CalOptima Health shall continue to enroll a Member in a Health Network or CCN if:

i. The Member selects the Health Network or CCN in accordance with CalOptima Health Policy DD.2008: Health Network and CalOptima Health Community Network Selection Process;

ii. The Member has Family Linked Members currently enrolled in the Health Network or CCN;

iii. The Member is re-enrolled in the Health Network or CCN after experiencing a lapse of Medi-Cal eligibility less than three-hundred-sixty-five (365) calendar days in accordance with CalOptima Health Policy DD.2008: Health Network and CalOptima Health Community Network Selection Process;

iv. The Member otherwise meets criteria for enrollment into CCN, in accordance with CalOptima Health Policy DD.2006: Enrollment In/Eligibility with CalOptima Health Direct;

v. CalOptima Health auto-assigns the Member to the Health Network or CCN based on auto-assignment allocation to a Community Clinic as set forth in CalOptima Health Policy AA.1207a: CalOptima Health Auto-Assignment; or

vi. CalOptima Health's Chief Medical Officer (CMO) or Designee determines that it is in the Member's best interest to enroll in the Health Network or CCN.

C. Health Network Enrollment Changes

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1. CCN, a Health Network, and Contracted Providers shall not advise, urge, or otherwise encourage Members to change Health Networks as a direct result of the Member's medical history or health status.

2. CCN or a Health Network shall be responsible for all Members who select or are otherwise assigned to CCN or a Health Network, and are strictly prohibited from discriminating against Members based on:

   a. Diagnosis;

   b. Medical or claims history;

   c. Age;

   d. Mental or physical disability;

   e. Genetic information;

   f. Source of payment;

   g. Sexual orientation;

   h. Marital status;

   i. Creed;

   j. Religion;

   k. Sex/Gender identity;

   l. Race;

   m. Color;

   n. Ancestry; and

   o. National origin.

3. CalOptima Health shall process alleged acts of discrimination in accordance with CalOptima Health Policy HH.1104: Complaints of Discrimination.

D. CalOptima Health's Board of Directors shall have the right to selectively waive a Health Network's or CCN's minimum and maximum enrollment, or limit a Health Network's or CCN's enrollment, if it determines that such action is in the best interest of Members.

III. PROCEDURE

A. CalOptima Health's Health Network Relations Department shall monitor monthly Health Network and CCN Member enrollment for compliance with the minimum and maximum enrollment limits set forth in this policy.

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1. Monitoring results shall be reported monthly to the Audit & Oversight Committee (AOC) and/or CalOptima Health's Audit & Oversight (External) Department.

B. If a Health Network fails to maintain an average enrollment over three (3) consecutive months of at least five thousand (5,000) Members after the initial thirty-six (36) months of initial Member enrollment:

1. CalOptima Health's Health Network Relations Department shall notify the Audit & Oversight Committee (AOC) of the Health Network's failure to maintain minimum Member enrollment as required in this Policy and propose options to the AOC for remediation and resolution of non-compliance with this requirement, up to and including contract termination, as authorized by CalOptima Health's Board of Directors.

2. CalOptima Health Network Operations and the AOC shall bring the approved recommendation for action to the CalOptima Health Compliance Committee for review and approval.

3. Upon approval of a recommended action from CalOptima Health's Compliance Committee, CalOptima Health's Regulatory Affairs & Compliance Department will review the Health Network's non-compliance and issue a notice in accordance with CalOptima Health Policies HH.2005: Corrective Action Plan and HH.2002: Sanctions.

C. If a Health Network reaches one hundred percent (100%) of the maximum enrollment limit for three (3) consecutive months:

1. CalOptima Health's Health Network Relations Department shall notify the AOC of the Health Network meeting the maximum Member enrollment limit as set forth in this Policy and propose options to the AOC for remediation and resolution of non-compliance with this requirement, including auto-assignment freeze, as authorized by CalOptima Health's Board of Directors.

2. Upon approval, the AOC shall bring the approved recommendation for action to CalOptima Health's Compliance Committee for review and approval.

3. Upon approval from CalOptima Health's Compliance Committee, and except as provided in Section II.B.3.d. of this Policy, CalOptima Health shall cease Member auto-assignment to the Health Network and shall make appropriate adjustments to the auto-assignment allocation set forth in CalOptima Health Policy AA.1207a: CalOptima Health Auto-Assignment.

4. CalOptima Health's Health Network Relations Department shall notify the Health Network as soon as practicable of the suspension of auto-assignment as a result of the Health Network's meeting the maximum enrollment limit as set forth in this Policy.

a. If the Health Network is a PHC Health Network, CalOptima Health's Health Network Relations Department shall notify the Health Network(s)' Primary Hospital it is not eligible to contract with CalOptima Health under a PHC agreement with any additional Health Network based on the terms of this Policy.

D. If CCN reaches one hundred percent (100%) of the maximum enrollment limit for three (3) consecutive months:

1. CalOptima Health's Health Network Relations Department shall notify the Provider Relations Department.

2. CalOptima Health's Provider Relations Department shall notify the AOC of CCN meeting the maximum member enrollment set forth in this policy and propose options to the AOC for remediation and resolution of non-compliance with this requirement, including auto-assignment freeze, as authorized by CalOptima Health's Board of Directors.

3. CalOptima Health Network Operations and the AOC shall bring the approved recommendation for action to CalOptima Health's Compliance Committee for review and approval.

4. Upon approval from CalOptima Health's Compliance Committee, and except as provided in Section II.B.3.b. of this Policy, CalOptima Health shall cease Member auto-assignment to CCN and shall make appropriate adjustments to the auto-assignment allocation as set forth in CalOptima Health Policy AA.1207a: CalOptima Health Auto-Assignment.

E. If Member enrollment in a Health Network or CCN falls below the maximum enrollment limit for three (3) consecutive months, CalOptima Health shall reinstate Member auto-assignment to the Health Network or CCN.

1. CalOptima Health's Health Network Relations Department shall notify the Health Network as soon as practicable of the reinstating of auto-assignment as a result of the Health Network's enrollment falling below the maximum enrollment limit for three (3) consecutive months.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract for Health Care Services
B. CalOptima Health Policy AA.1207a: CalOptima Health Auto-Assignment
C. CalOptima Health Policy DD.2006: Enrollment In/Eligibility with CalOptima Health Direct
D. CalOptima Health Policy DD.2008: Health Network and CalOptima Health Community Network Selection Process
E. CalOptima Health Policy HH.1104: Complaints of Discrimination
F. CalOptima Health Policy HH.2002: Sanctions
G. CalOptima Health Policy HH.2005: Corrective Action Plan

VI. REGULATORY AGENCY APPROVAL(S)

Date	**Regulatory Agency**
01/23/2015	Department of Health Care Services
03/29/2016	Department of Health Care Services

VII. BOARD ACTION(S)

Date	**Meeting**
03/12/1996	Regular Meeting of the CalOptima Health Board of Directors
01/05/1999	Regular Meeting of the CalOptima Health Board of Directors
05/07/2002	Regular Meeting of the CalOptima Health Board of Directors
08/30/2006	Regular Meeting of the CalOptima Health Board of Directors
03/06/2014	Regular Meeting of the CalOptima Health Board of Directors

08/04/2016	Regular Meeting of the CalOptima Health Board of Directors
	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	03/01/1996	EE.1106	Health Network Minimum and Maximum Member Enrollment	Medi-Cal
Revised	03/07/1996	EE.1106	Health Network Minimum and Maximum Member Enrollment	Medi-Cal
Revised	01/01/2007	EE.1106	Health Network Minimum and Maximum Member Enrollment	Medi-Cal
Revised	12/01/2011	EE.1106	Health Network Minimum and Maximum Member Enrollment	Medi-Cal
Revised	09/01/2014	EE.1106	Health Network Minimum and Maximum Member Enrollment	Medi-Cal
Revised	02/01/2016	EE.1106	Health Network and CalOptima Health Community Network Minimum and Maximum Member Enrollment	Medi-Cal
Revised	08/04/2016	EE.1106	Health Network and CalOptima Health Community Network Minimum and Maximum Member Enrollment	Medi-Cal
Revised	08/01/2017	EE.1106	Health Network and CalOptima Health Community Network Minimum and Maximum Member Enrollment	Medi-Cal
Revised	09/01/2022	EE.1106	Health Network and CalOptima Health Community Network Minimum and Maximum Member Enrollment	Medi-Cal

IX. GLOSSARY

Term	Definition
CalOptima Health Community Network (CCN)	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.
Community Clinic	Also known as Community Health Center—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; and 3. Ability to function as a Primary Care Provider (PCP).
Contracted Provider	A Provider who is obligated by written contract to provide Covered Services to Members on behalf of CalOptima Health, its contracted Health Networks or Physician Medical Groups.
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.
Family Linked Member	A Member who shares a county case number, as assigned by the County of Orange Social Services Agency, with another Member who is in his or her family and who resides in the same household.
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 (CCN).
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.
Primary Hospital	A hospital contracted with CalOptima Health on a capitated and delegated basis as the hospital partner of a Physician Hospital Consortium (PHC).
Primary Physician Group	A physician group contracted with CalOptima Health on a capitated and delegated basis as the physician partner of a Physician Hospital Consortium (PHC).

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 1, 2022
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

11. Approve Modification to CalOptima Health Policy AA.1223: Participation in Community Events with External Entities

Contacts

Michael Hunn, Chief Executive Officer, (657) 900-1481
Deanne Thompson, Executive Director, Marketing and Communications, (714) 954-2141

Recommended Actions

Approve proposed modification to CalOptima Health Policy AA.1223: Participation in Community Events Involving External Entities.

Background/Discussion

CalOptima Health has a long history of participating in community events, health and resource fairs, town halls, workshops, and other public activities in furtherance of the organization's mission. CalOptima Health leaders are highly engaged with community stakeholders and demonstrate the organization's support through a variety of activities, including providing staff and financial support for community events, including health and resource fairs, conferences, and seminars.

Staff submits approximately 10-14 requests for financial support to the Board for approval each fiscal year to provide financial support for community events. This does not include the timeframe when the community was most impacted by COVID-19 from March 2020 through December 2021. Most community events were supported virtually and by providing CalOptima Health educational materials.

For fiscal year 2021-2022, CalOptima Health participated in ninety-five (95) community events and provided nearly $71,000 in financial support. To date for fiscal year 2022-2023, CalOptima Health has participated in seventy-eight (78) community events and provided nearly $46,000 in financial support. With community stakeholders and healthcare partners resuming in-person services and community events, staff has received a significant increase for CalOptima Health's staff and financial participation in community events.

Currently, the Chief Executive Officer is authorized to approve community event requests up to $2,500 per organization per fiscal year. In an effort to streamline the process and to allow focus on the most critical information and requests, staff requests via the policy modifications that the Chief Executive Officer be authorized to approve community event requests up to ~~$10,000~~ $25,000 (per event or cumulative total per organization for the fiscal year). This modification will provide Board and staff efficiencies while retaining Board oversight of fiscal participation in community events. This action supports the tactical priority COBAR Clarity as identified in CalOptima Health's Strategic Plan.

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Fiscal Impact
The recommended action to revise CalOptima Health Policy AA.1223 has no additional fiscal impact in the current year. Staff will include updated administrative expenses in future operating budgets.

Rationale for Recommendation
Staff recommends approval of the recommended action as an opportunity to streamline internal processes, while supporting our community stakeholders' community events.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Previous Board Action dated August 5, 2021: Consider Approval of Modification to CalOptima Policy AA.1223: Participation in Community Events with External Entities to Update Staff Approval Threshold
2. Revised CalOptima Health Policy AA.1223: Participation in Community Events by External Entities (redlined and clean versions)

/s/ Michael Hunn *11/23/2022*
Authorized Signature **Date**

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CalOptima Board Action Agenda Referral

Action To Be Taken August 5, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

7. Consider Approval of Modification to CalOptima Policy AA.1223: Participation in Community Events with External Entities to Update Staff Approval Threshold

Contacts

Richard Sanchez, Chief Executive Officer, (657) 900-1481
Rachel Selleck, Executive Director, Public Affairs, (657) 900-1096

Recommended Actions

1. Approve proposed modifications to CalOptima Policy AA. 1223: Participation in Community Events Involving External Entities to increase the Chief Executive Officer's (CEO's) authority to approve financial participation in community events from $1,000 to $2,500 per organization per fiscal year; and
2. Authorize the CEO to implement the proposed policy changes.

Background

CalOptima has a long history of participating in community events, health and resource fairs, town halls, workshops and other public activities in furtherance of the organization's mission and statutory purpose.

Prior to September 2015, CalOptima's CEO was authorized to approve CalOptima's financial support of community events of up to $10,000. In September 2015, this cap was reduced to $500 pending an Ad Hoc Committee of the Board's review of CalOptima's policy on endorsements and financial support of community events. On February 2, 2017, at the recommendation of the Board Ad Hoc, CalOptima's Board of Directors approved CalOptima Policy AA.1223: Participation in Community Events by External Entities (the Policy), including a requirement that staff seek Board approval for financial support in excess of $1,000 per organization per fiscal year. This $1,000 threshold remains in place today. Since the Policy was adopted, the Board increased the recommended dollar amount for one event and has approved all others as recommended by staff.

Discussion

The Board more recently has voiced interest in streamlining meeting materials and agendas to allow focus on the most critical information and requests. For example, in October 2020, the Board adopted a Receive and File category as part of the Consent Item agenda.

Staff considered whether the existing $1,000 threshold could be modified while retaining meaningful opportunity for the Board to weigh in on events whose organizers are requesting greater financial participation levels. As a result of this review, staff recommends modification of the CEO's approval threshold from $1,000 to $2,500 per organization per fiscal year. As reflected in the table below, had the CEO's authority for the proposed dollar threshold been in place, the number of items requiring Board approval would have been reduced by nearly 50%.

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Comparison of Fiscal Support Recommendations Under Existing and Proposed Thresholds		
	Existing Threshold: In Excess of $1,000	Proposed Threshold: In Excess of $2,500
2017–18	10	5
2018–19	14	6
2019–20	14	7
2020–21	4	4
Total	**42**	**22**

Following is a description of the proposed changes to the impacted Policy, with an attachment showing the substantive changes in redline. The table below does not include non-substantive changes that may also be reflected in the redline (e.g., formatting, spelling, punctuation, minor clarifying language and grammatical changes).

Policy AA.1223: Participation in Community Events by External Entities establishes guidelines for CalOptima's participation in community events, programs, projects and activities involving external entities.

Policy Sections	Proposed Change	Rationale	Impact
Section II.G.2, 2a, c, e Section II.G.3, 3a, b, e Section IX Attachment A, Section V Attachment B	Change threshold from $1,000 to $2,500.	To provide efficiencies while maintaining Board oversight of financial participation recommendations of amounts in excess of $2,500.	Based on prior experience, the number of requests requiring Board consideration may be reduced by approximately 50%.

Staff recommends this change, which would provide Board and staff efficiencies, while retaining meaningful Board oversight. Staff will continue to regularly report CalOptima's participation in community events to the Board.

Fiscal Impact

The recommended action to modify CalOptima Policy AA.1223 is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Fiscal Year 2021-22 Operating Budget approved by the CalOptima Board of Directors on June 3, 2021.

Rationale for Recommendation

Approval of this recommended action would support more efficient processing of community requests for financial support, while ensuring Board approval is required for requests exceeding the $2,500 threshold. By reducing the number of required Board requests, staff will also be able to respond more quickly to community partners seeking CalOptima financial participation under the threshold. Thus, the proposed

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modifications are consistent with the Board-approved CalOptima Strategic Plan Priorities to Enhance Operational Excellence and Efficiency and Strengthen Community Partnerships.

Concurrence
Gary Crockett, Chief Counsel

Attachments

1. Previous Board Action dated February 2, 2017: Consider Approval and Implementation of the Revised CalOptima Endorsement Policy AA.1214 and Proposed New Policy Regarding Participation in Community Events
2. Revised CalOptima Policy AA.1223: Participation in Community Events by External Entities (redlined and clean versions -- with Attachments – redlined and clean)

/s/ Richard Sanchez *07/28/2021*
Authorized Signature **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken February 2, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item
11. Consider Approval and Implementation of the Revised CalOptima Endorsement Policy AA.1214 and Proposed New Policy Regarding Participation in Community Events

Contact
Phil Tsunoda, Executive Director Public Policy and Public Affairs, (714) 246-8400

Recommended Actions
1. Approve the Revised CalOptima Policy AA.1214: Guidelines for Endorsements by CalOptima, for Letters of Support and Use of CalOptima's Name or Logo;
2. Approve CalOptima Policy AA. 1223: Participation in Community Events Involving External Entities; and
3. Authorize the Chief Executive Officer to implement the policies.

Background
CalOptima has a long history of participating in community events and public activities as well as providing endorsements for our community partners. CalOptima has historically provided Letters of Support, approval of the Use of CalOptima's Name or Logo, staff participation and/or financial participation in external events. CalOptima routinely participates in events such as health and resource fairs, town halls, workshops, and other community activities in furtherance of the organization's statutory purpose. Consistent with these activities, staff participation provides opportunities to conduct outreach and education about CalOptima's programs and services to current and potential members.

CalOptima also provides financial participation through registration fees and/or financial sponsorships. CalOptima participates in community events when the events are open to the public and for the public good, in furtherance of CalOptima's mission and statutory purpose, and encourages broader participation in CalOptima's programs and services, or promotes health and wellness among the populations CalOptima serves. As a result, CalOptima develops and cultivates a strong reputation in Orange County with community partners and key stakeholders.

Requests for letter of support, use of CalOptima Name or Logo, and for staff and/or financial participation in community events are considered based on several factors, including the opportunity to create positive visibility for CalOptima in the community and promote CalOptima's mission, programs, and purpose. Additional considerations include the number of current and potential CalOptima members, other participating stakeholders the activity/event will reach, the opportunity for CalOptima to share information, staff and budget availability, and the opportunity to strengthen relationships with our community partners.

Discussion
In September 2015, the Board of Directors requested a comprehensive review of CalOptima's Policy AA.1214: Guidelines for Endorsements by CalOptima and Use of CalOptima Name or Logo. In

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addition, the CalOptima Board chairman appointed a Board Ad Hoc Committee to work with staff regarding policy AA.1214.

Staff conducted a thorough review and comprehensive analysis of the policy with the Board Ad Hoc committee. The review and analysis highlighted the permissible use of Medi-Cal and Medicare funds for sponsorships, endorsements, marketing and other relevant activities. Based on these findings, staff and the Ad Hoc committee are recommending revising the current Board approved Policy AA.1214: Guidelines for Endorsement by CalOptima and Use of CalOptima Name or Logo and creating a new policy for Participation in Community Events.

Revised Policy AA. 1214: Guidelines for Endorsement by CalOptima, for Letters of Support and Use of CalOptima Name or Logo

CalOptima's revised Policy AA.1214: Guidelines for Endorsements by CalOptima, for Letters of Support and Use of CalOptima Name or Logo establishes specific criteria to guide the decision-making process, which includes defining eligible external entities and establishing criteria for Letters of Support and Use of CalOptima Name or Logo. The most significant change to the policy is the reduction of the number of days in advance a request must be received to process from sixty (60) calendar days to twenty-one (21) calendar days.

New Policy AA.1223: Participation in Community Events Involving External Entities

The new Policy AA.1223: Participation in Community Events Involving External Entities establishes criteria and requirements to guide the decision-making process and administrative review, which includes defining eligible entities and establishing criteria for staff participation and/or financial participation in external events. The most significant changes to the policy are:

- Establishes the timeframe to receive requests for staff participation in community events to at least fourteen (14) calendar days in advance of the date of the event.

- Reduces the Board's prior delegation to the CEO to approve financial requests by 90% from ten thousand dollars ($10,000) to one thousand dollars ($1,000)

- Reduces the number of days requests must be received in advance to process for financial participation in an amount up to and including one thousand dollars ($1,000) from sixty (60) calendar days to at least twenty-one (21) calendar days in advance of the date of the event.

- Requires approval by the CalOptima Board of Directors for requests for financial participation in amounts more than one thousand dollars ($1,000). Requests must still be received at least sixty (60) calendar days in advance of the date of the event.

As part of the recommended actions, approval of this item would be based on the Board making a finding that the proposed activities are in the public interest and in furtherance of CalOptima's statutory purpose. In addition, as part of the Board's approval of the Policies, the Board will also be authorizing the CEO to implement the requirements of the Policies.

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Fiscal Impact
There is no fiscal impact. Staff will request separate Board requests for staff or financial participation in community events with funding included in the annual CalOptima Operating Budget.

Rationale for Recommendation
Staff recommends approval of the recommended actions in order to support activities that provide opportunities for CalOptima to collaborate and strengthen relationships with community partners. Participation in these activities support CalOptima's mission, encourage broader participation in CalOptima's programs and services, and promote health and wellness. The revised Policy AA.1214 and new Policy AA.1223 provides definitions, criteria, a procedure and requirements to support these activities.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Revised Policy AA.1214: Guidelines for Endorsements by CalOptima, for Letters of Support and Use of CalOptima Name or Logo New Policy (redlined and clean versions – with revised Attachments
2. New Policy AA.1223: Participation in Community Events Involving External Entities (clean) – with Attachments

/s/ Michael Schrader — *01/26/2017*
Authorized Signature — **Date**

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Policy #:	AA.1214
Title:	**Guidelines for Endorsements by CalOptima, for Letters of Support, and Use of CalOptima Name or Logo**
Department:	Administration
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	~~2/4~~02/04/97
Last Review Date:	02/02/17
Last Revised Date:	02/01/17
~~Board Approvals: 10/2/2008~~	~~Revised: 7/1/07, 10/2/08, 11/1/13~~

I. PURPOSE

~~To clarify CalOptima's~~This policy establishes guidelines for providing an Endorsement to external entities by CalOptima, for Letters of Support, and for approving the use of the CalOptima name, or logo, by external entities.

II. POLICY

A. CalOptima's name carries considerable value, particularly for external entities seeking to associate themselves with the organization. Moreover, CalOptima's role as a public agency requires that its name and reputation be preserved and protected, and that activities and organizations associated with CalOptima's name must be consistent with CalOptima's mission and purpose. Requests for an Endorsement, including ~~letters~~LOS and u~~U~~se of ~~support, commitments for financial participation, and collaborations or partnerships with~~ CalOptima n~~N~~ame, or l~~L~~ogo, shall be approved only if compatible with CalOptima's mission and~~,~~ in accordance with this policy.

B. An external entity may be eligible to submit a request for an Endorsement including requests for a LOS, or Use of CalOptima n~~N~~ame, or l~~L~~ogo, if the entity is a community-based, non-profit organization, or health care partner, that serves CalOptima members, or supports CalOptima's mission.

C. Except as provided in this policy, CalOptima prohibits direct and implied endorsements. The name, logo, or images of CalOptima may not be used in any statement, website, print, or electronic communication, or activity to explicitly, or implicitly, endorse any specific commercial product, or service, any religion, any ballot measure/initiative, or any candidate for public office. In addition, the name, logo, or images of CalOptima may not be used explicitly, or implicitly, to endorse, or create, the appearance of partiality towards any vendor, or particular health care provider.

~~B.~~ Requests for an Endorsement~~, in the form of financial participation by CalOptima in a project, program, event, or other effort proposed by an external entity~~ or LOS, shall require the written approval ~~as follows:~~

~~1.~~D. ~~Requests for financial participation up to and including ten thousand dollars ($10,000) shall require the prior written approval of CalOptima's~~ of the Chief Executive Officer (CEO). The CEO shall consider such requests based on:

a.1. The potential for such financial participationthe Endorsement, or LOS, to create a positive visibility for CalOptima; and

b. The potential for such financial participation to create a long-term collaborative partnership between CalOptima and the requesting entity.

2. Requests for financial participation above ten thousand dollars ($10,000) shall require the prior approval of the CalOptima Board of Directors. The CalOptima Board of Directors may approve the budgeting of such financial participation in the annual budget or may approve unbudgeted financial participation through a separate action.

2. Financial participation includes the use of CalOptima staff time (e.g., in their capacity as a CalOptima employee) and current or future CalOptima funds.Whether the Endorsement, or LOS, would promote, or advocate, positions that are consistent with CalOptima's mission, programs, standards, and purposes; and

3. Whether the Endorsement, or LOS, may conflict with CalOptima policies and/or applicable local, state, and federal laws and regulations, and/or whether the Endorsement, or LOS, could constitute any real, or perceived, conflict of interest.

C.E. Use, or reproduction, of the CalOptima name, or logo, by external entities shall be restricted by CalOptima, in accordance with federal and state trademark rules and regulations.

D.F. Requests to utilize the CalOptima name, or logo, for any project, document, event, or other purpose shall require the advance written approval of CalOptima's CEO for approval and signature.

E. CalOptima shall not explicitly or implicitly endorse any specific commercial product or service (e.g., pharmaceuticals or health care products).

F.G. CalOptima shall report any Endorsement, or LOS, approved by the CEO, including the use of CalOptima's name, or logo, for any project, document, event, or other purpose, to the CalOptima Board of Directors, in writing, within thirty (30) calendar daysat the next available regularly scheduled Board of Directors meeting after such approval.

G.H. Effective January 1, 2009, anAn Endorsement, LOS, and use of CalOptima's name, or logo, as approved, in accordance with this policy, shall be posted on CalOptima's website (www.caloptima.org) and updated on a monthly basis.

I. CalOptima employees should refrain from wearing attire containing CalOptima's logo while participating in non-CalOptima related activities, such as political fundraisers, in order to avoid the appearance of CalOptima's Eendorsement.

III. PROCEDURE

A. Requests for Endorsements, or LOS:

1. All requests shall be submitted to CalOptima's Public AffairsCommunity Relations Department,, in writing.

2. A written request shall include the following information, as appropriate:

a. Copy The name and description of the organization seeking an Endorsement, or LOS, and the organization's contact information;

b. Name of the program or project, and name of the program or project director, or primary contact;

a.c. The reason for the request, including, but not limited to, a copy of the program or project description for which the letter of support, Eendorsement, or commitmentLOS, is requestedsought;

b.d. Scope and purpose of the program or project, including projected outcome;

c.e. Description, background, and pertinent information (e.g., names of members of the Board of Directors) regarding the requesting entityorganization and any other entityorganization having a substantial role in the project;

d.f. Information regarding the entity'sorganization's ability to successfully carry out the program or project;

d.

f. Name of the program or project, name of the program or project director or principal investigator and his or her qualifications in regard to the program or project;

g. A list of other individuals, or entities, supporting the program or project;

h. Project budget information, including budget detail if the request is for financial participation by CalOptima;

i. Detailed timeline for the project, including planning, implementation, evaluation, and other phases of the project;

h. Purpose for Date Endorsement, or LOS, is due to the organization;

i. Conditions under which the name of CalOptima and/or its logo will be used;

j. Draft template letter provided by the organization, where applicable; and

j. Description of relationship between organization's work and CalOptima's involvement in the program or project and a detailed description of its proposed role;

k. Anticipated time commitment requiredprograms/lines of business, mission, values, and/or purpose.

k. of individual CalOptima staff;

l. Specific data elements requested from CalOptima and a description of their specific use in the proposed project;business, mission, values, and

1.Projected outcome of the proposed project/or purpose.

3. All requests shall be submitted at least sixty (60twenty-one (21) calendar days in advance of the date for which the Endorsement, is requiredor LOS, is requested, or if in a shorter amount of time, at the discretion of the CEO, so long as such request is submitted to the CEO in a reasonable and sufficient amount of time so that CalOptima can complete a meaningful review and evaluation of the request.

4. Upon receipt of a complete request for an Endorsement, or LOS, CalOptima's Public AffairsCommunity Relations Department shall review and analyze the request with input from appropriate internal departments, including the Finance within five (5) business days of receipt of the complete request.

4. The Community Relations Department for eachshall submit a request involving financial participation.

5. Endorsements involving requests for financial participation in the amount of ten thousand dollars ($10,000)for Endorsement, or less are forwardedLOS, to the CEO for review and consideration.

6. Endorsements that involve financial participation in an amount greater than ten thousand dollars ($10,000) are forwarded, to the Board of Directors for review and consideration.

7.6. CalOptima The Community Relations Department shall notify any entitythe organization that requests an Endorsement, or LOS, in writing, after CalOptima's determination is made.

7. The Community Relations Department shall process an approved Endorsement, or LOS, request within three (3) business days of approval.

8. The Community Relations Department shall document and track all Endorsements and LOS and shall be responsible for fulfillment of any stated commitment(s).

B. Use of the CalOptima name, or logo:

1. Requests shall be submitted to CalOptima's Public AffairsCommunity Relations Department, in writing, at least thirty (30twenty-one (21) calendar days in advance of the date for which use of the name, or logo, is requiredrequested, or if in a shorter amount of time, at the discretion of the CEO, so long as such request is submitted to the CEO in a reasonable and sufficient amount of time so that CalOptima can complete a meaningful review and evaluation of the request.

2. Requests shall include the following:

   a. Description of the project, event, publication, or other purpose for which the CalOptima name, or logo will be used;

   b. Intended audience for the project, event, or publication for which the name name, or logo, will be used;

c. Description, background, and pertinent information (e.g., names of members of the Board of Directors) regarding the requesting entity and any other entity whose name will appear on the document, project, or event;

d. Time frame during which the name, or logo, is requested to be used; and

e. Mock-up of how the name, or logo, will be used.

3. Upon receipt of a complete request for use of the CalOptima name, or logo, CalOptima's Public AffairsCommunity Relations Department shall review and analyze the request with input from appropriate internal departments within five (5) business days.

4. The Public AffairsCommunity Relations Department shall submit a request for use of the CalOptima name, or logo, to the CEO for review and consideration.

5. CalOptimaThe Community Relations Department shall notify anythe requesting entity, that requests use of the CalOptima name or logo, in writing, after CalOptima's determination is made.

6. The Community Relatoions Department shall process an approved request within three (3) business days of approval.

IV. ATTACHMENTS

A. Endorsement Request Form: Letter of Support & Use of Logo
B. Endorsement Transmittal Form: Letter of Support & Use of Logo

V. REFERENCES

A. California Constitution Article 16, §6
B. California Government Code, §8314
C. CalOptima Policy AA.1000: Glossary of Terms
D. CalOptima Policy AA.1223: Participation in Community Events Involving External Entities

~~California Constitution Article 16, section 6~~
~~California Government Code, section 8314~~
E. CalOptima Policy GA.5002: Purchasing Policy
~~CalOptima Policy GA.1223: Participation in Community Events Involving External Entities~~
F. CalOptima Policy MA.2002: Marketing Activity Standards

VI. REGULATORY AGENCY APPROVALS ~~OR~~

~~Not Applicable~~None to Date

~~VI.~~VII. BOARD ACTIONS

A. ~~10/2/2008:~~02/02/17: ~~_____~~Regular Meeting of the CalOptima Board ~~Meeting~~of Directors
~~_____~~

B. 10/02/~~20~~08: ~~_____~~Regular Meeting of the CalOptima Board of Directors

~~VII.~~VIII. REVIEW/REVISION HISTORY

~~A. 10/2/2008: AA.1214: Guidelines for Endorsements by CalOptima and Use of CalOptima Name or Logo~~
~~B. 7/1/07: AA.1214: Guidelines for Endorsements by CalOptima and Use of CalOptima Name or Logo~~
~~C. 2/4/97: AA.1214: Guidelines for Endorsements by CalOptima and Use of CalOptima Name or Logo~~

~~VIII. KEYWORDS~~

~~Endorsement~~
~~Logo~~
~~Name~~

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	02/04/1997	AA.1214	Guidelines for Endorsements by CalOptima and Use of CalOptima Name or Logo	Administrative
Revised	07/01/2007	AA.1214	Guidelines for Endorsements by CalOptima and Use of CalOptima Name or Logo	Administrative
Revised	10/02/2008	AA.1214	Guidelines for Endorsements by CalOptima and Use of CalOptima Name or Logo	Administrative
Revised	02/02/2017	AA.1214	Guidelines for Endorsements by CalOptima and Use of CalOptima Name or Logo	Administrative

IX. GLOSSARY

Term	Definition
Endorsement	The support or promotion of a project, event, document, program, or initiative conducted by an external entity for the benefit of that entity, and for which support or promotion CalOptima does not receive a comparable benefit. Endorsement does not include any sponsorship, educational activity, purchased service, presentation, attendance at an event, activity that is included in the definition of Marketing Activities, or joint development of an event, seminar, symposium, educational program, public information campaign, or similar event.
Letter of Support (LOS)	A letter supporting a community-based organization or health care partner detailing compelling reasons why the organization or project is credible and of value to the community and conveying the relationship between CalOptima and the organization, thereby lending credibility to the organization requesting support. LOS does not include a formal partnership agreement or interagency agreement.
Marketing Activities	Any activity conducted by or on behalf of CalOptima where information regarding the services offered by CalOptima is disseminated in order to persuade or influence eligible beneficiaries to enroll or to educate members and promote optimal program use and participation. Marketing also includes any similar activity to secure the endorsement of any individual or organization on behalf of CalOptima.

Policy #:	AA.1214
Title:	**Guidelines for Endorsements by CalOptima, for Letters of Support, and Use of CalOptima Name or Logo**
Department:	Administration
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	02/04/97
Last Review Date:	02/02/17
Last Revised Date:	02/01/17

I. PURPOSE

This policy establishes guidelines for providing an Endorsement to external entities by CalOptima, for Letters of Support, and for approving the use of the CalOptima name, or logo, by external entities.

II. POLICY

A. CalOptima's name carries considerable value, particularly for external entities seeking to associate themselves with the organization. Moreover, CalOptima's role as a public agency requires that its name and reputation be preserved and protected, and that activities and organizations associated with CalOptima's name must be consistent with CalOptima's mission and purpose. Requests for an Endorsement, including LOS and use of CalOptima name, or logo, shall be approved only if compatible with CalOptima's mission and in accordance with this policy.

B. An external entity may be eligible to submit a request for an Endorsement including requests for a LOS, or Use of CalOptima name, or logo, if the entity is a community-based, non-profit organization, or health care partner, that serves CalOptima members, or supports CalOptima's mission.

C. Except as provided in this policy, CalOptima prohibits direct and implied endorsements. The name, logo, or images of CalOptima may not be used in any statement, website, print, or electronic communication, or activity to explicitly, or implicitly, endorse any specific commercial product, or service, any religion, any ballot measure/initiative, or any candidate for public office. In addition, the name, logo, or images of CalOptima may not be used explicitly, or implicitly, to endorse, or create, the appearance of partiality towards any vendor, or particular health care provider.

D. Requests for an Endorsement, or LOS, shall require the written approval of the Chief Executive Officer (CEO). The CEO shall consider such requests based on:

1. The potential for the Endorsement, or LOS, to create a positive visibility for CalOptima;

2. Whether the Endorsement, or LOS, would promote, or advocate, positions that are consistent with CalOptima's mission, programs, standards, and purposes; and

3. Whether the Endorsement, or LOS, may conflict with CalOptima policies and/or applicable local, state, and federal laws and regulations, and/or whether the Endorsement, or LOS, could constitute any real, or perceived, conflict of interest.

E. Use, or reproduction, of the CalOptima name, or logo, by external entities shall be restricted by CalOptima, in accordance with federal and state trademark rules and regulations.

F. Requests to utilize the CalOptima name, or logo, for any project, document, event, or other purpose shall require the advance written approval of CalOptima's CEO.

G. CalOptima shall report any Endorsement, or LOS, approved by the CEO, including the use of CalOptima's name, or logo, for any project, document, event, or other purpose, to the CalOptima Board of Directors, in writing, at the next available regularly scheduled Board of Directors meeting after such approval.

H. An Endorsement, LOS, and use of CalOptima's name, or logo, as approved in accordance with this policy, shall be posted on CalOptima's website (www.caloptima.org) and updated on a monthly basis.

I. CalOptima employees should refrain from wearing attire containing CalOptima's logo while participating in non-CalOptima related activities, such as political fundraisers, in order to avoid the appearance of CalOptima's Endorsement.

III. PROCEDURE

A. Requests for Endorsements, or LOS:

1. All requests shall be submitted to CalOptima's Community Relations Department, in writing.

2. A written request shall include the following information, as appropriate:

a. The name and description of the organization seeking an Endorsement, or LOS, and the organization's contact information;

b. Name of the program or project, and name of the program or project director, or primary contact;

c. The reason for the request, including, but not limited to, a copy of the program or project description for which the Endorsement, or LOS, is sought;

d. Scope and purpose of the program or project, including projected outcome;

e. Description, background, and pertinent information (e.g., names of members of the Board of Directors) regarding the requesting organization and any other organization having a substantial role in the project;

f. Information regarding the organization's ability to successfully carry out the program or project;

g. A list of other individuals, or entities, supporting the program or project;

h. Date Endorsement, or LOS, is due to the organization;

i. Conditions under which the name of CalOptima and/or its logo will be used;

j. Draft template letter provided by the organization, where applicable; and

k. Description of relationship between organization's work and CalOptima's programs/lines of business, mission, values, and/or purpose.

3. All requests shall be submitted at least twenty-one (21) calendar days in advance of the date for which the Endorsement, or LOS, is requested, or if in a shorter amount of time, at the discretion of the CEO, so long as such request is submitted to the CEO in a reasonable and sufficient amount of time so that CalOptima can complete a meaningful review and evaluation of the request.

4. Upon receipt of a complete request for an Endorsement, or LOS, CalOptima's Community Relations Department shall review and analyze the request with input from appropriate internal departments within five (5) business days of receipt of the complete request.

5. The Community Relations Department shall submit a request for Endorsement, or LOS, to the CEO for review and consideration.

6. The Community Relations Department shall notify the organization that requests an Endorsement, or LOS, in writing, after CalOptima's determination is made.

7. The Community Relations Department shall process an approved Endorsement, or LOS, request within three (3) business days of approval.

8. The Community Relations Department shall document and track all Endorsements and LOS and shall be responsible for fulfillment of any stated commitment(s).

B. Use of the CalOptima name, or logo:

1. Requests shall be submitted to CalOptima's Community Relations Department, in writing, at least twenty-one (21) calendar days in advance of the date for which use of the name, or logo, is requested, or if in a shorter amount of time, at the discretion of the CEO, so long as such request is submitted to the CEO in a reasonable and sufficient amount of time so that CalOptima can complete a meaningful review and evaluation of the request.

2. Requests shall include the following:

a. Description of the project, event, publication, or other purpose for which the CalOptima name, or logo will be used;

b. Intended audience for the project, event, or publication for which the name, or logo, will be used;

c. Description, background, and pertinent information (e.g., names of members of the Board of Directors) regarding the requesting entity and any other entity whose name will appear on the document, project, or event;

d. Time frame during which the name, or logo, is requested to be used; and

e. Mock-up of how the name, or logo, will be used.

3. Upon receipt of a complete request for use of the CalOptima name, or logo, CalOptima's Community Relations Department shall review and analyze the request with input from appropriate internal departments within five (5) business days.

4. The Community Relations Department shall submit a request for use of the CalOptima name, or logo, to the CEO for review and consideration.

5. The Community Relations Department shall notify the requesting entity, in writing, after CalOptima's determination is made.

6. The Community Relations Department shall process an approved request within three (3) business days of approval.

IV. ATTACHMENTS

A. Endorsement Request Form: Letter of Support & Use of Logo
B. Endorsement Transmittal Form: Letter of Support & Use of Logo

V. REFERENCES

A. California Constitution Article 16, §6
B. California Government Code, §8314
C. CalOptima Policy AA.1000: Glossary of Terms
D. CalOptima Policy AA.1223: Participation in Community Events Involving External Entities
E. CalOptima Policy GA.5002: Purchasing Policy
F. CalOptima Policy MA.2002: Marketing Activity Standards

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 02/02/17: Regular Meeting of the CalOptima Board of Directors
B. 10/02/08: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	02/04/1997	AA.1214	Guidelines for Endorsements by CalOptima and Use of CalOptima Name or Logo	Administrative

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	07/01/2007	AA.1214	Guidelines for Endorsements by CalOptima and Use of CalOptima Name or Logo	Administrative
Revised	10/02/2008	AA.1214	Guidelines for Endorsements by CalOptima and Use of CalOptima Name or Logo	Administrative
Revised	02/02/2017	AA.1214	Guidelines for Endorsements by CalOptima and Use of CalOptima Name or Logo	Administrative

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IX. GLOSSARY

Term	Definition
Endorsement	The support or promotion of a project, event, document, program, or initiative conducted by an external entity for the benefit of that entity, and for which support or promotion CalOptima does not receive a comparable benefit. Endorsement does not include any sponsorship, educational activity, purchased service, presentation, attendance at an event, activity that is included in the definition of Marketing Activities, or joint development of an event, seminar, symposium, educational program, public information campaign, or similar event.
Letter of Support (LOS)	A letter supporting a community-based organization or health care partner detailing compelling reasons why the organization or project is credible and of value to the community and conveying the relationship between CalOptima and the organization, thereby lending credibility to the organization requesting support. LOS does not include a formal partnership agreement or interagency agreement.
Marketing Activities	Any activity conducted by or on behalf of CalOptima where information regarding the services offered by CalOptima is disseminated in order to persuade or influence eligible beneficiaries to enroll or to educate members and promote optimal program use and participation. Marketing also includes any similar activity to secure the endorsement of any individual or organization on behalf of CalOptima.

Endorsement Request Form – Letter of Support (LOS) & Use of Logo

Requests for Letter of Support (LOS) and/or Use of CalOptima's Logo must be submitted to the Community Relations Department no less than 21 calendar days in advance. ~~Please provide the information requested below, as appropriate. For Letters of Support, must complete at least the items marked by an asterisk (*).~~

Endorsement Details			
Organization:*			
Address:*			
City:*		**Zip Code:***	
POC Name & Title:*			
Phone Number:*	☒	**Fax #:**	
E-mail:*	☐		
~~**Type:***~~	~~Letter of Support~~		
Type:	☐ Letter of Support ~~Commitment for Financial Participation~~		
	☐ Use of CalOptima Name or Logo Only		
	☐ ~~Other:~~ ☐ ~~CalOptima Master Logo~~ ☐ ~~PACE Logo~~		
	☐ ~~OneCare Connect Logo~~ ☐ OneCare		
Endorsement Needed By:*			

If more space is needed, you may attach additional pages.	
1. Program or project description, including:* a. Name of the program or project b. Name of the program or project director or principle investigator, including his/her qualifications in regards to the program or project c. Scope and purpose of the program or project	
2. Background information of requesting entity, including:* a. Information regarding entity's ability to successfully carry out the program or project b. Names of members of the Board of Directors	

Endorsement Request Form – Letter of Support (LOS) & Use of Logo

3. Other individuals or entities supporting the program or project, including:* a. A description of their role in the program or project	
4. Detailed program or project timeline for planning, implementation, evaluation, and other phases of the program or project	
5. Projected outcome of the program or project	
~~6. Amount requested and program or project budget Information, including:~~ ~~a. Budget detail if the request is for financial participation by CalOptima~~ ~~*(Note: Requests for financial participation up to and including $10,000 shall require prior written approval of CalOptima's CEO. Requests for financial participation above $10,000 shall require prior approval of the CalOptima Board of Directors.)*~~	
6. Purpose for CalOptima's involvement in the program or ~~7.~~ project, including: a. Detailed description of its proposed role b. Anticipated time commitment required of CalOptima staff c. Specific data elements requested from CalOptima and a description of their specific use in the program or project	

Endorsement Request Form – Letter of Support (LOS) & Use of Logo

7. Conditions under which CalOptima's name and/or logo will be used.	
8. Time frame during which CalOptima's name or logo will be used.	
9. ~~Request for~~Please provide a LOS template letter and/or mock-up of how CalOptima's name or~~f~~ logo will be used.	

Endorsement Request Form – Letter of Support (LOS) & Use of Logo

Requests for Letter of Support (LOS) and/or Use of CalOptima's Logo must be submitted to the Community Relations Department no less than 21 calendar days in advance.

Endorsement Details			
Organization:			
Address:			
City:		**Zip Code:***	
POC Name & Title:			
Phone Number:		**Fax #:**	
E-mail:			
Type:	☐ Letter of Support		
	☐ Use of CalOptima Name or Logo Only		
	☐ CalOptima Master Logo ☐ PACE Logo		
	☐ OneCare Connect Logo ☐ OneCare		
Endorsement Needed By:			

If more space is needed, you may attach additional pages.	
1. Program or project description, including: a. Name of the program or project b. Name of the program or project director or principle investigator, including his/her qualifications in regards to the program or project c. Scope and purpose of the program or project	
2. Background information of requesting entity, including: a. Information regarding entity's ability to successfully carry out the program or project b. Names of members of the Board of Directors	

Endorsement Request Form – Letter of Support (LOS) & Use of Logo

3. Other individuals or entities supporting the program or project, including: a. A description of their role in the program or project	
4. Detailed program or project timeline for planning, implementation, evaluation, and other phases of the program or project	
5. Projected outcome of the program or project	
6. Purpose for CalOptima's involvement in the program or project, including: a. Detailed description of its proposed role b. Anticipated time commitment required of CalOptima staff c. Specific data elements requested from CalOptima and a description of their specific use in the program or project	
7. Conditions under which CalOptima's name and/or logo will be used.	

Endorsement Request Form – Letter of Support (LOS) & Use of Logo

8. Time frame during which CalOptima's name or logo will be used.	
9. Please provide a LOS template letter and/or mock-up of how CalOptima's name or logo will be used.	

Endorsement Transmittal Form: Letter of Support (LOS) & Use of Logo

Guidelines for Endorsements by CalOptima

A CalOptima endorsement is given to projects and programs that are strongly aligned with our mission to provide members with access to quality health care services delivered in a cost-effective and compassionate manner. Endorsements are considered for programs and projects that have:

1. Have tThe potential for the Endorsement or LOS to create positive visibility for CalOptima; and

2. The potential to create a long-term collaborative partnership between CalOptima and the requesting entity.
2. Whether the Endorsement LOS would pPromote or advocate positions that are consistent with CalOptima's mission, programs, standards and purposes; and.

3. CalOptima will also consider wWhether the Endorsement or LOS may conflict with CalOptima with CalOptima policies and/or applicable local, state and federal laws and regulations, and/or whether the Endorsement or LOS could constitute any real or perceived conflict of interest.
4.

Organization: _____

Endorsement Needed By: _____

Today's Date: _____

Endorsement Review					
Required to go to the Board: ☐ No ☐ Yes (If approved by CEO)					
Name	**Signature**	**Date**	**Decision**		**Remarks**
			☐ Yes	☐ No	
			☐ Yes	☐ No	
			☐ Yes	☐ No	
			☐ Yes	☐ No	
			☐ Yes	☐ No	
			☐ Yes	☐ No	
CEO Approved:			**Date:**		

For PA Department Use Only	
Notification Sent:	
Reported for Board Update:	
Posted on CalOptima Website:	

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Notes:	

Revised ~~08/15/2010~~1/26/17

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Endorsement Transmittal Form: Letter of Support (LOS) & Use of Logo

Guidelines for Endorsements by CalOptima

A CalOptima endorsement is given to projects and programs that are strongly aligned with our mission to provide members with access to quality health care services delivered in a cost-effective and compassionate manner. Endorsements are considered for programs and projects that:

1. Have the potential for the Endorsement or LOS to create positive visibility for CalOptima; and

2. Promote or advocate positions that are consistent with CalOptima's mission, programs, standards and purposes.

CalOptima will also consider whether the Endorsement or LOS may conflict with CalOptima policies and/or applicable local, state and federal laws and regulations, and/or whether the Endorsement or LOS could constitute any real or perceived conflict of interest.

Organization: _____

Endorsement Needed By: _____

Today's Date: _____

Endorsement Review					
Required to go to the Board: ☐ **No** ☐ **Yes (If approved by CEO)**					
Name	**Signature**	**Date**	**Decision**		**Remarks**
			☐ **Yes**	☐ **No**	
			☐ **Yes**	☐ **No**	
			☐ **Yes**	☐ **No**	
			☐ **Yes**	☐ **No**	
			☐ **Yes**	☐ **No**	
			☐ **Yes**	☐ **No**	
CEO Approved:			**Date:**		

For PA Department Use Only	
Notification Sent:	
Reported for Board Update:	
Posted on CalOptima Website:	
Notes:	

Policy #:	AA.1223
Title:	**Participation in Community Events Involving External Entities**
Department:	Administration
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	02/02/17
Last Review Date:	Not Applicable
Last Revised Date:	Not Applicable

I. PURPOSE

This policy establishes guidelines for CalOptima's Participation in community events, programs, projects, and activities involving external entities.

II. POLICY

A. CalOptima recognizes the value of partnering with external entities to provide additional health care related services of benefit to the local community, while still upholding its fiscal responsibilities as a steward of public funds. Requests for CalOptima's Participation in community events involving external entities, financially, or otherwise, shall be approved only if:

1. Compatible with CalOptima's mission to provide members with access to quality health care services delivered in a cost-effective and compassionate manner;

2. Consistent with CalOptima's specific statutory purpose to arrange for the provision of health care services to qualifying individuals who lack sufficient annual income to meet the cost of healthcare; and

3. In accordance with this Policy.

B. An external entity may be eligible for CalOptima's Participation in its event if the entity is a community-based, non-profit organization, or health care partner (collectively, "external entities") that serves CalOptima members, or supports CalOptima's mission. Religious organizations are not eligible for CalOptima's Participation unless the event is open to the general public and is for a non-sectarian purpose.

C. The expenditure of CalOptima's funds shall only be made for a direct and primary public purpose within CalOptima's authority and jurisdiction. Absent a legitimate and direct public purpose within CalOptima's authority and jurisdiction, CalOptima shall not use public funds to make monetary contributions to external entities solely for the purpose of goodwill, showing support, networking, public relations, or relationship building. External entities may not use CalOptima's Participation in any manner to donate, or endorse, political candidates to elected office, or to support/oppose a position on proposed legislation, ballot initiative, or proposition.

D. CalOptima's Participation shall include at least one (1) of the following:

1. A speaking opportunity for a CalOptima representative;

2. A presentation, or panel presentation, by a CalOptima representative;

3. A booth, or table, designated for CalOptima at the event to distribute CalOptima information to members and/or potential members who could be enrolled in any of CalOptima's programs; or

4. Other opportunity to promote CalOptima's services and increase awareness about CalOptima.

E. There may be circumstances where financial Participation for external entities, such as charitable organizations, or activities (*e.g.*, United Way, etc.), may be permitted based on a finding by the CalOptima Board of Directors that the request for financial Participation falls within CalOptima's authority and purpose, and meets one (1) of the following criteria:

1. The financial Participation will be used by the external entity to provide a service that complements, or enhances, one that CalOptima provides; or

2. There is an identifiable benefit to CalOptima and/or its members.

F. The expenditure of CalOptima funds and the use of resources, staff time, and CalOptima facilities shall not be inconsistent with, or in conflict with, CalOptima's obligations under applicable state and federal laws and contracts.

G. Requests for Participation by CalOptima in an event proposed by an external entity shall require approval as follows:

1. Requests for Participation, other than financial contributions, such as hosting booths at health fairs, conducting education programs and presentations, or organizing community/town hall meetings:

a. Requests for non-financial Participation from external entities shall be submitted no less than fourteen (14) calendar days in advance of the date of the event.

b. The Chief Executive Officer (CEO), or his/her designee, is authorized to approve non-financial requests from external entities for community/member oriented events that meet the eligibility requirements as provided in this Policy.

c. Non-financial Participation requests from external entities for community/member oriented events such as health fairs, educational events, and/or community/town hall forums shall meet the standards set forth above in Sections II.A. through II.F. along with the following criteria:

i. Member interaction/enrollment – The activity shall include participation from CalOptima members and/or potential members that could be enrolled in any of CalOptima's programs, or be in furtherance of CalOptima's mission, programs/lines of business, values, and/or purpose; and

ii. Inclusion of Details of the Event – Information about the organization and event, including name of the organization hosting the event, the name of the event itself, day/date, start and end time, location, event coordinator contact information, expected

number of attendees, primary demographics of people served, purpose and outcome of the proposed event, and description of CalOptima's Participation in the event.

2. Requests for financial Participation, up to and including, a cumulative value of one thousand dollars ($1,000) per organization per fiscal year, which shall include all materials and supplies:

   a. Requests for financial Participation in an amount up to and including one thousand dollars ($1,000) per organization per fiscal year, inclusive of all materials and supplies, shall be submitted no less than twenty-one (21) calendar days in advance of the date of the event, or if in a shorter amount of time, at the discretion of the CEO, so long as such request is submitted to the CEO in a reasonable and sufficient amount of time so that CalOptima can complete a meaningful review and evaluation of the request.

   b. The CEO, or his/her designee, is authorized to approve requests for financial Participation for qualifying external entities and events for a cumulative amount of up to and including one thousand dollars ($1,000) per organization per fiscal year, subject to availability of budgeted funds.

   c. All requests for financial Participation to CalOptima from external entities shall meet the standards set forth above in Sections II.A. through II.F. along with the following criteria:

      i. Member interaction/enrollment – The activity shall include participation from CalOptima members and/or potential members that could be enrolled in any of CalOptima's programs or be in furtherance of CalOptima's mission, programs/lines of business, values, and/or purpose; and

      ii. Inclusion of Details of the Event – Information about the organization and event, including the name of the organization hosting the event, the name of the event itself, day/date, start and end time, location, event coordinator contact information, expected number of attendees, primary demographics of people served, purpose and outcome of the proposed event, description of CalOptima's Participation in the event, and/or how CalOptima's financial Participation will be used, etc.

   d. The CEO, or his/her designee, is authorized to purchase and use in-kind contributions of items branded with CalOptima's logo for the purpose of outreach and promoting CalOptima's role and services in the community.

   e. The CEO, or his/her designee, will report all approved Participation in events involving financial Participation in an amount up to and including one thousand dollars ($1,000) per organization per fiscal year to the CalOptima Board of Directors in the CEO's regular Board communications, including, but not limited to, the CEO's weekly updates and reports included in the next available regularly scheduled Board of Directors meeting.

3. Requests for financial Participation in amounts of more than one thousand dollars ($1,000) per organization per fiscal year:

   a. Requests for financial Participation for the amount of more than one thousand dollars ($1,000) per organization per fiscal year shall be submitted no less than sixty (60) calendar days in advance of the date of the event.

b. Financial requests from qualified external entities for eligible events valued at more than one thousand dollars ($1,000) require approval from the CalOptima Board of Directors and a finding that such financial Participation is in the public good, subject to availability of budgeted funds, and within CalOptima's authority and statutory purpose.

c. All requests for financial Participation to CalOptima from external entities shall meet the standards set forth above in Sections II.A. through II.F. along with the following criteria:

i. Member interaction/enrollment – The activity shall include participation from CalOptima members and/or potential members that could be enrolled in any of CalOptima's program, or be in furtherance of CalOptima's mission, programs/lines of business, values, and/or purpose; and

ii. Inclusion of Details of the Event – Information about the organization and event, including name of the organization hosting the event, the name of the event itself, day/date, start and end time, location, event coordinator contact information, expected number of attendees, primary demographics of people served, purpose, and outcome of the proposed event, description of CalOptima's Participation in the event, and/or how CalOptima's financial Participation will be used, etc.

d. The CEO is authorized to purchase and use in-kind contributions of items branded with CalOptima's logo for the purpose of outreach and promoting CalOptima's role and services in the community.

e. The CEO, or his/her designee, will report all approved Participation in events involving financial Participation in amounts more than one thousand dollars ($1,000) per organization per fiscal year to the CalOptima Board of Directors in the CEO's weekly updates and reports included in the next available regularly scheduled Board of Directors meeting.

4. In determining the value of CalOptima's Participation in events involving external entities, the following factors shall be considered:

a. The use of CalOptima staff time (*e.g.*, in their capacity as a CalOptima employee) to attend events such as health fairs, educational or community events;

b. The use of CalOptima resources (*e.g.*, CalOptima facilities);

c. The use of current, or future, CalOptima eligible funds; and

d. The value of items donated with the CalOptima master brand/logo.

H. In no event shall approval of CalOptima's Participation in an event, or with an external entity, constitute an Endorsement of the external entity hosting the event, nor shall such Participation constitute Endorsement of any particular message, or initiative, commercial product or service, and/or any message advocated by the external entity. Endorsements and use of CalOptima's name, or logo, in any material by an external entity shall be governed by CalOptima Policy AA.1214: Guidelines for Endorsements, for Letters of Support, and Use of CalOptima's Name and Logo.

I. The CEO, or his/her designee, shall report any Participation approved by the CEO to the CalOptima Board of Directors, in writing, at the next available regularly scheduled Board of Directors meeting after such approval.

J. The CEO, or his/her designee, shall provide members of the CalOptima Board of Directors with advanced notice so they have the opportunity to attend events in which CalOptima Participates.

K. Payment for actual and necessary expenses incurred in the course of performing services for CalOptima, including expenses incurred in the course of attending functions of external entities, shall be reimbursed, or paid, according to CalOptima Policy GA.5004: Travel Policy to the extent there is a clear nexus between the attendance of the employee at such a function and the performance of the service for which such employees is regularly employed. In no event shall CalOptima pay, or reimburse, a CalOptima employee for expenses arising from personal expenses, political campaigns, or activities, charitable contributions, or events (including fundraisers, galas, dinners, unless expressly approved by the Board of Directors), family expenses, entertainment expenses, or religious activities.

L. In the event CalOptima's Participation in an event involving an external entity involves any Marketing Activities, such Marketing Activities shall be consistent with all applicable legal and contractual requirements, as well as all internal policies, including, but not limited to, CalOptima Policy MA.2002: Marketing Activity Standards.

III. PROCEDURE

A. All requests for Participation shall be submitted within the timeframe specified above, and include the following information, as appropriate:

1. Description of the external entity requesting Participation, including, but not limited to: whether the external entity is a non-profit organization, religious organization, for-profit organization, or other health care partner (including valid by-laws filed with the Secretary of State of the State of California); how long the external entity has been operating; where the external entity's principle office and base of operations is located; external entity's service area, etc.;

2. Description of the event such as name of the event, day/date, start and end time, location, event coordinator contact information, expected number of attendees, primary language of attendees, primary demographics of people served, purpose, and outcome of the proposed event;

3. The purpose of the event, including, but not limited to, a copy of any event materials, or description of the program or project;

4. Description of relationship between external entity's work, or event, and CalOptima's programs/lines of business, mission, values, and/or purpose;

5. Description, background, and pertinent information (*e.g.*, names of members of the Board of Directors) regarding the requesting entity and any other entity having a substantial role in the event;

6. A list of other individuals, or entities, supporting the event;

7. Event budget information; and

8. Purpose, role, and anticipated time commitment for CalOptima's involvement in the event, if applicable.

B. Upon receipt of a complete request for Participation, CalOptima's Community Relations Department shall:

1. Review and analyze the request to ensure each criteria is met;

2. Complete the Event Participation Request Form and place the completed form and all supporting documentation in a folder within five (5) business days of the date of receipt of completed request;

3. Submit the request to the CEO, his/her designee, or to the Board of Directors, where applicable, for consideration. If the request is denied, the requestor shall be so notified.

C. Upon receipt of the approved request for Participation from the CEO, his/her designee, or the Board of Directors, CalOptima's Community Relations Department shall:

1. Notify the requesting entity of CalOptima's determination; and

2. Process the financial request and any necessary documents within three (3) business days of the determination date.

3. Any payments for approved financial requests shall be issued only through checks paid directly to the external entity, and no cash disbursements will be made for events covered by this Policy.

D. Requests for In-Kind Contributions of Items Branded with the CalOptima Logo:

1. Requests shall be submitted to CalOptima's Community Relations Department, in writing, at least thirty (30) calendar days in advance of the date for which an entity wishes to distribute items branded with the CalOptima master logo.

2. Upon receipt of a complete request to distribute items branded with the CalOptima master logo, CalOptima's Community Relations Department shall review and analyze the request with input from appropriate internal departments within five (5) business days.

3. The Community Relations Department shall submit a request to the Chief Executive Officer (CEO), or his/her designee, for approval of a donation of items valued at five dollars ($5), or less, and up to and including a cumulative total of five hundred dollars ($500) worth of goods. Requests to distribute items that exceed a cumulative total of five hundred dollars ($500) shall require the prior approval of the CalOptima Board of Directors.

5. The Community Relations Department shall notify the requesting entity, in writing, after CalOptima's determination is made.

6. The Community Relations Department shall process an approved request to distribute items branded with the CalOptima master logo within three (3) business days of approval.

7. The requesting entity shall agree to return any items that it does not distribute at the conclusion of the event for which the item was used.

IV. ATTACHMENTS

A. CalOptima Public Activity Participation Request Form
B. CalOptima Public Activity Transmittal Form

V. REFERENCES

A. California Constitution Article 16, §6
B. California Government Code, §8314
C. CalOptima Policy AA.1000: Glossary of Terms
D. CalOptima Policy AA.1214: Guidelines for Endorsements by CalOptima, for Letters of Support, and Use of CalOptima Name or Logo
E. CalOptima Policy GA.5004: Travel Policy
F. CalOptima Policy MA.2002: Marketing Activity Standards

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

02/02/17: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	02/02/2017	AA.1223	Participation in Community Events Involving External Entities	Administrative

IX. GLOSSARY

Term	Definition
Endorsement	The support or promotion of a project, event, document, program, or initiative conducted by an external entity for the benefit of that entity, and for which support or promotion CalOptima does not receive a comparable benefit. Endorsement does not include any sponsored educational activity, purchased service, presentation, attendance at an event, activity that is included in the definition of Marketing Activities, or joint development of an event, seminar, symposium, educational program, public information campaign, or similar event.
Marketing Activities	Any activity conducted by or on behalf of CalOptima where information regarding the services offered by CalOptima is disseminated in order to persuade or influence eligible beneficiaries to enroll or to educate members and promote optimal program use and participation. Marketing also includes any similar activity to secure the endorsement of any individual or organization on behalf of CalOptima.
Participate/ Participation	The provision of financial assistance or in-kind contribution of goods, materials, facilities, staff time, and/or services by CalOptima to an external entity in support of one or more events, programs, projects, and/or activities (collectively, "events") in furtherance of CalOptima's mission, programs/lines of business, values, and/or purpose.

Public Activity Participation Request Form

Requesting Entity: _____

Requesting Entity's principal office/base of operations location: _____

How long Requesting Entity has been operating: _____

Requesting Entity's service area(s): _____

Description of relationship between Requesting Entity's work/event and CalOptima's lines of business, mission, values, and/or purpose: _____

Description, background and pertinent info. (eg. members of Board of Directors) and other entities with a substantial role in event: _____

List of individuals or entities supporting the event: _____

Entity Type: ☐ Non-Profit Org ☐ For-Profit Org ☐ Religious Org ☐ Health Care Partner

Purpose, role and anticipated time commitment for CalOptima's involvement: _____

Section I: Event Details			
Name:			
Day/Date:			
Start Time:		**End Time:**	
Location:			
City:		**Zip Code:**	
POC Name:			
Phone#:		**Fax #:**	
Email:			
Type of Event	☐1 Opportunity to outreach to members or potential members		
	☐2 Opportunity to outreach to health care professionals, non-profit orgs or policy-makers		
	☐3 Other:		
Expected # of Attendees:			
Event Budget:			

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Public Activity Participation Request Form

Section II: About the Attendees (check all that apply)				
Primary Language Spoken:	☐ English	☐ Spanish	☐ Vietnamese	☐ Other:

Event for:	☐ Children	☐ Persons with disabilities	
	☐ Low-income families	☐ General public	
	☐ Low-income older adults/seniors	☐ Other:	
Event for CalOptima LOB:	☐ OC/OCC	☐ PACE	☐ Medi-Cal

Section III: Cost to CalOptima to Participate		
Registration Fee:		
Sponsorship Request:	☐ No	☐ Yes, amount:

Section IV: Notes/Comments

Section V: Disclosures
Requests must be submitted to the Community Relations Department: Staff Participation - 14 calendar days in advance; Financial Participation at or under $1,000 - 21 calendar days in advance; Financial Participation more than $1,000 - 60 calendar days in advance. *****All event materials/information must be attached*****

Public Activity Transmittal Form

Please complete your portion of this form and route it in the order indicated below. Please contact Lisa Nguyen at ext. 8809 if you have any questions.

Today's Date: _____ **Complete Routing By:** _____

Routing Order			
1. Department POC:		**Complete Review By:**	
2. Department POC:		**Complete Review By:**	
3. Department POC:		**Complete Review By:**	

For CR Use Only: CR Initial Review		
Requests for CalOptima's Participation in community events involving external entities must be:		
1. Compatible with CalOptima's mission to provide members with access to quality health care services delivered in a cost-effective and compassionate manner.	☐ Yes	☐ No
2. Consistent with CalOptima's specific statutory purpose to arrange for the provision of health care services to qualifying individuals who lack sufficient annual income to meet the cost of health care; and	☐ Yes	☐ No
3. In accordance with Policy AA.1223: Participation in Community Events Involving External Entities	☐ Yes	☐ No
CalOptima's Participation shall include at least one (1) of the following:		
1. A speaking opportunity for a CalOptima representative	☐ Yes	☐ No
2. A presentation, or panel presentation, by a CalOptima representative	☐ Yes	☐ No
3. A booth, or table, designated for CalOptima at the event to distribute CalOptima information to members/potential members	☐ Yes	☐ No
4. Other opportunity to promote CalOptima's services and increase awareness about CalOptima	☐ Yes	☐ No
Financial Participation must meet one (1) of the following criteria, if applicable:		
1. The financial participation will be used by the external entity to provide a service that complements, or enhances, one that CalOptima provides	☐ Yes	☐ No
2. There is an identifiable benefit to CalOptima and/or its members	☐ Yes	☐ No

Other considerations:		
Process as an Endorsement (i.e. policy AA.1214)	☐ Yes	☐ No
Event affiliated with a member of the Board, MAC, PAC, or Employee	☐ Yes	☐ No
Request Legal Review (i.e. conflict analysis)	☐ Yes	☐ No
Included in budget	☐ Yes, amount	☐ No
CalOptima participated in the past	☐ Yes, year(s)	☐ No
Notes:		

CR Participation Commitment:	YES	NO	N/A
Assume "Lead Department" role	☐ Staff:	☐	☐
Assume "Support Department" role	☐ Staff:	☐	☐
Provide financial support (i.e. registration fee, sponsorship, etc.)	☐ Amount:	☐	☐

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Public Activity Transmittal Form

Provide promotional items	☐	☐	☐
Provide brochures/educational materials	☐	☐	☐
Other:	☐ Specify:	☐	☐
Notes:			

Signature Required Only for Sponsorships, Endorsements and Registration Fees.

Date:

Tiffany Kaaiakamanu, Manager of Community Relations

***CalOptima's CEO has delegated authority to approve requests for financial participation in an amount up to and including $1,000 if it is determined that CalOptima's participation is of public purpose.**

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Policy:	AA.1223
Title:	**Participation in Community Events by External Entities**
Department:	CalOptima Administrative
Section:	Strategic Development, Community Relations
CEO Approval:	*/s/*
Effective Date:	02/02/2017
Revised Date:	TBD

Applicable to:
- ☐ Medi-Cal
- ☐ OneCare
- ☐ OneCare Connect
- ☐ PACE
- ☒ Administrative

I. PURPOSE

This policy establishes guidelines for CalOptima's Participation in community events, programs, projects, and activities involving external entities.

II. POLICY

A. CalOptima recognizes the value of partnering with external entities to provide additional health care related services of benefit to the local community, while still upholding its fiscal responsibilities as a steward of public funds. Requests for CalOptima's Participation in community events involving external entities, financially, or otherwise, shall be approved only if:

1. Compatible with CalOptima's mission to provide members with access to quality health care services delivered in a cost-effective and compassionate manner;

2. Consistent with CalOptima's specific statutory purpose to arrange for the provision of health care services to qualifying individuals who lack sufficient annual income to meet the cost of healthcare; and

3. In accordance with this Policy.

B. An external entity may be eligible for CalOptima's Participation in its event if the entity is a community-based, non-profit organization, health care partner, public or government entity (collectively, "external entities") that serves CalOptima members~~,~~ or supports CalOptima's mission. Religious organizations are not eligible for CalOptima's Participation unless the event is open to the general public and is for a non-~~—~~sectarian purpose.

C. The expenditure of CalOptima's funds shall only be made for a direct and primary public purpose within CalOptima's authority and jurisdiction. Absent a legitimate and direct public purpose within CalOptima's authority and jurisdiction, CalOptima shall not use public funds to make monetary contributions to external entities solely for the purpose of goodwill, showing support, networking, public relations, or relationship building. External entities may not use CalOptima's Participation in any manner to donate, or endorse, political candidates to elected office, or to support/oppose a position on proposed legislation, ballot initiative, or proposition.

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D. CalOptima's Participation shall include at least one (1) of the following:

1. A speaking opportunity for a CalOptima representative;

2. A presentation, or panel presentation, by a CalOptima representative;

3. A booth, or table, designated for CalOptima at the event to distribute CalOptima information to members and/or potential members who could be enrolled in any of CalOptima's programs; or

4. Other opportunity to promote CalOptima's services and increase awareness about CalOptima.

E. There may be circumstances where financial Participation for external entities, such as charitable organizations, or activities (*e.g.*, United Way, etc.), may be permitted based on a finding by the CalOptima Board of Directors that the request for financial Participation falls within CalOptima's authority and purpose, and meets one (1) of the following criteria:

1. The financial Participation will be used by the external entity to provide a service that complements, or enhances, one that CalOptima provides; or

2. There is an identifiable benefit to CalOptima and/or its members.

F. The expenditure of CalOptima funds and the use of resources, staff time, and CalOptima facilities shall not be inconsistent with, or in conflict with, CalOptima's obligations under applicable state and federal laws and contracts.

G. Requests for Participation by CalOptima in an event proposed by an external entity shall require approval as follows:

1. Requests for Participation, other than financial contributions, such as hosting booths at health fairs, conducting education programs and presentations, or organizing community/town hall meetings:

a. Requests for non-financial Participation from external entities shall be submitted no less than fourteen (14) calendar days in advance of the date of the event.

b. The Chief Executive Officer (CEO~~),~~) or his/her designee~~,~~ is authorized to approve non-financial requests from external entities for community/member-oriented events that meet the eligibility requirements as provided in this Policy.

c. Non-financial Participation requests from external entities for community/member-oriented events such as health fairs, educational events, and/or community/town hall forums shall meet the standards set forth above in Sections II.A. through II.F. along with the following criteria:

i. Member interaction/enrollment – The activity shall include Participation from CalOptima members and/or potential members that could be enrolled in any of CalOptima's programs, or be in furtherance of CalOptima's mission, programs/lines of business, values, and/or purpose; and

ii. Inclusion of Details of the Event – Information about the organization and event, including name of the organization hosting the event, the name of the event itself, day/date, start and end time, location, event coordinator contact information, expected number of attendees, primary demographics of people served, purpose and outcome of ~~–~~the proposed event, and description of CalOptima's Participation in the event.

2. Requests for financial Participation, up to and including, a cumulative value of ~~one~~two thousand five hundred dollars ($~~1,000~~2,500) per organization per fiscal year, which shall include all materials and supplies:

   a. Requests for financial Participation in an amount up to and including ~~one~~two thousand five hundred dollars ($~~1,000~~2,500) per organization per fiscal year, inclusive of all materials and supplies, shall be submitted no less than twenty-one (21) calendar days in advance of the date of the event, or if in a shorter amount of time, at the discretion of the CEO, or his/her designee, so long as such request is submitted to the CEO, or his/her designee, in a reasonable and sufficient amount of time so that CalOptima can complete a meaningful review and evaluation of the request.

   b. The CEO~~,~~ or his/her designee~~,~~ is authorized to approve requests for financial Participation for qualifying external entities and events for a cumulative amount of up to and including ~~one~~two thousand five hundred dollars ($~~1,000~~2,500) per organization per fiscal year, subject to availability of budgeted funds.

   c. All requests for financial Participation to CalOptima from external entities shall meet the standards set forth above in Sections II.A. through II.F. along with the following criteria:

      i. Member interaction/enrollment – The activity shall include Participation from CalOptima members and/or potential members that could be enrolled in any of CalOptima's programs or be in furtherance of CalOptima's mission, programs/lines of business, values, and/or purpose; and

      ii. Inclusion of Details of the Event – Information about the organization and event, including the name of the organization hosting the event, the name of the event itself, day/date, start and end time, location, event coordinator contact information, expected number of attendees, primary demographics of people served, purpose and outcome of the proposed event, description of CalOptima's Participation in the event, and/or how CalOptima's financial Participation will be used, etc.

   d. The CEO~~,~~ or his/her designee~~,~~ is authorized to purchase and use in-kind contributions of items branded with CalOptima's logo for the purpose of outreach and promoting CalOptima's role and services in the community.

   e. The CEO~~,~~ or his/her designee~~,~~ will report all approved Participation in events involving financial Participation in an amount up to and including ~~one~~two thousand five hundred dollars ($~~1,000~~2,500) per organization per fiscal year to the CalOptima Board of Directors in the CEO's regular~~-~~ Board communications, including, but not limited to, the CEO's weekly updates and reports included in the next available regularly scheduled Board of Directors meeting.

3. Requests for financial Participation in amounts of more than ~~one~~two thousand five hundred dollars ($~~1,000~~2,500) per organization per fiscal year:

   a. Requests for financial Participation for the amount of more than ~~one~~two thousand five hundred dollars ($~~1,000~~2,500) per organization per fiscal year shall be submitted no less than sixty (60) calendar days in advance of the date of the event.

   b. Financial requests from qualified external entities for eligible events valued at more than ~~one~~two thousand five hundred dollars ($~~1,000~~2,500) require approval from the CalOptima Board of Directors and a finding that such financial Participation is in the public good, subject to availability of budgeted funds, and within CalOptima's authority and statutory purpose.

c. All requests for financial Participation to CalOptima from external entities shall meet the standards set forth above in Sections II.A. through II.F. along with the following criteria:

i. Member interaction/enrollment – The activity shall include Participation from CalOptima members and/or potential members that could be enrolled in any of CalOptima's program, or be in furtherance of CalOptima's mission, programs/lines of business, values, and/or purpose; and

ii. Inclusion of Details of the Event – Information about the organization and event, including name of the organization hosting the event, the name of the event itself, day/date, start and end time, location, event coordinator contact information, expected number of attendees, primary demographics of people served, purpose, and outcome of the proposed event, description of CalOptima's Participation in the event, and/or how CalOptima's financial Participation will be used, etc.

d. The CEO~~,~~ or his/her designee~~,~~ is authorized to purchase and use in-kind contributions of items branded with CalOptima's logo for the purpose of outreach and promoting CalOptima's role and services in the community.

e. The CEO~~,~~ or his/her designee~~,~~ will report all approved Participation in events involving financial Participation in amounts more than ~~one~~two thousand five hundred dollars ($~~1,000~~2,500) per organization per fiscal year to the CalOptima Board of Directors in the CEO's weekly updates and reports included in the next available regularly scheduled Board of Directors meeting.

4. In determining the value of CalOptima's Participation in events involving external entities, the following factors shall be considered:

a. The use of CalOptima staff time (*e.g.*, in their capacity as a CalOptima employee) to attend events such as health fairs, educational or community events;

b. The use of CalOptima resources (*e.g.*, CalOptima facilities);

c. The use of current, or future, CalOptima eligible funds; and

d. The value of items donated with the CalOptima master brand/logo.

H. In no event shall approval of CalOptima's Participation in an event, or with an external entity, constitute an Endorsement of the external entity hosting the event, nor shall such Participation constitute Endorsement of any particular message, or initiative, commercial product or service, and/or any message advocated by the external entity. Endorsements and use of CalOptima's name, or logo, in any material by an external entity shall be governed by CalOptima Policy AA.1214: Guidelines for Endorsements, for Letters of Support, and Use of CalOptima's Name and Logo.

I. The CEO~~,~~ or his/her designee~~,~~ shall report any Participation approved by the CEO to the CalOptima Board of Directors, in writing, at the next available regularly scheduled Board of Directors meeting after such approval.

J. The CEO~~,~~ or his/her designee~~,~~ shall provide members of the CalOptima Board of Directors with advanced notice so they have the opportunity to attend events in which CalOptima Participates.

K. Payment for actual and necessary expenses incurred in the course of performing services for CalOptima, including expenses incurred in the course of attending functions of external entities, shall be reimbursed, or paid~~, according to~~ in accordance with CalOptima Policy GA.5004: Travel Policy, to the extent there is a clear nexus between the attendance of the employee at such a function and the performance of the service for which such employees is regularly employed. In no event shall CalOptima pay~~,~~ or reimburse~~,~~ a CalOptima employee for expenses arising from personal expenses, political campaigns~~,~~ or activities, charitable contributions, or events (including fundraisers, galas, dinners, unless expressly approved by the Board of Directors), family expenses, entertainment expenses, or religious activities.

L. In the event CalOptima's Participation in an event involving an external entity involves any Marketing Activities, such Marketing Activities shall be consistent with all applicable legal and contractual requirements, as well as all internal policies, including, but not limited to, CalOptima ~~Policy~~Policies MA.2002: Marketing Activity Standards and PA.2010: Enrollment and Intake.

III. PROCEDURE

A. All requests for Participation shall be submitted within the timeframe specified above, and include the following information, as appropriate:

1. Description of the external entity requesting Participation, including, but not limited to: whether the external entity is a non-profit organization, religious organization, for-profit organization, or other health care partner (including valid by-laws filed with the Secretary of State of the State of California); how long the external entity has been operating; where the external entity's principle office and base of operations is located; external entity's service area, etc.;

2. Description of the event such as name of the event, day/date, start and end time, location, event coordinator contact information, expected number of attendees, primary language of attendees, primary demographics of people served, purpose, and outcome of the proposed event;

3. The purpose of the event, including, but not limited to, a copy of any event materials, or description of the program or project;

4. Description of relationship between external entity's work, or event, and CalOptima's programs/lines of business, mission, values, and/or purpose;

5. Description, background, and pertinent information (*e.g.*, names of members of the Board of Directors) regarding the requesting entity and any other entity having a substantial role in the event;

6. A list of other individuals, or entities, supporting the event;

7. Event budget information; and

8. Purpose, role, and anticipated time commitment for CalOptima's involvement in the event, if applicable.

B. Upon receipt of a complete request for Participation, CalOptima's Community Relations Department shall:

1. Review and analyze the request to ensure each criteria is met;

2. Complete the Event Participation Request Form and place the completed form and all supporting documentation in a folder within five (5) business days of the date of receipt of completed request;

3. Submit the request to the CEO, his/her designee, or to the Board of Directors, where applicable, for consideration. If the request is denied, the requestor shall be so notified.

C. Upon receipt of the approved request for Participation from the CEO, his/her designee, or the Board of Directors, CalOptima's Community Relations Department shall:

1. Notify the requesting entity of CalOptima's determination; and

2. Process the financial request and any necessary documents within three (3) business days of the determination date.

3. Any payments for approved financial requests shall be issued only through checks paid directly to the external entity, and no cash disbursements will be made for events covered by this Policy.

D. Requests for In-Kind Contributions of Items Branded with the CalOptima Logo:

1. Requests shall be submitted to CalOptima's Community Relations Department, in writing, at least thirty (30) calendar days in advance of the date for which an entity wishes to distribute items branded with the CalOptima master logo.

2. Upon receipt of a complete request to distribute items branded with the CalOptima master logo, CalOptima's Community Relations Department shall review and analyze the request with input from appropriate internal departments within five (5) business days.

3. The Community Relations Department shall submit a request to the Chief Executive Officer (CEO~~),~~) or his/her designee~~,~~ for approval of a donation of items valued at five dollars ($5~~),~~) or less, and up to and including a cumulative total of five hundred dollars ($500) worth of goods. Requests to distribute items that exceed a cumulative total of five hundred dollars ($500) shall require the prior approval of the CalOptima Board of Directors.

5. The Community Relations Department shall notify the requesting entity, in writing, after CalOptima's determination is made.

6. The Community Relations Department shall process an approved request to distribute items branded with the CalOptima master logo within three (3) business days of approval.

7. The requesting entity shall agree to return any items that it does not distribute at the conclusion of the event for which the item was used.

IV. ATTACHMENT(S)

A. CalOptima Public Activity Participation Request Form
B. CalOptima Public Activity Transmittal Form

V. REFERENCE(S)

A. California Constitution Article 16, §6
B. California Government Code, §8314
C. CalOptima Policy AA.1214: Guidelines for Endorsements by CalOptima, for Letters of Support, and Use of CalOptima Name or Logo
D. CalOptima Policy GA.5004: Travel Policy

E. CalOptima Policy MA.2002: Marketing Activity Standards
F. CalOptima Policy PA.2010: Enrollment and Intake

VI. REGULATORY AGENCY APPROVAL

None to Date

VII. BOARD ACTION(S)

Date	Meeting
02/02/2017	Regular Meeting of the CalOptima Board of Directors
10/01/2020	Regular Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program
Effective	02/02/2017	AA.1223	Participation in Community Events by External Entities	Administrative
Revised	11/01/2018	AA.1223	Participation in Community Events by External Entities	Administrative
Revised	02/01/2020	AA.1223	Participation in Community Events by External Entities	Administrative
Revised	10/01/2020	AA.1223	Participation in Community Events by External Entities	Administrative
Revised	TBD	AA.1223	Participation in Community Events by External Entities	Administrative

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IX. GLOSSARY

Term	Definition
Endorsement	~~The~~For purposes of this policy, the support or promotion of a project, event, document, program, or initiative conducted by an external entity for the benefit of that entity, and for which support or promotion CalOptima does not receive a comparable benefit. ~~-~~Endorsement does not include any sponsored educational activity, purchased service, presentation, attendance at an event, activity that is included in the definition of Marketing Activities, or joint development of an event, seminar, symposium, educational program, public information campaign, or similar event.
Marketing Activities	~~Any~~For purposes of this policy, any activity conducted by or on behalf of CalOptima where information regarding the services offered by CalOptima is disseminated in order to persuade or influence eligible beneficiaries to enroll or to educate members and promote optimal program use and Participation. Marketing also includes any similar activity to secure the Endorsement of any individual or organization on behalf of CalOptima.
Participate/ Participation	For purposes of this policy, this is the provision of financial assistance or in-kind contribution of goods, supplies, materials, facilities, staff time, and/or services by CalOptima to an external entity in support of one or more events, programs, projects, and/or activities (collectively, "events") in furtherance of CalOptima's mission, programs/lines of business, values, and/or purpose.

Policy:	AA.1223
Title:	**Participation in Community Events by External Entities**
Department:	CalOptima Administrative
Section:	Strategic Development, Community Relations
CEO Approval:	*/s/*
Effective Date:	02/02/2017
Revised Date:	TBD

Applicable to:
- ☐ Medi-Cal
- ☐ OneCare
- ☐ OneCare Connect
- ☐ PACE
- ☒ Administrative

I. PURPOSE

This policy establishes guidelines for CalOptima's Participation in community events, programs, projects, and activities involving external entities.

II. POLICY

A. CalOptima recognizes the value of partnering with external entities to provide additional health care related services of benefit to the local community, while still upholding its fiscal responsibilities as a steward of public funds. Requests for CalOptima's Participation in community events involving external entities, financially, or otherwise, shall be approved only if:

1. Compatible with CalOptima's mission to provide members with access to quality health care services delivered in a cost-effective and compassionate manner;

2. Consistent with CalOptima's specific statutory purpose to arrange for the provision of health care services to qualifying individuals who lack sufficient annual income to meet the cost of healthcare; and

3. In accordance with this Policy.

B. An external entity may be eligible for CalOptima's Participation in its event if the entity is a community-based, non-profit organization, health care partner, public or government entity (collectively, "external entities") that serves CalOptima members or supports CalOptima's mission. Religious organizations are not eligible for CalOptima's Participation unless the event is open to the general public and is for a non-sectarian purpose.

C. The expenditure of CalOptima's funds shall only be made for a direct and primary public purpose within CalOptima's authority and jurisdiction. Absent a legitimate and direct public purpose within CalOptima's authority and jurisdiction, CalOptima shall not use public funds to make monetary contributions to external entities solely for the purpose of goodwill, showing support, networking, public relations, or relationship building. External entities may not use CalOptima's Participation in any manner to donate, or endorse, political candidates to elected office, or to support/oppose a position on proposed legislation, ballot initiative, or proposition.

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D. CalOptima's Participation shall include at least one (1) of the following:

1. A speaking opportunity for a CalOptima representative;

2. A presentation, or panel presentation, by a CalOptima representative;

3. A booth, or table, designated for CalOptima at the event to distribute CalOptima information to members and/or potential members who could be enrolled in any of CalOptima's programs; or

4. Other opportunity to promote CalOptima's services and increase awareness about CalOptima.

E. There may be circumstances where financial Participation for external entities, such as charitable organizations, or activities (*e.g.*, United Way, etc.), may be permitted based on a finding by the CalOptima Board of Directors that the request for financial Participation falls within CalOptima's authority and purpose, and meets one (1) of the following criteria:

1. The financial Participation will be used by the external entity to provide a service that complements, or enhances, one that CalOptima provides; or

2. There is an identifiable benefit to CalOptima and/or its members.

F. The expenditure of CalOptima funds and the use of resources, staff time, and CalOptima facilities shall not be inconsistent with, or in conflict with, CalOptima's obligations under applicable state and federal laws and contracts.

G. Requests for Participation by CalOptima in an event proposed by an external entity shall require approval as follows:

1. Requests for Participation, other than financial contributions, such as hosting booths at health fairs, conducting education programs and presentations, or organizing community/town hall meetings:

a. Requests for non-financial Participation from external entities shall be submitted no less than fourteen (14) calendar days in advance of the date of the event.

b. The Chief Executive Officer (CEO) or his/her designee is authorized to approve non-financial requests from external entities for community/member-oriented events that meet the eligibility requirements as provided in this Policy.

c. Non-financial Participation requests from external entities for community/member-oriented events such as health fairs, educational events, and/or community/town hall forums shall meet the standards set forth above in Sections II.A. through II.F. along with the following criteria:

i. Member interaction/enrollment – The activity shall include Participation from CalOptima members and/or potential members that could be enrolled in any of CalOptima's programs, or be in furtherance of CalOptima's mission, programs/lines of business, values, and/or purpose; and

ii. Inclusion of Details of the Event – Information about the organization and event, including name of the organization hosting the event, the name of the event itself, day/date, start and end time, location, event coordinator contact information, expected number of attendees, primary demographics of people served, purpose and outcome of the proposed event, and description of CalOptima's Participation in the event.

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2. Requests for financial Participation, up to and including, a cumulative value of two thousand five hundred dollars ($2,500) per organization per fiscal year, which shall include all materials and supplies:

   a. Requests for financial Participation in an amount up to and including two thousand five hundred dollars ($2,500) per organization per fiscal year, inclusive of all materials and supplies, shall be submitted no less than twenty-one (21) calendar days in advance of the date of the event, or if in a shorter amount of time, at the discretion of the CEO, or his/her designee, so long as such request is submitted to the CEO, or his/her designee, in a reasonable and sufficient amount of time so that CalOptima can complete a meaningful review and evaluation of the request.

   b. The CEO or his/her designee is authorized to approve requests for financial Participation for qualifying external entities and events for a cumulative amount of up to and including two thousand five hundred dollars ($2,500) per organization per fiscal year, subject to availability of budgeted funds.

   c. All requests for financial Participation to CalOptima from external entities shall meet the standards set forth above in Sections II.A. through II.F. along with the following criteria:

      i. Member interaction/enrollment – The activity shall include Participation from CalOptima members and/or potential members that could be enrolled in any of CalOptima's programs or be in furtherance of CalOptima's mission, programs/lines of business, values, and/or purpose; and

      ii. Inclusion of Details of the Event – Information about the organization and event, including the name of the organization hosting the event, the name of the event itself, day/date, start and end time, location, event coordinator contact information, expected number of attendees, primary demographics of people served, purpose and outcome of the proposed event, description of CalOptima's Participation in the event, and/or how CalOptima's financial Participation will be used, etc.

   d. The CEO or his/her designee is authorized to purchase and use in-kind contributions of items branded with CalOptima's logo for the purpose of outreach and promoting CalOptima's role and services in the community.

   e. The CEO or his/her designee will report all approved Participation in events involving financial Participation in an amount up to and including two thousand five hundred dollars ($2,500) per organization per fiscal year to the CalOptima Board of Directors in the CEO's regular Board communications, including, but not limited to, the CEO's weekly updates and reports included in the next available regularly scheduled Board of Directors meeting.

3. Requests for financial Participation in amounts of more than two thousand five hundred dollars ($2,500) per organization per fiscal year:

   a. Requests for financial Participation for the amount of more than two thousand five hundred dollars ($2,500) per organization per fiscal year shall be submitted no less than sixty (60) calendar days in advance of the date of the event.

   b. Financial requests from qualified external entities for eligible events valued at more than two thousand five hundred dollars ($2,500) require approval from the CalOptima Board of Directors and a finding that such financial Participation is in the public good, subject to availability of budgeted funds, and within CalOptima's authority and statutory purpose.

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c. All requests for financial Participation to CalOptima from external entities shall meet the standards set forth above in Sections II.A. through II.F. along with the following criteria:

i. Member interaction/enrollment – The activity shall include Participation from CalOptima members and/or potential members that could be enrolled in any of CalOptima's program, or be in furtherance of CalOptima's mission, programs/lines of business, values, and/or purpose; and

ii. Inclusion of Details of the Event – Information about the organization and event, including name of the organization hosting the event, the name of the event itself, day/date, start and end time, location, event coordinator contact information, expected number of attendees, primary demographics of people served, purpose, and outcome of the proposed event, description of CalOptima's Participation in the event, and/or how CalOptima's financial Participation will be used, etc.

d. The CEO or his/her designee is authorized to purchase and use in-kind contributions of items branded with CalOptima's logo for the purpose of outreach and promoting CalOptima's role and services in the community.

e. The CEO or his/her designee will report all approved Participation in events involving financial Participation in amounts more than two thousand five hundred dollars ($2,500) per organization per fiscal year to the CalOptima Board of Directors in the CEO's weekly updates and reports included in the next available regularly scheduled Board of Directors meeting.

4. In determining the value of CalOptima's Participation in events involving external entities, the following factors shall be considered:

a. The use of CalOptima staff time (*e.g.*, in their capacity as a CalOptima employee) to attend events such as health fairs, educational or community events;

b. The use of CalOptima resources (*e.g.*, CalOptima facilities);

c. The use of current, or future, CalOptima eligible funds; and

d. The value of items donated with the CalOptima master brand/logo.

H. In no event shall approval of CalOptima's Participation in an event, or with an external entity, constitute an Endorsement of the external entity hosting the event, nor shall such Participation constitute Endorsement of any particular message, or initiative, commercial product or service, and/or any message advocated by the external entity. Endorsements and use of CalOptima's name, or logo, in any material by an external entity shall be governed by CalOptima Policy AA.1214: Guidelines for Endorsements, for Letters of Support, and Use of CalOptima's Name and Logo.

I. The CEO or his/her designee shall report any Participation approved by the CEO to the CalOptima Board of Directors, in writing, at the next available regularly scheduled Board of Directors meeting after such approval.

J. The CEO or his/her designee shall provide members of the CalOptima Board of Directors with advanced notice so they have the opportunity to attend events in which CalOptima Participates.

K. Payment for actual and necessary expenses incurred in the course of performing services for CalOptima, including expenses incurred in the course of attending functions of external entities, shall be reimbursed, or paid in accordance with CalOptima Policy GA.5004: Travel Policy, to the extent there is a clear nexus between the attendance of the employee at such a function and the performance of the service for which such employees is regularly employed. In no event shall CalOptima pay or reimburse a CalOptima employee for expenses arising from personal expenses, political campaigns or activities, charitable contributions, or events (including fundraisers, galas, dinners, unless expressly approved by the Board of Directors), family expenses, entertainment expenses, or religious activities.

L. In the event CalOptima's Participation in an event involving an external entity involves any Marketing Activities, such Marketing Activities shall be consistent with all applicable legal and contractual requirements, as well as all internal policies, including, but not limited to, CalOptima Policies MA.2002: Marketing Activity Standards and PA.2010: Enrollment and Intake.

III. PROCEDURE

A. All requests for Participation shall be submitted within the timeframe specified above, and include the following information, as appropriate:

1. Description of the external entity requesting Participation, including, but not limited to: whether the external entity is a non-profit organization, religious organization, for-profit organization, or other health care partner (including valid by-laws filed with the Secretary of State of the State of California); how long the external entity has been operating; where the external entity's principle office and base of operations is located; external entity's service area, etc.;

2. Description of the event such as name of the event, day/date, start and end time, location, event coordinator contact information, expected number of attendees, primary language of attendees, primary demographics of people served, purpose, and outcome of the proposed event;

3. The purpose of the event, including, but not limited to, a copy of any event materials, or description of the program or project;

4. Description of relationship between external entity's work, or event, and CalOptima's programs/lines of business, mission, values, and/or purpose;

5. Description, background, and pertinent information (*e.g.*, names of members of the Board of Directors) regarding the requesting entity and any other entity having a substantial role in the event;

6. A list of other individuals, or entities, supporting the event;

7. Event budget information; and

8. Purpose, role, and anticipated time commitment for CalOptima's involvement in the event, if applicable.

B. Upon receipt of a complete request for Participation, CalOptima's Community Relations Department shall:

1. Review and analyze the request to ensure each criteria is met;

2. Complete the Event Participation Request Form and place the completed form and all supporting documentation in a folder within five (5) business days of the date of receipt of completed request;

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3. Submit the request to the CEO, his/her designee, or to the Board of Directors, where applicable, for consideration. If the request is denied, the requestor shall be so notified.

C. Upon receipt of the approved request for Participation from the CEO, his/her designee, or the Board of Directors, CalOptima's Community Relations Department shall:

1. Notify the requesting entity of CalOptima's determination; and

2. Process the financial request and any necessary documents within three (3) business days of the determination date.

3. Any payments for approved financial requests shall be issued only through checks paid directly to the external entity, and no cash disbursements will be made for events covered by this Policy.

D. Requests for In-Kind Contributions of Items Branded with the CalOptima Logo:

1. Requests shall be submitted to CalOptima's Community Relations Department, in writing, at least thirty (30) calendar days in advance of the date for which an entity wishes to distribute items branded with the CalOptima master logo.

2. Upon receipt of a complete request to distribute items branded with the CalOptima master logo, CalOptima's Community Relations Department shall review and analyze the request with input from appropriate internal departments within five (5) business days.

3. The Community Relations Department shall submit a request to the Chief Executive Officer (CEO) or his/her designee for approval of a donation of items valued at five dollars ($5) or less, and up to and including a cumulative total of five hundred dollars ($500) worth of goods. Requests to distribute items that exceed a cumulative total of five hundred dollars ($500) shall require the prior approval of the CalOptima Board of Directors.

5. The Community Relations Department shall notify the requesting entity, in writing, after CalOptima's determination is made.

6. The Community Relations Department shall process an approved request to distribute items branded with the CalOptima master logo within three (3) business days of approval.

7. The requesting entity shall agree to return any items that it does not distribute at the conclusion of the event for which the item was used.

IV. ATTACHMENT(S)

A. CalOptima Public Activity Participation Request Form
B. CalOptima Public Activity Transmittal Form

V. REFERENCE(S)

A. California Constitution Article 16, §6
B. California Government Code, §8314
C. CalOptima Policy AA.1214: Guidelines for Endorsements by CalOptima, for Letters of Support, and Use of CalOptima Name or Logo
D. CalOptima Policy GA.5004: Travel Policy

E. CalOptima Policy MA.2002: Marketing Activity Standards
F. CalOptima Policy PA.2010: Enrollment and Intake

VI. REGULATORY AGENCY APPROVAL

None to Date

VII. BOARD ACTION(S)

Date	Meeting
02/02/2017	Regular Meeting of the CalOptima Board of Directors
10/01/2020	Regular Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program
Effective	02/02/2017	AA.1223	Participation in Community Events by External Entities	Administrative
Revised	11/01/2018	AA.1223	Participation in Community Events by External Entities	Administrative
Revised	02/01/2020	AA.1223	Participation in Community Events by External Entities	Administrative
Revised	10/01/2020	AA.1223	Participation in Community Events by External Entities	Administrative
Revised	TBD	AA.1223	Participation in Community Events by External Entities	Administrative

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IX. GLOSSARY

Term	Definition
Endorsement	For purposes of this policy, the support or promotion of a project, event, document, program, or initiative conducted by an external entity for the benefit of that entity, and for which support or promotion CalOptima does not receive a comparable benefit. Endorsement does not include any sponsored educational activity, purchased service, presentation, attendance at an event, activity that is included in the definition of Marketing Activities, or joint development of an event, seminar, symposium, educational program, public information campaign, or similar event.
Marketing Activities	For purposes of this policy, any activity conducted by or on behalf of CalOptima where information regarding the services offered by CalOptima is disseminated in order to persuade or influence eligible beneficiaries to enroll or to educate members and promote optimal program use and Participation. Marketing also includes any similar activity to secure the Endorsement of any individual or organization on behalf of CalOptima.
Participate/ Participation	For purposes of this policy, this is the provision of financial assistance or in-kind contribution of goods, supplies, materials, facilities, staff time, and/or services by CalOptima to an external entity in support of one or more events, programs, projects, and/or activities (collectively, "events") in furtherance of CalOptima's mission, programs/lines of business, values, and/or purpose.

Public Activity Participation Request Form

Requesting Entity:	
Requesting Entity's Principal Office/ Base Operations Location:	
How long Requesting Entity has been operating:	
Requesting Entity's service areas:	
Description of relationship between Requesting Entity's work/event and CalOptima's lines of business, mission, values, and/or purpose:	
Description, background and pertinent information (eg. Members of Board of Directors) and other entities with a substantial role in event:	
List of individuals or entities supporting the event:	
Entity Type:	Non-Profit Org ___ For-Profit Org ___ Religious Org ___ Health Care Partner

Section I: Event Details			
Name:			
Day/Date:			
Start Time:		**End Time:**	
Location:			
City:		**Zip Code:**	
POC Name:			
Phone#:		**Fax #:**	
Email:			
Type of Event	___ 1 Opportunity to outreach to members or potential members		
	___ 2 Opportunity to outreach to health care professionals, non-profit orgs or policy-makers		
	___ 3 Other:		
Expected # of Attendees:			

Public Activity Participation Request Form

Section II: About the Attendees (check all that apply)				
Primary Language Spoken:	☐ English	☐ Spanish	☐ Vietnamese	☐ Other:

Event for:	☐ Children	☐ Persons with disabilities
	☐ Low-income families	☐ General public
	☐ Low-income older adults/seniors	☐ Other:

Event for CalOptima LOB:	☐ OC/OCC	☐ PACE	☐ Medi-Cal

Section III: Cost to CalOptima to Participate		
Registration Fee:	☐ No	☐ Yes, amount:
Sponsorship Request:	☐ No	☐ Yes, amount:

Section IV: Notes/Comments

Section V: Disclosures

Requests must be submitted to the Community Relations Department: Staff Participation (14) days in advance; Financial Participation at or under $2,500~~1,000~~ (21) days in advance; Financial Participation more than $2,500~~1,000~~ (60) days in advance.

*****All event materials/information must be attached*****

Public Activity Participation Request Form

Requesting Entity:	
Requesting Entity's Principal Office/ Base Operations Location:	
How long Requesting Entity has been operating:	
Requesting Entity's service areas:	
Description of relationship between Requesting Entity's work/event and CalOptima's lines of business, mission, values, and/or purpose:	
Description, background and pertinent information (eg. Members of Board of Directors) and other entities with a substantial role in event:	
List of individuals or entities supporting the event:	
Entity Type:	Non-Profit Org ___ For-Profit Org ___ Religious Org ___ Health Care Partner

Section I: Event Details			
Name:			
Day/Date:			
Start Time:		**End Time:**	
Location:			
City:		**Zip Code:**	
POC Name:			
Phone#:		**Fax #:**	
Email:			
Type of Event	___ 1 Opportunity to outreach to members or potential members		
	___ 2 Opportunity to outreach to health care professionals, non-profit orgs or policy-makers		
	___ 3 Other:		
Expected # of Attendees:			

Public Activity Participation Request Form

Section II: About the Attendees (check all that apply)				
Primary Language Spoken:	☐ English	☐ Spanish	☐ Vietnamese	☐ Other:

Event for:	☐ Children	☐ Persons with disabilities	
	☐ Low-income families	☐ General public	
	☐ Low-income older adults/seniors	☐ Other:	
Event for CalOptima LOB:	☐ OC/OCC	☐ PACE	☐ Medi-Cal

Section III: Cost to CalOptima to Participate		
Registration Fee:	☐ No	☐ Yes, amount:
Sponsorship Request:	☐ No	☐ Yes, amount:

Section IV: Notes/Comments

Section V: Disclosures

Requests must be submitted to the Community Relations Department: Staff Participation (14) days in advance; Financial Participation at or under $2,500 (21) days in advance; Financial Participation more than $2,500 (60) days in advance.

*****All event materials/information must be attached*****

Public Activity Transmittal Form

Please complete your portion of this form and route it in the order indicated below. Please contact Lisa Nguyen at ext. 8809 if you have any questions.

Today's Date:_____ Complete Routing By: _____

Routing Order			
1. Department POC:		**Complete Review By:**	
2. Department POC:		**Complete Review By:**	
3. Department POC:		**Complete Review By:**	

For CR Use Only: CR Initial Review

Requests for CalOptima's Participation in community events involving external entities must be:

1. Compatible with CalOptima's mission to provide members with access to quality health care services delivered in a cost-effective and compassionate manner.	☐ Yes	☐ No
2. Consistent with CalOptima's specific statutory purpose to arrange for the provision of health care services to qualifying individuals who lack sufficient annual income to meet the cost of health care; and	☐ Yes	☐ No
3. In accordance with Policy AA.1223: Participation in Community Events Involving External Entities	☐ Yes	☐ No

CalOptima's Participation shall include at least one (1) of the following:

1. A speaking opportunity for a CalOptima representative	☐ Yes	☐ No
2. A presentation, or panel presentation, by a CalOptima representative	☐ Yes	☐ No
3. A booth, or table, designated for CalOptima at the event to distribute CalOptima information to members/potential members	☐ Yes	☐ No
4. Other opportunity to promote CalOptima's services and increase awareness about CalOptima	☐ Yes	☐ No

Financial Participation must meet one (1) of the following criteria, if applicable:

1. The financial participation will be used by the external entity to provide a service that complements, or enhances, one that CalOptima provides	☐ Yes	☐ No
2. There is an identifiable benefit to CalOptima and/or its members	☐ Yes	☐ No

Board of Directors Approval Required if an Entity Exceeds the $2,5001,000 per Fiscal Year Limit:

1. Is the requesting entity acting as the fiscal agent?	☐ Yes	☐ No
2. Has CalOptima provided prior financial sponsorship to the requesting entity within the current fiscal year?	☐ Yes	☐ No
3. Does the cumulative total for this FY exceed the $2,5001,000 limit per entity, which requires Board approval?	☐ Yes	☐ No
4. If yes, then date of Board of Directors approval:		

Other considerations:

Public Activity Transmittal Form

Process as an Endorsement (i.e. policy AA.1214)	☐ Yes	☐ No
Event affiliated with a member of the Board, MAC, PAC, or Employee	☐ Yes	☐ No
Request Legal Review (i.e. conflict analysis)	☐ Yes	☐ No
Included in budget	☐ Yes, amount	☐ No
CalOptima participated in the past	☐ Yes, year(s)	☐ No

Notes:

CR Participation Commitment:	**YES**	**NO**	**NA**
Assume "Lead Department" role	☐ Staff:	☐	☐
Assume "Support Department" role	☐ Staff:	☐	☐
Provide financial support (i.e. registration fee, sponsorship, etc.)	☐ Amount:	☐	☐
Provide promotional items	☐	☐	☐
Provide brochures/educational materials	☐	☐	☐
Other:	☐ Specify:	☐	☐

Note:

Signature Required Only for Sponsorships, Endorsements and Registration Fees.

Date:

Tiffany Kaaiakamanu, Manager of Community Relations

***CalOptima's CEO has delegated authority to approve requests for financial participation in an amount up to and including $2,5001,000 if it is determined that CalOptima's participation is of public purpose.**

Public Activity Transmittal Form

Please complete your portion of this form and route it in the order indicated below. Please contact Lisa Nguyen at ext. 8809 if you have any questions.

Today's Date:_____ Complete Routing By: _____

Routing Order			
1. Department POC:		**Complete Review By:**	
2. Department POC:		**Complete Review By:**	
3. Department POC:		**Complete Review By:**	

For CR Use Only: CR Initial Review

Requests for CalOptima's Participation in community events involving external entities must be:

1. Compatible with CalOptima's mission to provide members with access to quality health care services delivered in a cost-effective and compassionate manner.	☐ Yes	☐ No
2. Consistent with CalOptima's specific statutory purpose to arrange for the provision of health care services to qualifying individuals who lack sufficient annual income to meet the cost of health care; and	☐ Yes	☐ No
3. In accordance with Policy AA.1223: Participation in Community Events Involving External Entities	☐ Yes	☐ No

CalOptima's Participation shall include at least one (1) of the following:

1. A speaking opportunity for a CalOptima representative	☐ Yes	☐ No
2. A presentation, or panel presentation, by a CalOptima representative	☐ Yes	☐ No
3. A booth, or table, designated for CalOptima at the event to distribute CalOptima information to members/potential members	☐ Yes	☐ No
4. Other opportunity to promote CalOptima's services and increase awareness about CalOptima	☐ Yes	☐ No

Financial Participation must meet one (1) of the following criteria, if applicable:

1. The financial participation will be used by the external entity to provide a service that complements, or enhances, one that CalOptima provides	☐ Yes	☐ No
2. There is an identifiable benefit to CalOptima and/or its members	☐ Yes	☐ No

Board of Directors Approval Required if an Entity Exceeds the $2,500 per Fiscal Year Limit:

1. Is the requesting entity acting as the fiscal agent?	☐ Yes	☐ No
2. Has CalOptima provided prior financial sponsorship to the requesting entity within the current fiscal year?	☐ Yes	☐ No
3. Does the cumulative total for this FY exceed the $2,500 limit per entity, which requires Board approval?	☐ Yes	☐ No
4. If yes, then date of Board of Directors approval:		

Other considerations:

Public Activity Transmittal Form

Process as an Endorsement (i.e. policy AA.1214)	☐ Yes	☐ No
Event affiliated with a member of the Board, MAC, PAC, or Employee	☐ Yes	☐ No
Request Legal Review (i.e. conflict analysis)	☐ Yes	☐ No
Included in budget	☐ Yes, amount	☐ No
CalOptima participated in the past	☐ Yes, year(s)	☐ No

Notes:

CR Participation Commitment:	**YES**	**NO**	**NA**
Assume "Lead Department" role	☐ Staff:	☐	☐
Assume "Support Department" role	☐ Staff:	☐	☐
Provide financial support (i.e. registration fee, sponsorship, etc.)	☐ Amount:	☐	☐
Provide promotional items	☐	☐	☐
Provide brochures/educational materials	☐	☐	☐
Other:	☐ Specify:	☐	☐

Note:

Signature Required Only for Sponsorships, Endorsements and Registration Fees.

Date:

Tiffany Kaaiakamanu, Manager of Community Relations

***CalOptima's CEO has delegated authority to approve requests for financial participation in an amount up to and including $2,500 if it is determined that CalOptima's participation is of public purpose.**

Policy:	AA.1223
Title:	**Participation in Community Events by External Entities**
Department:	CalOptima Health Administrative
Section:	Strategic Development, Community Relations
CEO Approval:	
Effective Date:	02/02/2017
Revised Date:	
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy establishes guidelines for ~~CalOptima's~~CalOptima Health's Participation in community events, programs, projects, and activities involving external entities.

II. POLICY

A. CalOptima Health recognizes the value of partnering with external entities to provide additional health care related services ~~of~~ to benefit ~~to~~ the local community, while still upholding its fiscal responsibilities as a steward of public funds. Requests for ~~CalOptima's~~CalOptima Health's Participation in community events involving external entities, financially, or otherwise, shall be approved only if~~:~~ aligned with CalOptima Health's mission, vision and values.

~~1. Compatible with CalOptima's~~CalOptima Health's ~~mission to provide members with access to quality health care services delivered in a cost-effective and compassionate manner;~~

~~2. Consistent with CalOptima's~~CalOptima Health's ~~specific statutory purpose to arrange for the provision of health care services to qualifying individuals who lack sufficient annual income to meet the cost of healthcare; and~~

~~3. In accordance with this Policy.~~

B. An external entity may be eligible for ~~CalOptima's~~CalOptima Health's Participation in its event if the entity is a community-based, non-profit organization, health care partner, public or government entity (collectively, "external entities") that serves CalOptima Health members or supports ~~CalOptima's~~CalOptima Health's mission, vision and values. Religious organizations are not eligible for ~~CalOptima's~~CalOptima Health's Participation unless the event is open to the general public and is for a non-sectarian purpose.

C. The expenditure of ~~CalOptima's~~CalOptima Health's funds shall only be made for a direct and primary public purpose within ~~CalOptima's~~CalOptima Health's authority and jurisdiction. Absent a legitimate and direct public purpose within ~~CalOptima's~~CalOptima Health's authority and jurisdiction, CalOptima Health shall not use public funds to make monetary contributions to external entities solely for the purpose of goodwill, showing support, networking, public relations, or relationship building. External entities may not

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use ~~CalOptima's~~CalOptima Health's Participation in any manner to donate, or endorse, political candidates to elected office, or to support/oppose a position on proposed legislation, ballot initiative, or proposition.

D. CalOptima Health's Participation shall include at least one (1) of the following:

1. A speaking opportunity for a CalOptima Health representative;

2. A presentation, or panel presentation, by a CalOptima Health representative;

3. A booth, or table, designated for CalOptima Health at the event to distribute CalOptima Health information to members and/or potential members who could be enrolled in any of ~~CalOptima's~~CalOptima Health's programs; or

4. Other opportunity to promote ~~CalOptima's~~CalOptima Health's services and increase awareness about CalOptima.

E. There may be circumstances where financial Participation for external entities, such as charitable organizations, or activities (*e.g.*, United Way, etc.), may be permitted based on a finding by the CalOptima Health Board of Directors that the request for financial Participation falls within ~~CalOptima's~~CalOptima Health's authority and purpose, and meets one (1) of the following criteria:

1. The financial Participation will be used by the external entity to provide a service that complements, or enhances, one that CalOptima Health provides; or

2. There is an identifiable benefit to CalOptima Health and/or its members.

F. The expenditure of CalOptima Health funds and the use of resources, staff time, and CalOptima Health facilities shall not be inconsistent with, or in conflict with, ~~CalOptima's~~CalOptima Health's obligations under applicable state and federal laws and contracts.

G. Requests for Participation by CalOptima Health in an event proposed by an external entity shall require approval as follows:

1. Requests for Participation, other than financial contributions, such as hosting booths at health fairs, conducting education programs and presentations, or organizing community/town hall meetings:

a. Requests for non-financial Participation from external entities shall be submitted no less than fourteen (14) calendar days in advance of the date of the event.

b. The Chief Executive Officer (CEO) or his/her designee is authorized to approve non-financial requests from external entities for community/member-oriented events that meet the eligibility requirements as provided in this Policy.

c. Non-financial Participation requests from external entities for community/member-oriented events such as health fairs, educational events, and/or community/town hall forums shall meet the standards set forth above in Sections II.A. through II.F. along with the following criteria:

i. Member interaction/enrollment – The activity shall include Participation from CalOptima Health members and/or potential members that could be enrolled in any of ~~CalOptima's~~CalOptima Health's programs, or be in furtherance of ~~CalOptima's~~CalOptima Health's mission, vision & values, programs~~/lines of business~~, ~~values,~~ and/or purpose; and

ii. Inclusion of Details of the Event – Information about the organization and event, including

name of the organization hosting the event, the name of the event itself, day/date, start and end time, location, event coordinator contact information, expected number of attendees, primary demographics of people served, purpose and outcome of the proposed event, and description of ~~CalOptima's~~CalOptima Health's Participation in the event.

2. Requests for financial Participation, up to and including, a cumulative value of ~~two~~ten thousand ~~five hundred~~ dollars ($~~2,500~~10,000) per organization per fiscal year, which shall include all materials and supplies:

   a. Requests for financial Participation in an amount up to and including ~~two~~ten thousand ~~five hundred~~ dollars ($~~2,500~~10,000) per organization per fiscal year, inclusive of all materials and supplies, shall be submitted no less than twenty-one (21) calendar days in advance of the date of the event, or if in a shorter amount of time, at the discretion of the CEO, or his/her designee, so long as such request is submitted to the CEO, or his/her designee, in a reasonable and sufficient amount of time so that CalOptima Health can ~~-~~complete a meaningful review and evaluation of the request.

   b. The CEO or his/her designee is authorized to approve requests for financial Participation for qualifying external entities and events for a cumulative amount of up to and including ~~-~~ ~~two~~ten thousand ~~five hundred~~ dollars ($~~2,500~~10,000) per organization per fiscal year, subject to availability of budgeted funds.

   c. All requests for financial Participation to CalOptima Health from external entities shall meet the standards set forth above in Sections II.A. through II.F. along with the following criteria:

      i. Member interaction/enrollment – The activity shall include Participation from CalOptima Health members and/or potential members that could be enrolled in any of ~~CalOptima's~~CalOptima Health's programs or be in furtherance of ~~CalOptima's~~CalOptima Health's mission, vision & values, programs, and/or purpose~~programs/lines of business, values, and/or purpose~~; and

      ii. Inclusion of Details of the Event – Information about the organization and event, including the name of the organization hosting the event, the name of the event itself, day/date, start and end time, location, event coordinator contact information, expected number of attendees, primary demographics of people served, purpose and outcome of the proposed event, description of ~~CalOptima's~~CalOptima Health's Participation in the event, and/or how ~~CalOptima's~~CalOptima Health's financial Participation will be used, etc.

   d. The CEO or his/her designee is authorized to purchase and use in-kind contributions of items branded with ~~CalOptima's~~CalOptima Health's logo for the purpose of outreach and promoting ~~CalOptima's~~CalOptima Health's role and services in the community.

   e. The CEO or his/her designee will report all approved Participation in events involving financial Participation in an amount up to and including ~~two~~ten thousand ~~five hundred~~ dollars ($~~2,500~~10,000) per organization per fiscal year to the CalOptima Health Board of Directors in the CEO's regular Board communications, including, but not limited to, the CEO's weekly updates and reports included in the next available regularly scheduled Board of Directors meeting.

3. Requests for financial Participation in amounts of more than ~~two~~ten thousand ~~five hundred~~ dollars ($~~2,500~~10,000) per organization per fiscal year:

   a. Requests for financial Participation for the amount of more than ~~two~~ten thousand ~~five hundred~~ dollars ~~s -~~ ($~~2,500~~10,000) per organization per fiscal year shall be submitted no less than sixty (60) calendar days in advance of the date of the event.

b. Financial requests from qualified external entities for eligible events valued at more than ~~two~~ten thousand ~~five hundred~~ dollars ($~~2,500~~10,000) require approval from the CalOptima Health Board of Directors and a finding that such financial Participation is in the public good, subject to availability of budgeted funds, and within ~~CalOptima's~~CalOptima Health's authority and statutory purpose.

c. All requests for financial Participation to CalOptima Health from external entities shall meet the standards set forth above in Sections II.A. through II.F. along with the following criteria:

i. Member interaction/enrollment – The activity shall include Participation from CalOptima Health members and/or potential members that could be enrolled in any of ~~CalOptima's~~CalOptima Health's program, or be in furtherance of ~~CalOptima's~~CalOptima Health's mission, vision & values, programs, and/or purpose~~programs/lines of business, values, and/or purpose~~; and

ii. Inclusion of Details of the Event – Information about the organization and event, including name of the organization hosting the event, the name of the event itself, day/date, start and end time, location, event coordinator contact information, expected number of attendees, primary demographics of people served, purpose, and outcome of the proposed event, description of ~~CalOptima's~~CalOptima Health's Participation in the event, and/or how ~~CalOptima's~~CalOptima Health's financial Participation will be used, etc.

d. The CEO or his/her designee is authorized to purchase and use in-kind contributions of items branded with ~~CalOptima's~~CalOptima Health's logo for the purpose of outreach and promoting ~~CalOptima's~~CalOptima Health's role and services in the community.

e. The CEO or his/her designee will report all approved Participation in events involving financial Participation in amounts more than ~~two~~ten thousand ~~five hundred~~ dollars ($~~2,500~~10,000) per organization per fiscal year to the CalOptima Health Board of Directors in the CEO's weekly updates and reports included in the next available regularly scheduled Board of Directors meeting.

4. In determining the value of ~~CalOptima's~~CalOptima Health's Participation in events involving external entities, the following factors shall be considered:

a. The use of CalOptima Health staff time (*e.g.*, in their capacity as a CalOptima Health employee) to attend events such as health fairs, educational or community events;

b. The use of CalOptima Health resources (*e.g.*, CalOptima Health facilities);

c. The use of current, or future, CalOptima Health eligible funds; and

d. The value of items donated with the CalOptima Health master brand/logo.

H. In no event shall approval of ~~CalOptima's~~CalOptima Health's Participation in an event, or with an external entity, constitute an Endorsement of the external entity hosting the event, nor shall such Participation constitute Endorsement of any particular message, or initiative, commercial product or service, and/or any message advocated by the external entity. Endorsements and use of ~~CalOptima's~~CalOptima Health's name, or logo, in any material by an external entity shall be governed by CalOptima Health Policy AA.1214: Guidelines for Endorsements, for Letters of Support, and Use of ~~CalOptima's~~CalOptima Health's Name and Logo.

I. The CEO or his/her designee shall report any Participation approved by the CEO to the CalOptima Health Board of Directors, in writing, at the next available regularly scheduled Board of Directors meeting after such

approval.

J. The CEO or his/her designee shall provide members of the CalOptima Health Board of Directors with advanced notice, so they have the opportunity to attend events in which CalOptima ~~Participates.~~Health participates.

K. Payment for actual and necessary expenses incurred in the course of performing services for CalOptima, including expenses incurred in the course of attending functions of external entities, shall be reimbursed, or paid in accordance with CalOptima Health Policy GA.5004: Travel Policy, to the extent there is a clear nexus between the attendance of the employee at such a function and the performance of the service for which such employees is regularly employed. In no event shall CalOptima Health pay or reimburse a CalOptima Health employee for expenses arising from personal expenses, political campaigns or activities, charitable contributions, or events (including fundraisers, galas, dinners, unless expressly approved by the Board of Directors), family expenses, entertainment expenses, or religious activities.

L. In the event ~~CalOptima's~~CalOptima Health's Participation in an event involving an external entity involves any Marketing Activities, such Marketing Activities shall be consistent with all applicable legal and contractual requirements, as well as all internal policies, including, but not limited to, CalOptima Health Policies MA.2002: Marketing Activity Standards ~~and PA.2010: Enrollment and Intake~~.

III. PROCEDURE

A. All requests for Participation shall be submitted within the timeframe specified above, and include the following information, as appropriate:

1. Description of the external entity requesting Participation, including, but not limited to: whether the external entity is a non-profit organization, religious organization, for-profit organization, or other health care partner (including valid by-laws filed with the Secretary of State of the State of California); how long the external entity has been operating; where the external entity's principle office and base of operations is located; external entity's service area, etc.;

2. Description of the event such as name of the event, day/date, start and end time, location, event coordinator contact information, expected number of attendees, primary language of attendees, primary demographics of people served, purpose, and outcome of the proposed event;

3. The purpose of the event, including, but not limited to, a copy of any event materials, or description of the program or project;

4. Description of relationship between external entity's work, or event, and ~~CalOptima's~~CalOptima Health's programs/lines of business, mission, vision & values, programs, and/or purpose~~values, and/or purpose~~;

5. Description, background, and pertinent information (*e.g.*, names of members of the Board of Directors) regarding the requesting entity and any other entity having a substantial role in the event;

6. A list of other individuals, or entities, supporting the event;

7. Event budget information; and

8. Purpose, role, and anticipated time commitment for ~~CalOptima's~~CalOptima Health's involvement in the event, if applicable.

B. Upon receipt of a complete request for Participation, ~~CalOptima's~~CalOptima Health's Community Relations Department shall:

1. Review and analyze the request to ensure each criteria is met;

2. Complete the Event Participation Request Form and place the completed form and all supporting documentation in a folder within five (5) business days of the date of receipt of completed request;

3. Submit the request to the CEO, his/her designee, or to the Board of Directors, where applicable, for consideration. If the request is denied, the requestor shall be so notified.

C. Upon receipt of the approved request for Participation from the CEO, his/her designee, or the Board of Directors, ~~CalOptima's~~CalOptima Health's Community Relations Department shall:

1. Notify the requesting entity of ~~CalOptima's~~CalOptima Health's determination; and

2. Process the financial request and any necessary documents within three (3) business days of the determination date.

3. Any payments for approved financial requests shall be issued only through checks paid directly to the external entity, and no cash disbursements will be made for events covered by this Policy.

D. Requests for In-Kind Contributions of Items Branded with the CalOptima Health Logo:

1. Requests shall be submitted to ~~CalOptima's~~CalOptima Health's Community Relations Department, in writing, at least thirty (30) calendar days in advance of the date for which an entity wishes to distribute items branded with the CalOptima Health master logo.

2. Upon receipt of a complete request to distribute items branded with the CalOptima Health master logo, ~~CalOptima's~~CalOptima Health's Community Relations Department shall review and analyze the request with input from appropriate internal departments within five (5) business days.

3. The Community Relations Department shall submit a request to the Chief Executive Officer (CEO) or his/her designee for approval of a donation of items valued at five dollars ($5) or less, and up to and including a cumulative total of five hundred dollars ($500) worth of goods. Requests to distribute items that exceed a cumulative total of five hundred dollars ($500) shall require the prior approval of the CalOptima Health Board of Directors.

5. The Community Relations Department shall notify the requesting entity, in writing, after ~~CalOptima's~~CalOptima Health's determination is made.

6. The Community Relations Department shall process an approved request to distribute items branded with the CalOptima Health master logo within three (3) business days of approval.

7. The requesting entity shall agree to return any items that it does not distribute at the conclusion of the event for which the item was used.

IV. ATTACHMENT(S)

A. CalOptima Health Public Activity Participation Request Form
B. CalOptima Health Public Activity Transmittal Form

V. REFERENCE(S)

A. California Constitution Article 16, §6
B. California Government Code, §8314

C. CalOptima Health Policy AA.1214: Guidelines for Endorsements by CalOptima, for Letters of Support, and Use of CalOptima Health Name or Logo
D. CalOptima Health Policy GA.5004: Travel Policy

E. CalOptima Health Policy MA.2002: Marketing Activity Standards
~~CalOptima Health Policy PA.2010: Enrollment and Intake~~

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
02/02/2017	Regular Meeting of the CalOptima Board of Directors
10/01/2020	Regular Meeting of the CalOptima Board of Directors
08/05/2021	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	02/02/2017	AA.1223	Participation in Community Events by External Entities	Administrative
Revised	11/01/2018	AA.1223	Participation in Community Events by External Entities	Administrative
Revised	02/01/2020	AA.1223	Participation in Community Events by External Entities	Administrative
Revised	10/01/2020	AA.1223	Participation in Community Events by External Entities	Administrative
Revised	08/05/2021	AA.1223	Participation in Community Events by External Entities	Administrative
Revised		AA.1223	Participation in Community Events by External Entities	Administrative

IX. GLOSSARY

Term	Definition
Endorsement	For purposes of this policy, the support or promotion of a project, event, document, program, or initiative conducted by an external entity for the benefit of that entity, and for which support or promotion CalOptima Health does not receive a comparable benefit. Endorsement does not include any sponsored educational activity, purchased service, presentation, attendance at an event, activity that is included in the definition of Marketing Activities, or joint development of an event, seminar, symposium, educational program, public information campaign, or similar event.
Marketing Activities	For purposes of this policy, any activity conducted by or on behalf of CalOptima Health where information regarding the services offered by CalOptima Health is disseminated in order to persuade or influence eligible beneficiaries to enroll or to educate members and promote optimal program use and Participation. Marketing also includes any similar activity to secure the Endorsement of any individual or organization on behalf of CalOptima.
Participate/ Participation	For purposes of this policy, this is the provision of financial assistance or in-kind contribution of goods, supplies, materials, facilities, staff time, and/or services by CalOptima Health to an external entity in support of one or more events, programs, projects, and/or activities (collectively, "events") in furtherance of ~~CalOptima's~~CalOptima Health's mission, vision & values, programs, and/or purpose~~programs/lines of business, values, and/or purpose~~.

Policy:	AA.1223
Title:	**Participation in Community Events by External Entities**
Department:	CalOptima Health Administrative
Section:	Strategic Development, Community Relations
CEO Approval:	
Effective Date:	02/02/2017
Revised Date:	
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy establishes guidelines for CalOptima Health's Participation in community events, programs, projects, and activities involving external entities.

II. POLICY

A. CalOptima Health recognizes the value of partnering with external entities to provide additional health care related services to benefit the local community, while still upholding its fiscal responsibilities as a steward of public funds. Requests for CalOptima Health's Participation in community events involving external entities, financially, or otherwise, shall be approved only if aligned with CalOptima Health's mission, vision and values.

B. An external entity may be eligible for CalOptima Health's Participation in its event if the entity is a community-based, non-profit organization, health care partner, public or government entity (collectively, "external entities") that serves CalOptima Health members or supports CalOptima Health's mission, vision and values. Religious organizations are not eligible for CalOptima Health's Participation unless the event is open to the general public and is for a non-sectarian purpose.

C. The expenditure of CalOptima Health's funds shall only be made for a direct and primary public purpose within CalOptima Health's authority and jurisdiction. Absent a legitimate and direct public purpose within CalOptima Health's authority and jurisdiction, CalOptima Health shall not use public funds to make monetary contributions to external entities solely for the purpose of goodwill, showing support, networking, public relations, or relationship building. External entities may not use CalOptima Health's Participation in any manner to donate, or endorse, political candidates to elected office, or to support/oppose a position on proposed legislation, ballot initiative, or proposition.

D. CalOptima Health's Participation shall include at least one (1) of the following:

1. A speaking opportunity for a CalOptima Health representative;

2. A presentation, or panel presentation, by a CalOptima Health representative;

3. A booth, or table, designated for CalOptima Health at the event to distribute CalOptima Health

information to members and/or potential members who could be enrolled in any of CalOptima Health's programs; or

4. Other opportunity to promote CalOptima Health's services and increase awareness about CalOptima.

E. There may be circumstances where financial Participation for external entities, such as charitable organizations, or activities (*e.g.*, United Way, etc.), may be permitted based on a finding by the CalOptima Health Board of Directors that the request for financial Participation falls within CalOptima Health's authority and purpose, and meets one (1) of the following criteria:

1. The financial Participation will be used by the external entity to provide a service that complements, or enhances, one that CalOptima Health provides; or

2. There is an identifiable benefit to CalOptima Health and/or its members.

F. The expenditure of CalOptima Health funds and the use of resources, staff time, and CalOptima Health facilities shall not be inconsistent with, or in conflict with, CalOptima Health's obligations under applicable state and federal laws and contracts.

G. Requests for Participation by CalOptima Health in an event proposed by an external entity shall require approval as follows:

1. Requests for Participation, other than financial contributions, such as hosting booths at health fairs, conducting education programs and presentations, or organizing community/town hall meetings:

a. Requests for non-financial Participation from external entities shall be submitted no less than fourteen (14) calendar days in advance of the date of the event.

b. The Chief Executive Officer (CEO) or his/her designee is authorized to approve non-financial requests from external entities for community/member-oriented events that meet the eligibility requirements as provided in this Policy.

c. Non-financial Participation requests from external entities for community/member-oriented events such as health fairs, educational events, and/or community/town hall forums shall meet the standards set forth above in Sections II.A. through II.F. along with the following criteria:

i. Member interaction/enrollment – The activity shall include Participation from CalOptima Health members and/or potential members that could be enrolled in any of CalOptima Health's programs, or be in furtherance of CalOptima Health's mission, vision & values, programs, and/or purpose; and

ii. Inclusion of Details of the Event – Information about the organization and event, including name of the organization hosting the event, the name of the event itself, day/date, start and end time, location, event coordinator contact information, expected number of attendees, primary demographics of people served, purpose and outcome of the proposed event, and description of CalOptima Health's Participation in the event.

2. Requests for financial Participation, up to and including, a cumulative value of ten thousand dollars ($10,000) per organization per fiscal year, which shall include all materials and supplies:

a. Requests for financial Participation in an amount up to and including ten thousand dollars

($10,000) per organization per fiscal year, inclusive of all materials and supplies, shall be submitted no less than twenty-one (21) calendar days in advance of the date of the event, or if in a shorter amount of time, at the discretion of the CEO, or his/her designee, so long as such request is submitted to the CEO, or his/her designee, in a reasonable and sufficient amount of time so that CalOptima Health can complete a meaningful review and evaluation of the request.

b. The CEO or his/her designee is authorized to approve requests for financial Participation for qualifying external entities and events for a cumulative amount of up to and including ten thousand dollars ($10,000) per organization per fiscal year, subject to availability of budgeted funds.

c. All requests for financial Participation to CalOptima Health from external entities shall meet the standards set forth above in Sections II.A. through II.F. along with the following criteria:

i. Member interaction/enrollment – The activity shall include Participation from CalOptima Health members and/or potential members that could be enrolled in any of CalOptima Health's programs or be in furtherance of CalOptima Health's mission, vision & values, programs, and/or purpose; and

ii. Inclusion of Details of the Event – Information about the organization and event, including the name of the organization hosting the event, the name of the event itself, day/date, start and end time, location, event coordinator contact information, expected number of attendees, primary demographics of people served, purpose and outcome of the proposed event, description of CalOptima Health's Participation in the event, and/or how CalOptima Health's financial Participation will be used, etc.

d. The CEO or his/her designee is authorized to purchase and use in-kind contributions of items branded with CalOptima Health's logo for the purpose of outreach and promoting CalOptima Health's role and services in the community.

e. The CEO or his/her designee will report all approved Participation in events involving financial Participation in an amount up to and including ten thousand dollars ($10,000) per organization per fiscal year to the CalOptima Health Board of Directors in the CEO's regular Board communications, including, but not limited to, the CEO's weekly updates and reports included in the next available regularly scheduled Board of Directors meeting.

3. Requests for financial Participation in amounts of more than ten thousand dollars ($10,000) per organization per fiscal year:

a. Requests for financial Participation for the amount of more than ten thousand dollars ($10,000) per organization per fiscal year shall be submitted no less than sixty (60) calendar days in advance of the date of the event.

b. Financial requests from qualified external entities for eligible events valued at more than ten thousand dollars ($10,000) require approval from the CalOptima Health Board of Directors and a finding that such financial Participation is in the public good, subject to availability of budgeted funds, and within CalOptima Health's authority and statutory purpose.

c. All requests for financial Participation to CalOptima Health from external entities shall meet the standards set forth above in Sections II.A. through II.F. along with the following criteria:

i. Member interaction/enrollment – The activity shall include Participation from CalOptima

Health members and/or potential members that could be enrolled in any of CalOptima Health's program, or be in furtherance of CalOptima Health's mission, vision & values, programs, and/or purpose; and

ii. Inclusion of Details of the Event – Information about the organization and event, including name of the organization hosting the event, the name of the event itself, day/date, start and end time, location, event coordinator contact information, expected number of attendees, primary demographics of people served, purpose, and outcome of the proposed event, description of CalOptima Health's Participation in the event, and/or how CalOptima Health's financial Participation will be used, etc.

d. The CEO or his/her designee is authorized to purchase and use in-kind contributions of items branded with CalOptima Health's logo for the purpose of outreach and promoting CalOptima Health's role and services in the community.

e. The CEO or his/her designee will report all approved Participation in events involving financial Participation in amounts more than ten thousand dollars ($10,000) per organization per fiscal year to the CalOptima Health Board of Directors in the CEO's weekly updates and reports included in the next available regularly scheduled Board of Directors meeting.

4. In determining the value of CalOptima Health's Participation in events involving external entities, the following factors shall be considered:

a. The use of CalOptima Health staff time (*e.g.*, in their capacity as a CalOptima Health employee) to attend events such as health fairs, educational or community events;

b. The use of CalOptima Health resources (*e.g.*, CalOptima Health facilities);

c. The use of current, or future, CalOptima Health eligible funds; and

d. The value of items donated with the CalOptima Health master brand/logo.

H. In no event shall approval of CalOptima Health's Participation in an event, or with an external entity, constitute an Endorsement of the external entity hosting the event, nor shall such Participation constitute Endorsement of any particular message, or initiative, commercial product or service, and/or any message advocated by the external entity. Endorsements and use of CalOptima Health's name, or logo, in any material by an external entity shall be governed by CalOptima Health Policy AA.1214: Guidelines for Endorsements, for Letters of Support, and Use of CalOptima Health's Name and Logo.

I. The CEO or his/her designee shall report any Participation approved by the CEO to the CalOptima Health Board of Directors, in writing, at the next available regularly scheduled Board of Directors meeting after such approval.

J. The CEO or his/her designee shall provide members of the CalOptima Health Board of Directors with advanced notice, so they have the opportunity to attend events in which CalOptima Health participates.

K. Payment for actual and necessary expenses incurred in the course of performing services for CalOptima, including expenses incurred in the course of attending functions of external entities, shall be reimbursed, or paid in accordance with CalOptima Health Policy GA.5004: Travel Policy, to the extent there is a clear nexus between the attendance of the employee at such a function and the performance of the service for which such employees is regularly employed. In no event shall CalOptima Health pay or reimburse a CalOptima Health employee for expenses arising from personal

expenses, political campaigns or activities, charitable contributions, or events (including fundraisers, galas, dinners, unless expressly approved by the Board of Directors), family expenses, entertainment expenses, or religious activities.

L. In the event CalOptima Health's Participation in an event involving an external entity involves any Marketing Activities, such Marketing Activities shall be consistent with all applicable legal and contractual requirements, as well as all internal policies, including, but not limited to, CalOptima Health Policies MA.2002: Marketing Activity Standards.

III. PROCEDURE

A. All requests for Participation shall be submitted within the timeframe specified above, and include the following information, as appropriate:

1. Description of the external entity requesting Participation, including, but not limited to: whether the external entity is a non-profit organization, religious organization, for-profit organization, or other health care partner (including valid by-laws filed with the Secretary of State of the State of California); how long the external entity has been operating; where the external entity's principle office and base of operations is located; external entity's service area, etc.;

2. Description of the event such as name of the event, day/date, start and end time, location, event coordinator contact information, expected number of attendees, primary language of attendees, primary demographics of people served, purpose, and outcome of the proposed event;

3. The purpose of the event, including, but not limited to, a copy of any event materials, or description of the program or project;

4. Description of relationship between external entity's work, or event, and CalOptima Health's programs/lines of business, mission, vision & values, programs, and/or purpose;

5. Description, background, and pertinent information (*e.g.*, names of members of the Board of Directors) regarding the requesting entity and any other entity having a substantial role in the event;

6. A list of other individuals, or entities, supporting the event;

7. Event budget information; and

8. Purpose, role, and anticipated time commitment for CalOptima Health's involvement in the event, if applicable.

B. Upon receipt of a complete request for Participation, CalOptima Health's Community Relations Department shall:

1. Review and analyze the request to ensure each criteria is met;

2. Complete the Event Participation Request Form and place the completed form and all supporting documentation in a folder within five (5) business days of the date of receipt of completed request;

3. Submit the request to the CEO, his/her designee, or to the Board of Directors, where applicable, for consideration. If the request is denied, the requestor shall be so notified.

C. Upon receipt of the approved request for Participation from the CEO, his/her designee, or the Board of Directors, CalOptima Health's Community Relations Department shall:

1. Notify the requesting entity of CalOptima Health's determination; and

2. Process the financial request and any necessary documents within three (3) business days of the determination date.

3. Any payments for approved financial requests shall be issued only through checks paid directly to the external entity, and no cash disbursements will be made for events covered by this Policy.

D. Requests for In-Kind Contributions of Items Branded with the CalOptima Health Logo:

1. Requests shall be submitted to CalOptima Health's Community Relations Department, in writing, at least thirty (30) calendar days in advance of the date for which an entity wishes to distribute items branded with the CalOptima Health master logo.

2. Upon receipt of a complete request to distribute items branded with the CalOptima Health master logo, CalOptima Health's Community Relations Department shall review and analyze the request with input from appropriate internal departments within five (5) business days.

3. The Community Relations Department shall submit a request to the Chief Executive Officer (CEO) or his/her designee for approval of a donation of items valued at five dollars ($5) or less, and up to and including a cumulative total of five hundred dollars ($500) worth of goods. Requests to distribute items that exceed a cumulative total of five hundred dollars ($500) shall require the prior approval of the CalOptima Health Board of Directors.

5. The Community Relations Department shall notify the requesting entity, in writing, after CalOptima Health's determination is made.

6. The Community Relations Department shall process an approved request to distribute items branded with the CalOptima Health master logo within three (3) business days of approval.

7. The requesting entity shall agree to return any items that it does not distribute at the conclusion of the event for which the item was used.

IV. ATTACHMENT(S)

A. CalOptima Health Public Activity Participation Request Form
B. CalOptima Health Public Activity Transmittal Form

V. REFERENCE(S)

A. California Constitution Article 16, §6
B. California Government Code, §8314
C. CalOptima Health Policy AA.1214: Guidelines for Endorsements by CalOptima, for Letters of Support, and Use of CalOptima Health Name or Logo
D. CalOptima Health Policy GA.5004: Travel Policy

E. CalOptima Health Policy MA.2002: Marketing Activity Standards

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
02/02/2017	Regular Meeting of the CalOptima Board of Directors
10/01/2020	Regular Meeting of the CalOptima Board of Directors
08/05/2021	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	02/02/2017	AA.1223	Participation in Community Events by External Entities	Administrative
Revised	11/01/2018	AA.1223	Participation in Community Events by External Entities	Administrative
Revised	02/01/2020	AA.1223	Participation in Community Events by External Entities	Administrative
Revised	10/01/2020	AA.1223	Participation in Community Events by External Entities	Administrative
Revised	08/05/2021	AA.1223	Participation in Community Events by External Entities	Administrative
Revised		AA.1223	Participation in Community Events by External Entities	Administrative

IX. GLOSSARY

Term	Definition
Endorsement	For purposes of this policy, the support or promotion of a project, event, document, program, or initiative conducted by an external entity for the benefit of that entity, and for which support or promotion CalOptima Health does not receive a comparable benefit. Endorsement does not include any sponsored educational activity, purchased service, presentation, attendance at an event, activity that is included in the definition of Marketing Activities, or joint development of an event, seminar, symposium, educational program, public information campaign, or similar event.
Marketing Activities	For purposes of this policy, any activity conducted by or on behalf of CalOptima Health where information regarding the services offered by CalOptima Health is disseminated in order to persuade or influence eligible beneficiaries to enroll or to educate members and promote optimal program use and Participation. Marketing also includes any similar activity to secure the Endorsement of any individual or organization on behalf of CalOptima.
Participate/ Participation	For purposes of this policy, this is the provision of financial assistance or in-kind contribution of goods, supplies, materials, facilities, staff time, and/or services by CalOptima Health to an external entity in support of one or more events, programs, projects, and/or activities (collectively, "events") in furtherance of CalOptima Health's mission, vision & values, programs, and/or purpose.

CalOptima Health

A Public Agency

Public Activity Participation Request Form

Requesting Entity:	
Requesting Entity's Principal Office/ Base Operations Location:	
How long Requesting Entity has been operating:	
Requesting Entity's service areas:	
Description of relationship between Requesting Entity's work/event and CalOptima Health's programs, mission, vision, values, and/or purpose:	
Description, background and pertinent information (e.g., Members of Board of Directors) and other entities with a substantial role in event:	
List of individuals or entities supporting the event:	
Entity Type:	☐ Non-Profit Org ☐ For-Profit Org ☐ Religious Org ☐ Health Care Partner

Section I: Event Details	
Name:	
Day/Date:	
Start Time:	End Time:
Location:	
City:	Zip Code:
POC Name:	
Phone#:	Fax#:
Email:	
Type of Event	1 Opportunity to outreach to members or potential members
	2 Opportunity to outreach to health care professionals, non-profit orgs or policy-makers
	3 Other:
Expected # of Attendees:	

A Public Agency

Public Activity Participation Request Form

Section II: About the Attendees (check all that apply)				
Primary Language Spoken:	☐ English	☐ Spanish	☐ Vietnamese	☐ Other:

Event for:	☐ Children	☐ Persons with disabilities
	☐ Low-income families	☐ General public
	☐ Low-income older adults/seniors	☐ Other:
Event for CalOptima Health's Program:	☐ OneCare ☐ PACE	☐ Medi-Cal

Section III: Cost to CalOptima Health to Participate

Registration Fee:	No	Yes, amount:
Sponsorship Request:	No	Yes, amount:

Section IV: Notes/Comments

Section V: Disclosures

Requests must be submitted to the Community Relations Department: Staff Participation (14) calendar days in advance; Financial Participation at or under $10,000 (21) calendar days in advance; Financial Participation more than $10,000 (60) calendar days in advance.

[All event materials/information must be attached]

Public Activity Transmittal Form

Please complete your portion of this form and route it in the order indicated below. Please contact Holly Mendez at holly.mendez@caloptima.org if you have any questions.

Today's Date:_____ Complete Routing **By:** _____

Routing Order			
1. Department **POC:**		Complete Review By:	
2. Department **POC:**		Complete Review By:	
3. Department **POC:**		Complete Review By:	

For CR Use Only: CR Initial Review

Requests for CalOptima Health 's Participation in community events involving external entities must be:

1. Compatible with CalOptima Health 's mission to provide members with access to quality healthcare services delivered in a cost-effective and compassionate manner.	☐Yes	☐No
2. Consistent with CalOptima Health 's specific statutory purpose to arrange for the provision of health care services to qualifying individuals who lack sufficient annual income to meet the cost of health care; and	☐Yes	☐No
3. In accordance with CalOptima Health Policy AA.1223: Participation in Community Events Involving External Entities	☐Yes	☐No

CalOptima Health 's Participation shall include at least one (1) of the following:

1. A speaking opportunity for a CalOptima Health representative	☐Yes	☐No
2. A presentation, or panel presentation, by a CalOptima Health representative	☐Yes	☐No
3. A booth, or table, designated for CalOptima Health at the event to distribute CalOptima Health information to members/potential members	☐Yes	☐No
4. Other opportunity to promote CalOptima Health 's services and increase awareness about CalOptima Health	☐Yes	☐No

Financial Participation must meet one (1) of the following criteria, if applicable:

1. The financial participation will be used by the external entity to provide a service that complements, or enhances, one that CalOptima Health provides	☐Yes	☐No
2. There is an identifiable benefit to CalOptima Health and/or its members	☐Yes	☐No

Board of Directors Approval Required if an Entity Exceeds the $10,000 per Fiscal Year Limit:

1. Is the requesting entity acting as the fiscal agent?	☐Yes	☐No
2. Has CalOptima Health provided prior financial sponsorship to the requesting entity within the current fiscal year?	☐Yes	☐No
3. Does the cumulative total for this FY exceed the $10,000 limit per entity, which requires Board approval?	☐Yes	☐No
4. If yes, then date of Board of Directors approval:		

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Public Activity Transmittal Form

Other considerations:

Process as an Endorsement (i.e., CalOptima Health Policy AA.1214)	☐ Yes	☐ No
Event affiliated with a member of the Board, MAC, PAC, or Employee	☐ Yes	☐ No
Request Legal Review (i.e., conflict analysis)	☐ Yes	☐ No
Included in budget	☐ Yes, amount	☐ No
CalOptima Health participated in the past	☐ Yes, year(s)	☐ No

Notes:

CR Participation Commitment:	**YES**	**NO**	**NA**
Assume "Lead Department" role	☐ Staff:	☐	☐
Assume "Support Department" role	☐ Staff:	☐	☐
Provide financial support (i.e., registration fee, sponsorship, etc.)	☐ Amount:	☐	☐
Provide promotional items	☐	☐	☐
Provide brochures/educational materials	☐	☐	☐
Other:	☐ Specify:	☐	☐

Note:

Signature Required Only for Sponsorships, Endorsements and Registration Fees.

Date:

Tiffany Kaaiakamanu, Manager of Community Relations

***CalOptima Health 's CEO has delegated authority to approve requests for financial participation in an amount up to and including $10,000 if it is determined that CalOptima Health 's participation is of public purpose.**

CalOptima Health Board Action Agenda Referral

Action To Be Taken December 1, 2022
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

12. Approve CalOptima Health Board of Directors' Member Advisory Committee, Provider Advisory Committee, and Whole-Child Model Family Advisory Committee Policies and Procedures

Contact

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

Recommended Actions

Authorize updates to the following policies and procedures in accordance with CalOptima Health's regular review process and consistent with regulatory requirements:

1. AA.1219a: Member Advisory Committee;
2. AA.1219b: Provider Advisory Committee; and
3. AA.1271: Whole-Child Model Family Advisory Committee.

Background

Since CalOptima Health's inception, the CalOptima Health Board of Directors (Board) has benefited from stakeholder involvement via its advisory committees. The CalOptima Health Board established the Member Advisory Committee (MAC) and Provider Advisory Committee (PAC) by resolution on February 14, 1995, to serve solely in an advisory capacity providing input and recommendations concerning the CalOptima Health program. The Board established the Whole-Child Model Family Advisory Committee (WCM FAC) by resolution on November 2, 2017, to provide advice and recommendations to the Board and staff on issues concerning CalOptima Health's Whole-Child Model program.

The MAC is comprised of fifteen (15) voting members, including one (1) standing member that represents the Social Services Agency (SSA). The PAC is comprised of fifteen (15) voting members, including one (1) standing member from the Orange County Health Care Agency. The WCM FAC is comprised of eleven (11) voting members with seven (7) Authorized Family Members and four (4) Consumer Advocates/Community Based Organization members.

Discussion

CalOptima Health policies and procedures AA.1219a, AA.1219b, and AA.1271 provide guidance on MAC, PAC, and WCM FAC operations. Staff recommends approving updates to the three policies, as outlined below:

1. **AA.1219a: Member Advisory Committee:** This policy defines the composition and role of the MAC and establishes a process for recruiting, evaluating, and selecting prospective candidates to the MAC including the Chair and the Vice Chair. The proposed revisions include:
   a. Authorizing a fifty-dollar ($50) stipend per meeting for the Medi-Cal and OneCare members on the MAC, effective July 1, 2023.
   b. Moving the nominations for the Chair and Vice Chair to the first meeting of the new fiscal year to allow new members to provide their input in the selection process.

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c. Updating committee member terms from the current two (2)-year term with no term limits, to a three (3)-year term with a two (2)-term limit. The policy will require that a member take a six (6)-year hiatus (equivalent to two (2) terms) before reapplying to sit on the MAC.
d. Effective July 1, 2023, the MAC will be comprised of fifteen (15) voting members with each seat representing a constituency that works with CalOptima Health and its members. The policy authorizes term staggering to achieve the new three (3)-year term as follows:
    1. One (1) of the fifteen (15) positions is a standing seat represented by the SSA with no term change.
    2. The remaining fourteen (14) members shall serve staggered terms of three (3) years. The three (3)-year term shall coincide with CalOptima Health's fiscal year (i.e., July 1st through June 30th). Effective July 1, 2023, staggered nominations shall occur at a rate of approximately one-third (1/3) of the membership each year. To achieve the staggered rate of one-third (1/3) each year, the current term for the Behavioral Health seat, Consumer Seat, Foster Children seat, OneCare Member and Seniors seat, will be extended from a two (2) year term to a three (3) year term effective July 1, 2023.
e. To encourage diversity in stakeholder input, the policy allows for only one (1) member per organization to sit on the committee.
f. Replacing and renaming the seats as approved by the Board at the September 1, 2022, meeting.

2. **AA.1219b: Provider Advisory Committee:** This policy defines the composition and role of the Provider Advisory Committee and establishes a process for recruiting, evaluating, and selecting prospective candidates to PAC including the Chair and the Vice Chair. The proposed revisions include:
    a. Updating the currently required one (1)-year hiatus to six (6) years before the individual can reapply to sit on the PAC.
    b. To encourage diversity in stakeholder input, the policy allows for only one (1) member per organization to sit on the committee.
    c. Moving the nominations for the Chair and Vice Chair to the first meeting of the new fiscal year to allow new members to provide their input in the selection process.

3. **AA.1271: Whole-Child Model Family Advisory Committee:** This policy defines the composition and role of the FAC WCM and establishes a process for recruiting, evaluating, and selecting prospective candidates to the WCM FAC, including the Chair and the Vice Chair. The proposed revisions include:
    a. Moving the nominations for Chair and Vice Chair to the first meeting of the new fiscal year to allow new members to provide their input in the selection process.
    b. Allowing only one (1) member per each organization to sit on the committee.

Fiscal Impact

The recommended action to revise Board advisory committee policies has no additional fiscal impact in the current year. Staff will include updated administrative expenses in future operating budgets.

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Rationale for Recommendation

To ensure CalOptima's continuous commitment to its Board Advisory Committees and in compliance with all applicable requirements, staff recommends that the Board approve and adopt the proposed updates to the individual MAC, PAC, and WCM FAC policies and procedures as identified above. These updates will continue to support the valuable feedback from community stakeholders and promote diversity in stakeholder participation. The updated policies and procedures for each committee will supersede the prior versions.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. AA.1219a: Member Advisory Committee
2. AA.1219b: Provider Advisory Committee
3. AA.1271: Whole-Child Model Family Advisory Committee

/s/ Michael Hunn *11/23/2022*
Authorized Signature **Date**

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Policy:	AA.1219a
Title:	**Member Advisory Committee**
Department:	Customer Service
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	02/14/1995
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy describes the composition and role of ~~CalOptima's~~CalOptima Health's Member Advisory Committee (MAC) and to establish a process for recruiting, evaluating, and selecting prospective candidates to ~~CalOptima's~~CalOptima Health's MAC.

II. POLICY

A. As directed by ~~CalOptima's~~CalOptima Health's Board of Directors (CalOptima Health Board), MAC shall report to the CalOptima Health Board and shall provide advice and recommendations to the CalOptima Health Board relative to ~~CalOptima's~~CalOptima Health's programs.

B. ~~CalOptima's~~CalOptima Health's Board encourages Member involvement in the CalOptima Health program.

C. MAC members shall recuse themselves from voting or from decisions where a conflict of interest may exist and shall abide by ~~CalOptima's~~CalOptima Health's conflict of interest code and, CalOptima Health Policy AA.1204: Gifts, Honoraria, and Travel Payments.

D. The composition of MAC shall reflect the diversity of the health care consumer. ~~-~~All MAC members shall have direct or indirect contact with CalOptima Health Members.

E. An organization may have no more than one (1) employee or representative on the ~~P~~MAC at any one time.

F. An individual may participate in no more than one (1) CalOptima Advisory Committee at any one time.

~~E.~~G. In accordance with CalOptima Health Board Resolution Numbers 2-14-95 (effective February 14, 1995) and 11-1103 (effective November 3, 2011), MAC shall be comprised of fifteen (15) voting members, each seat representing a constituency served by CalOptima Health.

1. ~~Two (2~~One (1) of the fifteen (15) positions ~~are~~is a standing ~~seats~~seat and ~~are~~is held by the ~~Orange County Health Care Agency (HCA) and the~~ Social Services Agency (SSA).

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2. The remaining ~~thirteen (13~~fourteen (14) members shall serve staggered terms of three (3) years~~a two (2) year term with no limits on the number of terms a representative may serve~~.

   a. One (1) of the remaining ~~thirteen (13~~fourteen (14) positions shall be a dedicated Consumer seat.

   b. Two (2) of the fourteen (14) positions shall be dedicated OneCare Member or Authorized Family Member seats.

   a. The ~~two (2)~~three (3) year term shall coincide with ~~CalOptima's~~CalOptima Health's fiscal year (i.e., July 1 through June 30).

   b. Effective July 1, 2023, staggered nominations shall occur at a rate of approximately one-third (1/3) of the membership each year.

   c. MAC Members may serve no more than two (2) consecutive terms or the equivalent of six (6) consecutive years.

   ~~b.~~d. MAC Members shall be allowed to reapply after a hiatus of six (6) years.

3. MAC may include, but is not limited to, individuals representing, or that represent the interests of:

   a. Adult beneficiaries;

   b. Behavioral/Mental Health;

   c. Children;

   d. Consumer;

   e. Family Support Representative;

   f. Foster children;

   ~~g. Long Term Services and Supports (LTSS);~~

   ~~h.~~g. Medi-Cal beneficiaries;

   ~~i. Medical Safety Net;~~

   h. ~~Orange County HCA;~~Member Advocate;

   i. OneCare Member/Family Member;

   j. OneCare Member/Family Member;

   k. Orange County SSA;

   l. Persons with disabilities;

m. Persons with Special Needs;

n. Recipients of CalWORKs; or

o. Seniors.

H. Stipends

1. CalOptima Health may provide a reasonable per diem payment of up to $50 per meeting to a Member or family representative serving on the MAC. CalOptima Health shall maintain a log of each payment provided to the Member or family representative, including type and value, and shall provide such log to DHCS upon request.

2. Representatives of provider organizations, community-based organizations and consumer advocates are not eligible for stipends.

~~F.~~I. The MAC shall conduct a nomination process to recruit potential candidates for the impending vacant seats, in accordance with this policy.

1. The MAC shall conduct an annual recruitment and nomination process.

a. At the end of each fiscal year, approximately ~~half~~ one-third (1/3) of the MAC seats' terms expire, alternating between ~~six (6seven~~six (~~6~~7) vacancies, one (1) year and ~~seven~~ four (~~4~~7) vacancies each of, the ~~subsequent~~ following two (2) years. ~~Standing seats in~~The standing seat on the MAC ~~are~~is not impacted by term expiration.

2. The MAC shall conduct a recruitment and nomination process if a seat is vacated mid-term.

a. Candidates that fill a vacated seat mid-term shall complete the term for that specific seat, which will be less than a full three ~~two~~ (3~~2~~) year term.

~~a.~~

~~G.~~J. Special Elections

1. Special elections for MAC shall occur under the following circumstances:

a. When a MAC seat is vacant due to the resignation of a sitting MAC member; or

b. The current MAC member is deemed unqualified to serve in his or her current capacity as a MAC member.

2. Any new MAC member appointed to fill an open seat created mid-term shall serve the remainder of the resigning member's term.

~~H.~~K. MAC Vacancies

1. If a vacancy occurs prior to the start of the nomination process, there shall be no need for a special election and the vacant seat shall be filled during that nomination process.

2. If a vacancy occurs after the annual nomination process is complete, a special election may be conducted to fill the open seat, subject to approval by the MAC.

~~I.~~L. On a bi-annual basis, MAC shall select a chair and vice chair from its membership to coincide with the annual recruitment and nomination process. Recruitment and selection shall be conducted in accordance with Section III.C-E of this policy.

1. The MAC chair and vice chair may serve one (1) two (2) year term.

2. The MAC chairperson or vice chair may be removed by a majority vote from ~~CalOptima's~~CalOptima Health's Board.

~~J.~~M. To establish a nomination ad hoc subcommittee, the MAC chair or vice chair shall ask for three (3) to four (4) members to serve on the ad hoc subcommittee. MAC members, who are being considered for reappointment, cannot participate in the nomination ad hoc subcommittee.

1. The MAC nomination ad hoc subcommittee shall:

   a. Review, evaluate, and select a prospective chair, vice chair and a candidate for each of the open seats, in accordance with Section III.C-E of this policy; and

   b. Forward the prospective chair, vice chair and slate of candidate(s) to the full MAC for consideration.

2. Following approval from the MAC, the recommended chair, vice chair and slate of candidate(s) shall be forwarded to ~~CalOptima's~~CalOptima Health's Board for review and approval.

~~K.~~N. ~~CalOptima's~~CalOptima Health's Board shall review and have final approval for all appointments, reappointments, and chair and vice chair appointments to the MAC.

~~L.~~O. MAC members shall attend all regularly scheduled meetings, unless they have an excused absence. An absence shall be considered excused if a MAC member provides notification of an absence to CalOptima Health staff prior to the MAC meeting. CalOptima Health staff shall maintain an attendance log of the MAC members' attendance at MAC meetings. Upon request from the MAC chair, the vice chair, the Chief Executive Officer, or the CalOptima Health Board, CalOptima Health staff shall provide a copy of the attendance log to the requester. In addition, the MAC chair or vice chair shall contact any committee member who has three consecutive unexcused absences.

1. MAC members' attendance shall be considered as a criterion upon reapplication.

III. PROCEDURE

A. MAC composition

1. The composition of MAC shall reflect the cultural diversity and special needs of the CalOptima Health population.

2. Specific agency representatives shall serve on the MAC as standing members.

   ~~a. The MAC shall include the Public Health Officer (or his or her designee) of the HCA and the Director (or his or her designee) of the~~ SSA~~.~~

~~b.~~a. ~~SSA and HCA representatives~~ representative shall serve as a standing ~~members~~member and shall not be subject to reapplying.

B. MAC meeting frequency

1. The MAC shall meet at least quarterly.

2. The MAC shall adopt a yearly meeting schedule at the first regularly scheduled meeting in or after January of each year.

3. Attendance by a simple majority of appointed members shall constitute a quorum.

   a. A quorum must be present for any votes to be valid.

C. MAC recruitment process

1. CalOptima Health shall begin recruitment of potential candidates in ~~March~~ February of each year. In the recruitment of potential candidates, the ethnic and cultural diversity and special needs of the CalOptima Health population shall be considered. Nominations and input from interest groups and agencies shall be given due consideration.

2. CalOptima Health shall recruit potential candidates utilizing a variety of ~~-~~notification methods, which may include, but are not~~-~~ limited to, the following:

   a. Outreach to the respective Member community;

   b. Placement of vacancy notices on the CalOptima Health Website~~; and~~

   ~~c. Advertisement of vacancies in local newspapers in Threshold Languages.~~

3. Prospective candidates shall be notified at the time of recruitment regarding the deadline to submit their application to CalOptima Health.

4. ~~The~~During the MAC meeting held before June 30 of a recruitment year for the chair and vice chair, the current chair or vice~~-~~-chair shall inquire of its membership whether there are interested candidates who wish to be considered as a chair or vice~~-~~-chair for the upcoming fiscal year. The candidates are requested to submit a letter of interest for these positions.

D. CalOptima Health shall conduct a special election with a truncated recruitment process to fill a MAC seat that has been vacated mid-term.

E. MAC nomination process

1. The MAC chair or vice chair shall request three (3) to four (4) members, who are not being considered for reappointment, to serve on the nomination ad hoc subcommittee.

   a. At the discretion of the MAC nomination ad hoc subcommittee, a subject matter expert (SME) may be included on the subcommittee to provide consultation and advisement.

2. Prior to the MAC nomination ad hoc subcommittee meeting:

   a. Ad hoc subcommittee members shall individually evaluate and score the application for each of the prospective candidates using the Applicant Evaluation Tool.

   b. Ad hoc subcommittee members shall individually evaluate and select a chair and vice chair.

   c. At the discretion of the ad hoc subcommittee, subcommittee members may contact a prospective candidate's references for additional information and background validation.

3. The ad hoc subcommittee shall convene to discuss and select a ~~chair, vice chair and a~~ candidate for each of the expiring seats by using the findings from the Applicant Evaluation Tool, the attendance record if relevant, and the prospective candidate's references.

F. MAC selection and approval process for prospective chair, vice chair and MAC candidates

1. Upon selection of a recommendation for ~~a chair, vice chair and~~ a slate of candidates, the ad hoc subcommittee shall forward its recommendation to the MAC for consideration.

2. Following consideration, the MAC's recommendation for a ~~chair, vice chair and~~ slate of candidates shall be submitted to ~~CalOptima's~~CalOptima Health's Board for review and final approval.

3. Chair and vice chair candidates who submitted a letter of interest will be reviewed at the first MAC meeting of the fiscal year and the members will vote on their candidate of choice for both positions. Candidates must have a quorum of members approving their recommendation in order to be submitted to CalOptima Health's ~~the~~ Board for appointment.

~~3.~~4. Following ~~CalOptima's~~CalOptima Health's Board approval of MAC's recommendation, the new MAC members' terms shall be effective July 1.

   a. In the case of a selected candidate filling a seat that was vacated mid-term, the new candidate shall attend the immediately following MAC meeting.

4. CalOptima Health shall provide new MAC members with a new member orientation.

IV. ATTACHMENT(S)

A. Member Advisory Committee - Consumer Application
B. Member Advisory Committee - Community Application
C. Member Advisory Committee - Applicant Evaluation Tool
D. Member Advisory Committee - Seat Descriptions

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Policy AA.1204: Gifts, Honoraria, and Travel Payments
C. CalOptima Board Resolution 2-14-95
D. CalOptima Board Resolution 06-0707
E. CalOptima Board Resolution 11-1103
F. CalOptima Board Resolution 13-0307
G. CalOptima Board Resolution 15-08-06-02
H. CalOptima Board Resolution 16-08-04-02

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
09/15/2014	Department of Health Care Services (DHCS)	Approved as Submitted
08/11/2017	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
02/14/1995	Regular Meeting of the CalOptima Board of Directors
07/07/2006	Regular Meeting of the CalOptima Board of Directors
11/03/2011	Regular Meeting of the CalOptima Board of Directors
03/07/2013	Regular Meeting of the CalOptima Board of Directors
08/06/2015	Regular Meeting of the CalOptima Board of Directors
08/04/2016	Regular Meeting of the CalOptima Board of Directors
06/01/2017	Regular Meeting of the CalOptima Board of Directors
05/07/2020	Regular Meeting of the CalOptima Board of Directors
08/06/2020	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	02/14/1995	AA.1219	MAC and PAC	Medi-Cal
Revised	07/07/2006	AA.1219	MAC and PAC	Medi-Cal
Revised	12/01/2011	AA.1219	MAC and PAC	Medi-Cal
Revised	12/01/2013	AA.1219	MAC and PAC	Medi-Cal
Revised	07/01/2015	AA.1219a	Member Advisory Committee	Medi-Cal
Revised	08/04/2016	AA.1219a	Member Advisory Committee	Medi-Cal
Revised	07/01/2017	AA.1219a	Member Advisory Committee	Medi-Cal
Revised	03/01/2020	AA.1219a	Member Advisory Committee	Medi-Cal
Revised	08/06/2020	AA.1219a	Member Advisory Committee	Medi-Cal
Revised	02/01/2022	AA.1219a	Member Advisory Committee	Medi-Cal
Revised	TBD	AA.1219a	Member Advisory Committee	Medi-Cal

IX. GLOSSARY

Term	Definition
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.
Member Advisory Committee (MAC)	A committee comprised of community advocates and Members, each of whom represents a constituency served by CalOptima Health, which was established by CalOptima Health to advise its Board of Directors on issues impacting Members.
Threshold Language	Those languages identified based upon State requirements and/or findings of the Population Needs Assessment (PNA).

Policy:	AA.1219a
Title:	**Member Advisory Committee**
Department:	Customer Service
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	02/14/1995
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy describes the composition and role of CalOptima Health's Member Advisory Committee (MAC) and to establish a process for recruiting, evaluating, and selecting prospective candidates to CalOptima Health's MAC.

II. POLICY

A. As directed by CalOptima Health's Board of Directors (CalOptima Health Board), MAC shall report to the CalOptima Health Board and shall provide advice and recommendations to the CalOptima Health Board relative to CalOptima Health's programs.

B. CalOptima Health's Board encourages Member involvement in the CalOptima Health program.

C. MAC members shall recuse themselves from voting or from decisions where a conflict of interest may exist and shall abide by CalOptima Health's conflict of interest code and, CalOptima Health Policy AA.1204: Gifts, Honoraria, and Travel Payments.

D. The composition of MAC shall reflect the diversity of the health care consumer. All MAC members shall have direct or indirect contact with CalOptima Health Members.

E. An organization may have no more than one (1) employee or representative on the MAC at any one time.

F. An individual may participate in no more than one (1) CalOptima Advisory Committee at any one time.

G. In accordance with CalOptima Health Board Resolution Numbers 2-14-95 (effective February 14, 1995) and 11-1103 (effective November 3, 2011), MAC shall be comprised of fifteen (15) voting members, each seat representing a constituency served by CalOptima Health.

1. One (1) of the fifteen (15) positions is a standing seat and is held by the Social Services Agency (SSA).

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2. The remaining fourteen (14) members shall serve staggered terms of three (3) years.

   a. One (1) of the remaining fourteen (14) positions shall be a dedicated Consumer seat.

   b. Two (2) of the fourteen (14) positions shall be dedicated OneCare Member or Authorized Family Member seats.

   a. The three (3) year term shall coincide with CalOptima Health's fiscal year (i.e., July 1 through June 30).

   b. Effective July 1, 2023, staggered nominations shall occur at a rate of approximately one-third (1/3) of the membership each year.

   c. MAC Members may serve no more than two (2) consecutive terms or the equivalent of six (6) consecutive years.

   d. MAC Members shall be allowed to reapply after a hiatus of six (6) years.

3. MAC may include, but is not limited to, individuals representing, or that represent the interests of:

   a. Adult beneficiaries;

   b. Behavioral/Mental Health;

   c. Children;

   d. Consumer;

   e. Family Support Representative;

   f. Foster children;

   g. Medi-Cal beneficiaries;

   h. Member Advocate;

   i. OneCare Member/Family Member;

   j. OneCare Member/Family Member;

   k. Orange County SSA;

   l. Persons with disabilities;

   m. Persons with Special Needs;

   n. Recipients of CalWORKs; or

   o. Seniors.

H. Stipends

1. CalOptima Health may provide a reasonable per diem payment of up to $50 per meeting to a Member or family representative serving on the MAC. CalOptima Health shall maintain a log of each payment provided to the Member or family representative, including type and value, and shall provide such log to DHCS upon request.

2. Representatives of provider organizations, community-based organizations and consumer advocates are not eligible for stipends.

I. The MAC shall conduct a nomination process to recruit potential candidates for the impending vacant seats, in accordance with this policy.

1. The MAC shall conduct an annual recruitment and nomination process.

a. At the end of each fiscal year, approximately one-third (1/3) of the MAC seats' terms expire, alternating between six (6) vacancies, one (1) year and four (4) vacancies each of the following two (2) years. The standing seat on the MAC is not impacted by term expiration.

2. The MAC shall conduct a recruitment and nomination process if a seat is vacated mid-term.

a. Candidates that fill a vacated seat mid-term shall complete the term for that specific seat, which will be less than a full three (3) year term.

J. Special Elections

1. Special elections for MAC shall occur under the following circumstances:

a. When a MAC seat is vacant due to the resignation of a sitting MAC member; or

b. The current MAC member is deemed unqualified to serve in his or her current capacity as a MAC member.

2. Any new MAC member appointed to fill an open seat created mid-term shall serve the remainder of the resigning member's term.

K. MAC Vacancies

1. If a vacancy occurs prior to the start of the nomination process, there shall be no need for a special election and the vacant seat shall be filled during that nomination process.

2. If a vacancy occurs after the annual nomination process is complete, a special election may be conducted to fill the open seat, subject to approval by the MAC.

L. On a bi-annual basis, MAC shall select a chair and vice chair from its membership to coincide with the annual recruitment and nomination process. Recruitment and selection shall be conducted in accordance with Section III.C-E of this policy.

1. The MAC chair and vice chair may serve one (1) two (2) year term.

2. The MAC chairperson or vice chair may be removed by a majority vote from CalOptima Health's Board.

M. To establish a nomination ad hoc subcommittee, the MAC chair or vice chair shall ask for three (3) to four (4) members to serve on the ad hoc subcommittee. MAC members, who are being considered for reappointment, cannot participate in the nomination ad hoc subcommittee.

1. The MAC nomination ad hoc subcommittee shall:

a. Review, evaluate, and select a prospective chair, vice chair and a candidate for each of the open seats, in accordance with Section III.C-E of this policy; and

b. Forward the prospective chair, vice chair and slate of candidate(s) to the full MAC for consideration.

2. Following approval from the MAC, the recommended chair, vice chair and slate of candidate(s) shall be forwarded to CalOptima Health's Board for review and approval.

N. CalOptima Health's Board shall review and have final approval for all appointments, reappointments, and chair and vice chair appointments to the MAC.

O. MAC members shall attend all regularly scheduled meetings, unless they have an excused absence. An absence shall be considered excused if a MAC member provides notification of an absence to CalOptima Health staff prior to the MAC meeting. CalOptima Health staff shall maintain an attendance log of the MAC members' attendance at MAC meetings. Upon request from the MAC chair, the vice chair, the Chief Executive Officer, or the CalOptima Health Board, CalOptima Health staff shall provide a copy of the attendance log to the requester. In addition, the MAC chair or vice chair shall contact any committee member who has three consecutive unexcused absences.

1. MAC members' attendance shall be considered as a criterion upon reapplication.

III. PROCEDURE

A. MAC composition

1. The composition of MAC shall reflect the cultural diversity and special needs of the CalOptima Health population.

2. Specific agency representatives shall serve on the MAC as standing members.

a. The SSA representative shall serve as a standing member and shall not be subject to reapplying.

B. MAC meeting frequency

1. The MAC shall meet at least quarterly.

2. The MAC shall adopt a yearly meeting schedule at the first regularly scheduled meeting in or after January of each year.

3. Attendance by a simple majority of appointed members shall constitute a quorum.

a. A quorum must be present for any votes to be valid.

C. MAC recruitment process

1. CalOptima Health shall begin recruitment of potential candidates in February of each year. In the recruitment of potential candidates, the ethnic and cultural diversity and special needs of the CalOptima Health population shall be considered. Nominations and input from interest groups and agencies shall be given due consideration.

2. CalOptima Health shall recruit potential candidates utilizing a variety of notification methods, which may include, but are not limited to, the following:

    a. Outreach to the respective Member community;

    b. Placement of vacancy notices on the CalOptima Health Website

3. Prospective candidates shall be notified at the time of recruitment regarding the deadline to submit their application to CalOptima Health.

4. During the MAC meeting held before June 30 of a recruitment year for the chair and vice chair, the current chair or vice-chair shall inquire of its membership whether there are interested candidates who wish to be considered as a chair or vice-chair for the upcoming fiscal year. The candidates are requested to submit a letter of interest for these positions.

D. CalOptima Health shall conduct a special election with a truncated recruitment process to fill a MAC seat that has been vacated mid-term.

E. MAC nomination process

1. The MAC chair or vice chair shall request three (3) to four (4) members, who are not being considered for reappointment, to serve on the nomination ad hoc subcommittee.

    a. At the discretion of the MAC nomination ad hoc subcommittee, a subject matter expert (SME) may be included on the subcommittee to provide consultation and advisement.

2. Prior to the MAC nomination ad hoc subcommittee meeting:

    a. Ad hoc subcommittee members shall individually evaluate and score the application for each of the prospective candidates using the Applicant Evaluation Tool.

    b. Ad hoc subcommittee members shall individually evaluate and select a chair and vice chair.

    c. At the discretion of the ad hoc subcommittee, subcommittee members may contact a prospective candidate's references for additional information and background validation.

3. The ad hoc subcommittee shall convene to discuss and select a candidate for each of the expiring seats by using the findings from the Applicant Evaluation Tool, the attendance record if relevant, and the prospective candidate's references.

F. MAC selection and approval process for prospective chair, vice chair and MAC candidates

1. Upon selection of a recommendation for a slate of candidates, the ad hoc subcommittee shall forward its recommendation to the MAC for consideration.

2. Following consideration, the MAC's recommendation for a slate of candidates shall be submitted to CalOptima Health's Board for review and final approval.

3. Chair and vice chair candidates who submitted a letter of interest will be reviewed at the first MAC meeting of the fiscal year and the members will vote on their candidate of choice for both positions. Candidates must have a quorum of members approving their recommendation in order to be submitted to CalOptima Health's Board for appointment.

4. Following CalOptima Health's Board approval of MAC's recommendation, the new MAC members' terms shall be effective July 1.

   a. In the case of a selected candidate filling a seat that was vacated mid-term, the new candidate shall attend the immediately following MAC meeting.

4. CalOptima Health shall provide new MAC members with a new member orientation.

IV. ATTACHMENT(S)

A. Member Advisory Committee - Consumer Application
B. Member Advisory Committee - Community Application
C. Member Advisory Committee - Applicant Evaluation Tool
D. Member Advisory Committee - Seat Descriptions

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Policy AA.1204: Gifts, Honoraria, and Travel Payments
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E. CalOptima Board Resolution 11-1103
F. CalOptima Board Resolution 13-0307
G. CalOptima Board Resolution 15-08-06-02
H. CalOptima Board Resolution 16-08-04-02

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
09/15/2014	Department of Health Care Services (DHCS)	Approved as Submitted
08/11/2017	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
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08/06/2015	Regular Meeting of the CalOptima Board of Directors
08/04/2016	Regular Meeting of the CalOptima Board of Directors

06/01/2017	Regular Meeting of the CalOptima Board of Directors
05/07/2020	Regular Meeting of the CalOptima Board of Directors
08/06/2020	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	02/14/1995	AA.1219	MAC and PAC	Medi-Cal
Revised	07/07/2006	AA.1219	MAC and PAC	Medi-Cal
Revised	12/01/2011	AA.1219	MAC and PAC	Medi-Cal
Revised	12/01/2013	AA.1219	MAC and PAC	Medi-Cal
Revised	07/01/2015	AA.1219a	Member Advisory Committee	Medi-Cal
Revised	08/04/2016	AA.1219a	Member Advisory Committee	Medi-Cal
Revised	07/01/2017	AA.1219a	Member Advisory Committee	Medi-Cal
Revised	03/01/2020	AA.1219a	Member Advisory Committee	Medi-Cal
Revised	08/06/2020	AA.1219a	Member Advisory Committee	Medi-Cal
Revised	02/01/2022	AA.1219a	Member Advisory Committee	Medi-Cal
Revised	TBD	AA.1219a	Member Advisory Committee	Medi-Cal

IX. GLOSSARY

Term	Definition
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.
Member Advisory Committee (MAC)	A committee comprised of community advocates and Members, each of whom represents a constituency served by CalOptima Health, which was established by CalOptima Health to advise its Board of Directors on issues impacting Members.
Threshold Language	Those languages identified based upon State requirements and/or findings of the Population Needs Assessment (PNA).

MEMBER ADVISORY COMMITTEE
CalOptima Health Member Application

Instructions: Please answer all questions. You may write or type your answers. If you have any questions regarding the application, call 1-714-347-5785.

Name: _____ Phone: _____

Address: _____ Cell: _____

City, State, ZIP: _____ Fax: _____

Email: _____

I hereby submit my application for the following Member Advisory Committee (MAC) seat, and I understand that service on the MAC is on a voluntary basis:

- ☐ **Consumer representative**
- ☐ **Medi-Cal beneficiaries representative**
- ☐ **OneCare member or family member representative**

Current position (e.g., title, student, volunteer, retired, etc.):_____

_____

1a. What is your direct or indirect experience working with the CalOptima Health population you wish to represent on the MAC?

_____

_____

_____

1b. Include any relevant community experience.

_____

_____

_____

2a. What is your understanding of and familiarity with the diverse cultural and/or special needs populations in Orange County?

_____

_____

_____

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2b. Include relevant experience related to working with diverse populations.

3. What is your current understanding of managed care systems and/or CalOptima Health?

4a. Please explain why you wish to serve on CalOptima Health's MAC.

4b. Please explain why you would be a qualified representative to serve on the MAC.

5. Please specify which of CalOptima Health's threshold languages you speak fluently:

☐ English ☐ Spanish ☐ Vietnamese ☐ Farsi ☐ Korean ☐ Chinese ☐ Arabic

6. If selected, are you able to commit to a monthly MAC meeting as well as serve on at least one subcommittee? ☐ Yes ☐ No

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7. References (professional, community or personal):

Name: _____	Name: _____
Relationship: _____	Relationship: _____
Address: _____	Address: _____
City, State, ZIP: _____	City, State, ZIP: _____
Phone: _____	Phone: _____
Email: _____	Email: _____

Do you agree that you will advocate on behalf of all CalOptima Health members and/or providers during your service on the MAC? ☐ Yes ☐ No

If selected as a representative on MAC, do you agree that you will complete the required annual compliance courses within the appointed time frame? ☐ Yes ☐ No

PUBLIC RECORDS ACT NOTICE

Under California law, this form, the information it contains and any further information submitted with it, such as biographical summaries and resumes, are public records, with the exception of your address, email address and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the board materials that are available on CalOptima Health's website and, even if not presented to the Board, will be available on request to members of the public.

_____ _____

Signature **Date**

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LIMITED PRIVACY WAIVER

Under state and federal law, the fact that a person is eligible for Medi-Cal is a private matter that may only be disclosed by CalOptima Health as necessary to administer the Medi-Cal program, unless other disclosures are authorized by the eligible member. Because the position of Consumer Representative on the Member Advisory Committee requires that the person appointed must be a member, the member's Medi-Cal eligibility will be disclosed to the general public. The member should check the box below and sign this waiver to allow his or her name to be nominated for the advisory committee.

☐ **MEMBER APPLICANT**

I understand that by signing below and applying to serve on the MAC, I am disclosing my eligibility for the Medi-Cal program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.

_____

Member (Printed Name)

_____ _____

Member (Signature) Date

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AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Federal HIPAA Privacy Regulations require that you complete this form to authorize CalOptima Health to use or disclose your protected health information (PHI) to another person or organization. Please complete, sign and return the form to CalOptima Health.

Date of Request: _____ Phone: _____

Member Name: _____ Member CIN: _____

AUTHORIZATION:

I, _____, hereby authorize CalOptima Health, to use or disclose my health information as described below.

Describe the health information that will be used or disclosed under this authorization (please be specific):

Medi-Cal beneficiary status and any information member chooses to disclose in connection with his or her application for appointment to the CalOptima Health Member Advisory Committee (MAC).

Person or organization authorized to receive the health information: **General public**

Describe each purpose of the requested use or disclosure (please be specific): **To allow service as beneficiary representative on the CalOptima Health Member Advisory Committee (MAC).**

EXPIRATION DATE:

This authorization shall become effective immediately and shall expire on: **The end of the term of the applied-for position.**

Right to Revoke: I understand that I have the right to revoke this authorization in writing at any time. To revoke this authorization, I understand that I must make my request in writing and clearly state that I am revoking this specific authorization. In addition, I must sign my request and then mail or deliver my request to:

Cheryl Simmons
CalOptima Health
505 City Parkway West
Orange, CA 92868

I understand that a revocation will not affect the ability of CalOptima Health or any health care provider to use or disclose the health information to the extent that it has acted in reliance on this authorization.

*** Revocation of this authorization will immediately terminate involvement in the MAC.*

RESTRICTIONS:

I understand that certain information (e.g. Medi-Cal beneficiary status and name) used or disclosed as a result of my signing this authorization may be further used or disclosed in accordance with the California Public Records Act. Information precluded from the Public Records Act maintained by CalOptima Health will not be used or

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disclosed unless another authorization is obtained from me or unless such use or disclosure is specifically permitted or required by law.

MEMBER RIGHTS:

- I understand that I must receive a copy of this authorization.
- I understand that I may receive additional copies of the authorization.
- I understand that I may refuse to sign this authorization.
- I understand that I may withdraw this authorization at any time.
- I understand that neither treatment nor payment will be dependent upon my refusing or agreeing to sign this authorization.

SIGNATURE:

By signing below, I acknowledge receiving a copy of this authorization.

Member Signature: _____ Date: _____

Submit the completed application, your biography or resume, and signed authorization forms to:

CalOptima Health
505 City Parkway West
Orange, CA 92868
Attn: Cheryl Simmons

For questions, call **1-714-347-5785**

MEMBER ADVISORY COMMITTEE APPLICATION

Instructions: Please answer all questions. You may write or type your answers. Please use a separate sheet if necessary. If you have any questions regarding the application, please call Cheryl Simmons at 714-347-5785.

Name: _____ Work Phone: _____

Address: _____ Cell Phone: _____

City, State, ZIP: _____ Fax: _____

Email: _____ Date: _____

I hereby submit my application for the following Member Advisory Committee (MAC) seat(s), and I understand that service on the MAC is on a voluntary basis:

- ☐ **Adult Beneficiaries Representative**
- ☐ **CalWORKs Representative**
- ☐ **Family Support Representative**
- ☐ **Persons with Disabilities Representative**
- ☐ **Seniors Representative**

Current position and tenure (i.e., employee, student, volunteer, retired, agency).

_____

_____

_____

Education and/or licenses (if applicable):

_____

_____

_____

_____

_____

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What is your direct or indirect experience working with the CalOptima Health population you wish to represent on MAC? Please include any relevant community experience.

Explain your ability and specific plan to reach out for input and communicate with the CalOptima Health population you would represent on the MAC (i.e., primary professional/trade association(s), stakeholder involvement, etc.)

Please list similar committees on which you have served or describe your ability to collaborate in a multidisciplinary way.

What is your understanding, experience, and familiarity with the diverse cultural community in Orange County?

What is your current understanding and experience with CalOptima Health programs?

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Please explain why you wish to serve on the MAC and how you might uniquely contribute to this advisory committee on behalf of all CalOptima Health members.

Please specify which of CalOptima Health's threshold languages you speak fluently:

☐ English ☐ Spanish ☐ Vietnamese ☐ Farsi ☐ Korean ☐ Chinese ☐ Arabic

Include a biography or résumé and two references (below) with this application. **Submitting letters of recommendation from your references is preferred but not required.**

1) Professional
2) Community or Personal

Name: _____

Relationship: _____

Address: _____

City, State, ZIP: _____

Phone: _____

Email: _____

Name: _____

Relationship: _____

Address: _____

City, State, ZIP: _____

Phone: _____

Email: _____

If selected, are you able to commit to attend all regularly scheduled bi-monthly MAC meetings and volunteer to serve on at least one subcommittee? ☐ Yes ☐ No

Do you agree that you will advocate on behalf of all CalOptima Health members and/or providers during your service on the MAC? ☐ Yes ☐ No

If selected as a representative on MAC, do you agree that you will complete the required annual compliance courses within the appointed time frame? ☐ Yes ☐ No

All Member Advisory Committee Representatives are appointed by the CalOptima Health Board of Directors and are subject to the CalOptima Health Code of Conduct.

Public Records Act Notice

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Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published with the contact information removed, as part of the Board materials that are available on CalOptima Health's website, and even if not presented to the Board, will be available on request to members of the public.

Signature **Date**

Submit this application, along with a biography or résumé and the preferred but optional letters of recommendation to:

CalOptima Health
505 City Parkway West
Orange, CA 92868
Attn: Cheryl Simmons

Phone: **714-347-5785** Fax: **714-571-2479** Email: csimmons@caloptima.org

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Attachment C

Applicant Name:

Member Advisory Committee

Position Applying for:

Applicant Evaluation Tool (use one per applicant)

Please rate questions 1 through 5 based on how well the applicant satisfies the following statements where:
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1a. Direct or indirect experience working with members the applicant wishes to represent	1–5	
1b. Include relevant community involvement	1–5	
2a. Understanding of and familiarity with the diverse cultural and/or special needs populations in Orange County	1–5	
2b. Include relevant experience with diverse populations	1–5	
3. Knowledge of managed care systems and/or CalOptima Health programs	1–5	
4a. Expressed desire to serve on the MAC	1–5	
4b. Explanation why applicant is a qualified representative	1–5	
5. Ability to speak one of the threshold languages (other than English)	Yes/No	
6. Availability and willingness to attend meetings	Yes/No	
7. Supportive references	Yes/No	

Total Possible Points 35

_____

Name of MAC Evaluator

Total Points Awarded _____

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2022 MAC Position Description

Adult Beneficiaries Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima Health adult members in pursuit of their health and wellness
- At least three years of employment in the field and/or three years of experience in field or "is a member with lived-experience"
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of CalOptima Health managed care systems and programs
- Minimum three years of experience directly representing CalOptima Health members
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc MAC meetings
- All appointments to the committee will be appointed by the CalOptima Health Board and are subject to OIG/GSA verification and possible background checks

Behavioral/Mental Health Representative (Formerly Persons with Mental Illness Representative)

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima Health members with behavioral/mental health needs such as:
  - Licensed Clinical Social Worker (LCSW)
  - Marriage and Family Therapist (MFT)
  - Mental Health Facility or Hospital Psychiatric Facility
  - Psychologists
  - Psychiatrist
  - Registered Psychiatric Nurse (Psych RN)
  - Multi-Specialty Clinics/Group Practice
  - Community Mental Health Center
  - Board Certified Behavior Analyst-D (BCBA-D)
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of CalOptima Health managed care systems and programs
- Minimum three years of experience directly representing CalOptima Health members
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc MAC meetings
- All appointments to the committee will be appointed by the CalOptima Health Board and are subject to OIG/GSA verification and possible background checks

Children Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima Health Medi-Cal children in pursuit of their health and wellness
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of CalOptima Health managed care systems and programs
- Minimum three years of experience directly representing CalOptima Health members
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc MAC meetings
- All appointments to the committee will be appointed by the CalOptima Health Board and are subject to OIG/GSA verification and possible background checks

Consumer Representative

Position Description

- Must be a current CalOptima Health Medi-Cal member
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc MAC meetings
- All appointments to the committee will be appointed by the CalOptima Health Board and are subject to OIG/GSA verification and possible background checks

Family Support Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima Health families in pursuit of their health and wellness
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of CalOptima Health managed care systems and programs
- Minimum three years of experience directly representing CalOptima Health members
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc MAC meetings
- All appointments to the committee will be appointed by the CalOptima Health Board and are subject to OIG/GSA verification and possible background checks

Foster Children Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima Health foster children in pursuit of their health and wellness
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of CalOptima Health managed care systems and programs
- Minimum three years of experience representing CalOptima Health members directly
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc MAC meetings
- All appointments to the committee will be appointed by the CalOptima Health Board and are subject to OIG/GSA verification and possible background checks

Member Advocate Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima Health members in pursuit of their health and wellness
- When license or credential is required, applicant must have an active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of CalOptima Health managed care systems and programs
- Minimum three years of experience directly representing CalOptima Health's Members
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc MAC meetings
- All appointments to the committee will be appointed by the CalOptima Health Board and are subject to OIG/GSA verification and possible background checks

Medi-Cal Beneficiaries Representative

Position Description

- Current CalOptima Health Medi-Cal member or current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima Health Medi-Cal beneficiaries
- When license or credential is required, applicant must have an active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of CalOptima Health managed care systems and programs
- Minimum three years of experience directly representing CalOptima Health Medi-Cal members
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County

- Availability and willingness to attend regular, special and ad hoc MAC meetings
- All appointments to the committee will be appointed by the CalOptima Health Board and are subject to OIG/GSA verification and possible background checks

OneCare Member or Authorized Family Member Representative

Position Description

- Must be a current CalOptima Health OneCare member or authorized family member
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc MAC meetings
- All appointments to the committee will be appointed by the CalOptima Health Board and are subject to OIG/GSA verification and possible background checks

Persons with Disabilities Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima Health persons with disabilities in pursuit of their health and wellness
- Candidate should represent an organization that does advocacy work on behalf of persons with disabilities with either direct medical or non-medical services for Medi-Cal members of all ages
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s) and local chapters.
- Knowledge of CalOptima Health managed care systems and programs
- Minimum three years of experience directly representing CalOptima Health members
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc MAC meetings
- All appointments to the committee will be appointed by the CalOptima Health Board and are subject to OIG/GSA verification and possible background checks

Persons with Special Needs Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima Health persons with special needs in pursuit of their health and wellness
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of CalOptima Health managed care systems and programs
- Minimum three years of experience directly representing CalOptima Health members
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County

- Availability and willingness to attend regular, special and ad hoc MAC meetings
- All appointments to the committee will be appointed by the CalOptima Health Board and are subject to OIG/GSA verification and possible background checks

Recipients of CalWORKs Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima Health CalWORKs members in pursuit of their health and wellness
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Knowledge of CalOptima Health managed care systems and programs
- Minimum three years of experience as a CalWORKs recipient or representative
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc MAC meetings and actively contribute
- All appointments to the committee will be appointed by the CalOptima Health Board and are subject to OIG/GSA verification and possible background checks

Seniors Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input, and advocate for CalOptima Health seniors including, but not limited to:
  - Community Based Adult Services (CBAS) Centers
  - Community-Based Organization (CBO)
  - Senior centers
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Knowledge of CalOptima Health managed care systems and programs
- Minimum three years of experience directly representing CalOptima Health members
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc MAC meetings and actively contribute
- All appointments to the committee will be appointed by the CalOptima Health Board and are subject to OIG/GSA verification and possible background checks

Social Services Representative (Standing Seat)

Position Description

- Represents CalOptima Health members and is appointed by the Orange County Social Services Agency
- No term limits
- Must have understanding and familiarity with the diverse cultural and/or social environments of Orange County

- Availability and willingness to attend regular, special and ad hoc MAC meetings
- All appointments to the committee will be appointed by the CalOptima Health Board and are subject to OIG/GSA verification and possible background checks

MAC Chair

Position Description

- Availability and willingness to attend regular and special MAC meetings
- Facilitate all MAC meetings using standard meeting rules of order
- Demonstrate leadership and openness, enabling meeting attendees to achieve preset meeting goals
- Liaison between MAC and the Board of Directors
- Provides MAC Report to CalOptima Health Board of Directors' monthly meetings
- Two-year term
- All appointments to the committee will be appointed by the CalOptima Health Board and are subject to OIG/GSA verification and possible background checks

MAC Vice-Chair

Position Description

- Availability and willingness to attend regular and special MAC meetings
- Facilitate in absence of the MAC Chair all MAC meetings using standard meeting rules of order
- Demonstrate leadership and openness, enabling meeting attendees to achieve preset meeting goals
- Liaison in absence of the MAC Chair between MAC and the Board of Directors
- Provide MAC Report to CalOptima Health Board of Directors' at monthly meetings when MAC Chair is unavailable
- Two-year term
- All appointments to the committee will be appointed by the CalOptima Health Board and are subject to OIG/GSA verification and possible background checks

Policy:	AA.1219b
Title:	**Provider Advisory Committee**
Department:	Network Operations
Section:	Provider Relations
CEO Approval:	*/s/*
Effective Date:	07/01/2015
Revised Date:	12/31/2022
Applicable to:	☒ Medi-Cal ☒ OneCare ~~☒ OneCare Connect~~ ☒ PACE ☐ Administrative

I. PURPOSE

This policy describes the composition and role of ~~CalOptima's~~CalOptima Health's Provider Advisory Committee (PAC) and establishes a process for recruiting, evaluating, and selecting prospective candidates to ~~CalOptima's~~CalOptima Health's PAC.

II. POLICY

A. As directed by ~~CalOptima's~~CalOptima Health's Board of Directors (CalOptima Health Board), PAC shall report to the CalOptima Health Board and shall provide advice and recommendations to the CalOptima Health Board relative to ~~CalOptima's~~CalOptima Health's programs.

B. ~~CalOptima's~~CalOptima Health's Board encourages Provider involvement in the CalOptima Health program.

C. PAC Members shall recuse themselves from voting or from decisions where a conflict of interest may exist and shall abide by ~~CalOptima's~~CalOptima Health's conflict of interest code and, in accordance with CalOptima Health Policy AA.1204: Gifts, Honoraria, and Travel Payments.

D. The composition of PAC shall reflect the diversity of the healthcare Provider community. All PAC Members shall have direct or indirect contact with CalOptima Health Members.

E. An organization may have no more than one (1) employee or representative on the PAC at any one time.

F. An individual may participate in no more than one (1) CalOptima Advisory Committee at any one time.

~~E.~~G. In accordance with CalOptima Health Board Resolution Numbers 2-14-95 (effective February 14, 1995), 06-0707 (effective July 7, 2006), and 15-0806-02 (effective July 1, 2015), PAC shall be comprised of fifteen (15) voting Members, each seat representing a constituency that works with CalOptima Health and its Members.

1. One (1) of the fifteen (15) positions is a standing seat represented by the Orange County Health Care Agency (HCA).

2. The remaining fourteen (14) Members shall serve staggered terms of three (3) years.

   a. The three (3) year term shall coincide with ~~CalOptima's~~CalOptima Health's fiscal year (i.e., July 1st through June 30th).

   b. Effective July 1, 2015, staggered nominations shall occur at a rate of approximately one-third (1/3) of the membership each year.

      i. In order to achieve the staggered rate of one-third (1/3) each year, effective upon the completion date of the current term for the remaining eleven (11) PAC seats. The length of a term for the Allied Health Services seat, Health Network seat and Nurse seat will extend from a two (2)-year term to a three (3)-year term.

   c. PAC Members may serve no more than two (2) consecutive terms or the equivalent of six (6) consecutive years ~~in the category of membership they hold~~.

   d. PAC Members shall be allowed to reapply after a hiatus of ~~one (1) year~~six (6) years.

      ~~i. PAC Members may submit an application for a different category of membership without a hiatus, if they qualify for the new category for which they are applying.~~

      ~~ii. In the event that a vacancy occurs, in which there are no qualified applicants, PAC shall approach the current incumbent to serve one (1) additional term.~~

      ~~iii. If the incumbent chooses not to serve, a special election shall be conducted, in accordance with this policy.~~

3. PAC may include, but is not limited to, individuals representing, or that represent the interest of:

   a. Allied Health Services Providers (two (2) seats);

   b. Behavioral/Mental health Providers;

   c. Community Health Centers;

   d. Health Networks;

   e. Hospitals;

   f. Long Term Services and Supports;

   g. Nurses;

   h. Non-Physician Medical Practitioners;

   i. Orange County HCA;

   j. Physicians (three seats);

   k. Pharmacists; or

   l. Safety Net Providers.

~~F.~~H. PAC shall conduct a nomination process to recruit potential candidates for the impending vacant seats, in accordance with this policy.

1. PAC shall conduct an annual recruitment and nomination process.

    a. At the end of each fiscal year, approximately one-third (1/3) of the seat terms expire on PAC, alternating between six (6) vacancies one (1) year and four (4) vacancies each of the following two (2) years. Standing seat in PAC is not impacted by term expiration.

2. PAC shall conduct a recruitment and nomination process if a seat is vacated mid-term.

    a. Candidates that fill a vacated set mid-term shall complete the term for that specific seat, which will be less than a full three (3) year term for PAC.

~~G.~~I. Special Elections for PAC

1. Special elections for PAC shall occur under the following circumstances:

    a. When a PAC seat is vacant due to the resignation of a sitting PAC Member; or

    b. The current PAC Member is deemed unqualified to serve in his or her current capacity as a PAC Member;

2. Any new Member appointed to fill an open seat created mid-term shall serve the remainder of the resigning Member's term.

~~H.~~J. PAC Vacancies

1. If the vacancy occurs prior to the start of the nomination process, there shall be no need for a special election, and the vacant seat shall be filled during that nomination process.

2. If the vacancy occurs after the annual nomination process is complete then a special election may be conducted to fill the open seat, subject to approval by the PAC.

~~I.~~K. On a bi-annual basis, PAC shall select a chair and vice-chair from its membership to coincide with the annual recruitment and nomination process. Recruitment and selection shall be conducted in accordance with Section III.C-G of this policy.

1. The PAC chair and vice-chair may serve one (1) two (2) year term.

2. The PAC chair and vice-chair may be removed by a majority vote from ~~CalOptima's~~CalOptima Health's Board.

~~J.~~L. To establish a nomination ad hoc subcommittee, PAC chair shall ask for three (3) to four (4) Members to serve the ad hoc subcommittee. PAC Members, who are being considered for reappointment, cannot participate in their respective nomination ad hoc subcommittee.

1. Each PAC nomination ad hoc subcommittee shall:

    a. Review, evaluate, and select a prospective chair and vice-chair as well as a candidate for each of the open seats, in accordance with Section III. C-G of this policy; and

b. Forward the prospective chair's and vice-chair's name and slate of candidate(s) to the full advisory committee for review and approval.

2. Following approval from the full PAC, the recommended chair and vice chair as well as the slate of candidate(s) shall be forwarded to ~~CalOptima's~~CalOptima Health's Board for review and approval.

~~K.~~M. ~~CalOptima's~~CalOptima Health's Board shall review and have final approval for all appointments, reappointments, and chair appointments to PAC.

~~L.~~N. PAC Members shall attend all regularly scheduled meetings~~,~~ unless they have an excused absence. An absence shall be considered excused if a PAC Member provides notification of an absence to CalOptima Health staff prior to the PAC meeting. CalOptima Health staff shall maintain an attendance log of the PAC Members' attendance at PAC meetings. Upon request from the PAC chair, the Chief Executive Officer, or the CalOptima Health Board, CalOptima Health staff shall provide a copy of the attendance log to the requester. In addition, the chair of the PAC shall contact any committee Member who has three consecutive unexcused absences.

1. PAC Members' attendance shall be considered as a criterion upon reappointment.

III. PROCEDURE

A. PAC composition

1. The composition of PAC shall reflect the cultural diversity and special needs of the CalOptima Health population.

2. Specific agency representatives shall serve on the advisory committee as standing Members.

a. The PAC shall include the Director (or his or her designee) of the HCA.

b. HCA representative shall serve as a standing Member and shall not be subject to reapplying.

B. PAC meeting frequency

1. PAC shall meet at least quarterly.

2. PAC shall adopt a yearly meeting schedule at the first regularly scheduled meeting in or after January of each year.

3. Attendance by a simple majority of appointed Members shall constitute a quorum.

a. A quorum must be present for any votes to be valid, and a quorum consists of half (1/2) total membership plus one.

C. PAC recruitment process

1. CalOptima Health shall begin recruitment of potential candidates in ~~March~~ February of each year. In the recruitment of potential candidates, the ethnic and cultural diversity and special needs of the CalOptima Health population shall be considered. Nominations and input from interest groups and agencies shall be given due consideration.

2. CalOptima Health shall recruit for potential candidates utilizing a variety of notification methods, which may include, but are not limited to, the following:

   a. Outreach to the respective Provider ~~community~~and Stakeholder communities; and

   b. Placement of vacancy notices on the CalOptima Health website.~~; and~~

   ~~Advertisement of vacancies in local newspapers in Threshold Languages.~~

3. Prospective candidates shall be notified at the time of recruitment regarding the deadline to submit their application to CalOptima Health.

4. During the PAC meeting held ~~in March,~~before June 30 of a recruitment year for the chair and vice chair, the current chair or vice-chair shall inquire of its membership whether there are interested candidates who wish to be considered as a chair or vice-chair for the upcoming fiscal year. ~~An application is not required for the chair or vice-chair nomination.~~The candidates are requested to submit a letter of interest for these positions.

D. PAC nomination process

1. The PAC chair or vice-chair shall request three (3) to four (4) Members, who are not being considered for reappointment, to serve on the nominations ad hoc subcommittee.

   a. At the discretion of the PAC nomination ad hoc subcommittee, a subject matter expert (SME) may be included on the subcommittee to provide consultation and advisement.

2. Prior to the PAC nomination ad hoc subcommittee meeting:

   a. Ad hoc subcommittee Members shall individually evaluate and score the application for each of the prospective candidates using the Application Evaluation Tool.

   b. The ad hoc subcommittee Members shall individually evaluate and select a chair.

3. The ad hoc subcommittee shall convene to discuss and select a candidate for each of the expiring seats by using the findings from the Application Evaluation Tool, the attendance record if relevant, and the prospective candidate's letters of support.

   a. At the discretion of the ad hoc subcommittee, subcommittee Members may contact a prospective candidate's references for additional information and background validation.

E. Term limits and length of term for PAC Members

1. Pursuant to the Board approved Resolution 15-08-06-02, effective July 1, 2015, PAC Members are appointed for three-year terms by the CalOptima Health Board of Directors with two consecutive term limits.

F. CalOptima Health shall conduct a special election with a truncated recruitment and nomination process to fill a PAC seat that has been vacated mid-term.

G. PAC selection and approval process for prospective chairs and candidates

1. Upon selection of a recommendation for ~~a chair and vice chair, as well as~~ the slate of candidates, the ad hoc subcommittee shall forward its recommendation to the PAC for consideration.

2. Following consideration, the PAC's recommendation for ~~a chair and~~the slate of candidates shall be submitted to ~~CalOptima's~~CalOptima Health's Board for review and final approval.

3. Chair and vice chair candidates who submitted a letter of interest will be reviewed at the first PAC meeting of the fiscal year and the members will vote on their candidate of choice for both positions. Candidates must have a quorum of members approving their recommendation in order to be submitted to the Board for appointment.

~~3.~~4. Following ~~CalOptima's~~CalOptima Health's Board approval of PAC's recommendations, the new PAC Members' terms shall be effective July 1.

~~4.~~5. In the case of a selected candidate filling a seat that was vacated mid-term, the new candidate shall attend the immediately following PAC meeting.

~~5.~~6. CalOptima Health shall provide new PAC Members with a new Member orientation.

IV. ATTACHMENT(S)

A. PAC Nomination Position Descriptions
B. PAC Application Evaluation Tool (AET)
C. PAC Application

V. REFERENCE(S)

A. CalOptima Board Resolution 2-14-95
B. CalOptima Board Resolution 06-0707
C. CalOptima Board Resolution 15-0806-02
D. CalOptima Board Resolution 16-0804-02
E. CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments

VI. REGULATORY AGENCY APPROVAL(S)

Not Applicable

VII. BOARD ACTION(S)

Date	Meeting
02/14/1995	Regular Meeting of the CalOptima Board of Directors
07/07/2006	Regular Meeting of the CalOptima Board of Directors
08/06/2015	Regular Meeting of the CalOptima Board of Directors
08/04/2016	Regular Meeting of the CalOptima Board of Directors
03/05/2020	Regular Meeting of the CalOptima Board of Directors
08/06/2020	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	02/14/1995	AA.1219	MAC and PAC	Medi-Cal
Revised	07/07/2006	AA.1219	MAC and PAC	Medi-Cal
Revised	12/01/2011	AA.1219	MAC and PAC	Medi-Cal
Revised	12/01/2013	AA.1219	MAC and PAC	Medi-Cal
Revised	07/01/2015	AA.1219b	Provider Advisory Committee	Medi-Cal OneCare OneCare Connect PACE
Revised	08/04/2016	AA.1219b	Provider Advisory Committee	Medi-Cal OneCare OneCare Connect PACE
Revised	08/01/2017	AA.1219b	Provider Advisory Committee	Medi-Cal OneCare OneCare Connect PACE
Revised	03/05/2020	AA.1219b	Provider Advisory Committee	Medi-Cal OneCare OneCare Connect PACE
Revised	08/06/2020	AA.1219b	Provider Advisory Committee	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022~~TBD~~	AA.1219b	Provider Advisory Committee	Medi-Cal OneCare PACE

IX. GLOSSARY

Term	Definition
Member	~~An enrollee~~ A beneficiary ~~of a~~enrolled in the 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.~~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.
Provider Advisory Committee (PAC)	A committee comprised of Providers, representing a cross-section of the broad Provider community that serves Members, established by CalOptima Health to advise its Board of Directors on issues impacting the CalOptima Health Provider community.
Threshold Language	Medi-Cal: Those languages identified based upon State requirements and/or findings of the Population Needs Assessment (PNA). 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.

Policy:	AA.1219b
Title:	**Provider Advisory Committee**
Department:	Network Operations
Section:	Provider Relations
CEO Approval:	*/s/*
Effective Date:	07/01/2015
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I. PURPOSE

This policy describes the composition and role of CalOptima Health's Provider Advisory Committee (PAC) and establishes a process for recruiting, evaluating, and selecting prospective candidates to CalOptima Health's PAC.

II. POLICY

A. As directed by CalOptima Health's Board of Directors (CalOptima Health Board), PAC shall report to the CalOptima Health Board and shall provide advice and recommendations to the CalOptima Health Board relative to CalOptima Health's programs.

B. CalOptima Health's Board encourages Provider involvement in the CalOptima Health program.

C. PAC Members shall recuse themselves from voting or from decisions where a conflict of interest may exist and shall abide by CalOptima Health's conflict of interest code and, in accordance with CalOptima Health Policy AA.1204: Gifts, Honoraria, and Travel Payments.

D. The composition of PAC shall reflect the diversity of the healthcare Provider community. All PAC Members shall have direct or indirect contact with CalOptima Health Members.

E. An organization may have no more than one (1) employee or representative on the PAC at any one time.

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G. In accordance with CalOptima Health Board Resolution Numbers 2-14-95 (effective February 14, 1995), 06-0707 (effective July 7, 2006), and 15-0806-02 (effective July 1, 2015), PAC shall be comprised of fifteen (15) voting Members, each seat representing a constituency that works with CalOptima Health and its Members.

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2. The remaining fourteen (14) Members shall serve staggered terms of three (3) years.

a. The three (3) year term shall coincide with CalOptima Health's fiscal year (i.e., July 1st through June 30th).

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i. In order to achieve the staggered rate of one-third (1/3) each year, effective upon the completion date of the current term for the remaining eleven (11) PAC seats. The length of a term for the Allied Health Services seat, Health Network seat and Nurse seat will extend from a two (2)-year term to a three (3)-year term.

c. PAC Members may serve no more than two (2) consecutive terms or the equivalent of six (6) consecutive years.

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a. Allied Health Services Providers (two (2) seats);

b. Behavioral/Mental health Providers;

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d. Health Networks;

e. Hospitals;

f. Long Term Services and Supports;

g. Nurses;

h. Non-Physician Medical Practitioners;

i. Orange County HCA;

j. Physicians (three seats);

k. Pharmacists; or

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H. PAC shall conduct a nomination process to recruit potential candidates for the impending vacant seats, in accordance with this policy.

1. PAC shall conduct an annual recruitment and nomination process.

a. At the end of each fiscal year, approximately one-third (1/3) of the seat terms expire on PAC, alternating between six (6) vacancies one (1) year and four (4) vacancies each of the following two (2) years. Standing seat in PAC is not impacted by term expiration.

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a. When a PAC seat is vacant due to the resignation of a sitting PAC Member; or

b. The current PAC Member is deemed unqualified to serve in his or her current capacity as a PAC Member;

2. Any new Member appointed to fill an open seat created mid-term shall serve the remainder of the resigning Member's term.

J. PAC Vacancies

1. If the vacancy occurs prior to the start of the nomination process, there shall be no need for a special election, and the vacant seat shall be filled during that nomination process.

2. If the vacancy occurs after the annual nomination process is complete then a special election may be conducted to fill the open seat, subject to approval by the PAC.

K. On a bi-annual basis, PAC shall select a chair and vice-chair from its membership to coincide with the annual recruitment and nomination process. Recruitment and selection shall be conducted in accordance with Section III.C-G of this policy.

1. The PAC chair and vice-chair may serve one (1) two (2) year term.

2. The PAC chair and vice-chair may be removed by a majority vote from CalOptima Health's Board.

L. To establish a nomination ad hoc subcommittee, PAC chair shall ask for three (3) to four (4) Members to serve the ad hoc subcommittee. PAC Members, who are being considered for reappointment, cannot participate in their respective nomination ad hoc subcommittee.

1. Each PAC nomination ad hoc subcommittee shall:

a. Review, evaluate, and select a prospective chair and vice-chair as well as a candidate for each of the open seats, in accordance with Section III. C-G of this policy; and

b. Forward the prospective chair's and vice-chair's name and slate of candidate(s) to the full advisory committee for review and approval.

2. Following approval from the full PAC, the recommended chair and vice chair as well as the slate of candidate(s) shall be forwarded to CalOptima Health's Board for review and approval.

M. CalOptima Health's Board shall review and have final approval for all appointments, reappointments, and chair appointments to PAC.

N. PAC Members shall attend all regularly scheduled meetings unless they have an excused absence. An absence shall be considered excused if a PAC Member provides notification of an absence to

CalOptima Health staff prior to the PAC meeting. CalOptima Health staff shall maintain an attendance log of the PAC Members' attendance at PAC meetings. Upon request from the PAC chair, the Chief Executive Officer, or the CalOptima Health Board, CalOptima Health staff shall provide a copy of the attendance log to the requester. In addition, the chair of the PAC shall contact any committee Member who has three consecutive unexcused absences.

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III. PROCEDURE

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1. The composition of PAC shall reflect the cultural diversity and special needs of the CalOptima Health population.

2. Specific agency representatives shall serve on the advisory committee as standing Members.

   a. The PAC shall include the Director (or his or her designee) of the HCA.

   b. HCA representative shall serve as a standing Member and shall not be subject to reapplying.

B. PAC meeting frequency

1. PAC shall meet at least quarterly.

2. PAC shall adopt a yearly meeting schedule at the first regularly scheduled meeting in or after January of each year.

3. Attendance by a simple majority of appointed Members shall constitute a quorum.

   a. A quorum must be present for any votes to be valid, and a quorum consists of half (1/2) total membership plus one.

C. PAC recruitment process

1. CalOptima Health shall begin recruitment of potential candidates in February of each year. In the recruitment of potential candidates, the ethnic and cultural diversity and special needs of the CalOptima Health population shall be considered. Nominations and input from interest groups and agencies shall be given due consideration.

2. CalOptima Health shall recruit for potential candidates utilizing a variety of notification methods, which may include, but are not limited to, the following:

   a. Outreach to the respective Provider and Stakeholder communities; and

   b. Placement of vacancy notices on the CalOptima Health website.

3. Prospective candidates shall be notified at the time of recruitment regarding the deadline to submit their application to CalOptima Health.

4. During the PAC meeting held before June 30 of a recruitment year for the chair and vice chair, the current chair or vice-chair shall inquire of its membership whether there are interested

candidates who wish to be considered as a chair or vice-chair for the upcoming fiscal year. The candidates are requested to submit a letter of interest for these positions.

D. PAC nomination process

1. The PAC chair or vice-chair shall request three (3) to four (4) Members, who are not being considered for reappointment, to serve on the nominations ad hoc subcommittee.

    a. At the discretion of the PAC nomination ad hoc subcommittee, a subject matter expert (SME) may be included on the subcommittee to provide consultation and advisement.

2. Prior to the PAC nomination ad hoc subcommittee meeting:

    a. Ad hoc subcommittee Members shall individually evaluate and score the application for each of the prospective candidates using the Application Evaluation Tool.

    b. The ad hoc subcommittee Members shall individually evaluate and select a chair.

3. The ad hoc subcommittee shall convene to discuss and select a candidate for each of the expiring seats by using the findings from the Application Evaluation Tool, the attendance record if relevant, and the prospective candidate's letters of support.

    a. At the discretion of the ad hoc subcommittee, subcommittee Members may contact a prospective candidate's references for additional information and background validation.

E. Term limits and length of term for PAC Members

1. Pursuant to the Board approved Resolution 15-08-06-02, effective July 1, 2015, PAC Members are appointed for three-year terms by the CalOptima Health Board of Directors with two consecutive term limits.

F. CalOptima Health shall conduct a special election with a truncated recruitment and nomination process to fill a PAC seat that has been vacated mid-term.

G. PAC selection and approval process for prospective chairs and candidates

1. Upon selection of a recommendation for the slate of candidates, the ad hoc subcommittee shall forward its recommendation to the PAC for consideration.

2. Following consideration, the PAC's recommendation for the slate of candidates shall be submitted to CalOptima Health's Board for review and final approval.

3. Chair and vice chair candidates who submitted a letter of interest will be reviewed at the first PAC meeting of the fiscal year and the members will vote on their candidate of choice for both positions. Candidates must have a quorum of members approving their recommendation in order to be submitted to the Board for appointment.

4. Following CalOptima Health's Board approval of PAC's recommendations, the new PAC Members' terms shall be effective July 1.

5. In the case of a selected candidate filling a seat that was vacated mid-term, the new candidate shall attend the immediately following PAC meeting.

6. CalOptima Health shall provide new PAC Members with a new Member orientation.

IV. ATTACHMENT(S)

A. PAC Nomination Position Descriptions
B. PAC Application Evaluation Tool (AET)
C. PAC Application

V. REFERENCE(S)

A. CalOptima Board Resolution 2-14-95
B. CalOptima Board Resolution 06-0707
C. CalOptima Board Resolution 15-0806-02
D. CalOptima Board Resolution 16-0804-02
E. CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments

VI. REGULATORY AGENCY APPROVAL(S)

Not Applicable

VII. BOARD ACTION(S)

Date	Meeting
02/14/1995	Regular Meeting of the CalOptima Board of Directors
07/07/2006	Regular Meeting of the CalOptima Board of Directors
08/06/2015	Regular Meeting of the CalOptima Board of Directors
08/04/2016	Regular Meeting of the CalOptima Board of Directors
03/05/2020	Regular Meeting of the CalOptima Board of Directors
08/06/2020	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	02/14/1995	AA.1219	MAC and PAC	Medi-Cal
Revised	07/07/2006	AA.1219	MAC and PAC	Medi-Cal
Revised	12/01/2011	AA.1219	MAC and PAC	Medi-Cal
Revised	12/01/2013	AA.1219	MAC and PAC	Medi-Cal
Revised	07/01/2015	AA.1219b	Provider Advisory Committee	Medi-Cal OneCare OneCare Connect PACE
Revised	08/04/2016	AA.1219b	Provider Advisory Committee	Medi-Cal OneCare OneCare Connect PACE

Action	Date	Policy	Policy Title	Program(s)
Revised	08/01/2017	AA.1219b	Provider Advisory Committee	Medi-Cal OneCare OneCare Connect PACE
Revised	03/05/2020	AA.1219b	Provider Advisory Committee	Medi-Cal OneCare OneCare Connect PACE
Revised	08/06/2020	AA.1219b	Provider Advisory Committee	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	AA.1219b	Provider Advisory Committee	Medi-Cal OneCare PACE

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IX. GLOSSARY

Term	Definition
Member	A beneficiary enrolled in the CalOptima Health program.
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.
Provider Advisory Committee (PAC)	A committee comprised of Providers, representing a cross-section of the broad Provider community that serves Members, established by CalOptima Health to advise its Board of Directors on issues impacting the CalOptima Health Provider community.
Threshold Language	Medi-Cal: Those languages identified based upon State requirements and/or findings of the Population Needs Assessment (PNA). 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.

PAC Position Descriptions

Allied Health Services (two seats)

Position Description

- Current experience collaborating with, and ability to reach out, seek input and represent; independent, non-hospital, non-network allied providers, such as:
  - Ambulatory surgery centers
  - Audiology
  - Certified Acupuncturist
  - Chronic Dialysis Center
  - Dialysis providers
  - Dispensing Opticians
  - DME providers
  - Emergency Transportation
  - Exempt from Licensure Clinics
  - Family planning centers
  - Hearing Aid Dispensers
  - Home health providers
  - Home infusion providers
  - Hospice
  - Laboratory
  - Non-emergency transportation (NEMT) providers
  - Occupational therapists
  - Physical therapists
  - Podiatrists
  - Portable X-ray Lab
  - Prosthetics
  - Psychologists
  - Radiation therapy centers
  - Radiology
  - Rehabilitation Clinics
  - Respiratory Care Practice
  - Speech Therapist
  - Surgery Clinics

- When license or credential is required, applicant must have active CA license/credential as appropriate

- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of managed care systems and CalOptima Health programs
- Minimum three years of experience as a provider for CalOptima Health or representing CalOptima Health providers directly
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc PAC meetings
- All appointments to the committee will be appointed by the CalOptima Health Board and are subject to OIG/GSA verification and possible background checks

Behavioral/Mental Health Provider

Position Description

- Current experience collaborating with, and ability to reach out, seek input and represent providers such as:
  - Licensed Clinical Social Worker (LCSW)
  - Marriage and Family Therapist (MFT)
  - Mental Health Facility
  - Psychologists
  - Psychiatrist
  - Registered Psychiatric Nurse (Psych RN)
  - Multi-Specialty Clinics/Group Practice
  - Community Mental Health Center
  - Board Certified Behavior Analyst-D (BCBA-D)
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of managed care systems and CalOptima Health programs
- Minimum three years of experience as a provider for CalOptima Health or representing CalOptima Health providers directly
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc PAC meetings
- All appointments to the committee will be appointed by the CalOptima Health Board and are subject to OIG/GSA verification and possible background checks

Community Health Centers

Position Description

- Current experience collaborating with, and ability to reach out, seek input and represent Orange County Community Health Centers:
  - Representing a licensed community clinic
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of managed care systems and CalOptima Health programs
- Minimum three years of experience as a provider for CalOptima Health or representing CalOptima Health providers directly
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc PAC meetings
- All appointments to the committee will be appointed by the CalOptima Health Board and are subject to OIG/GSA verification and possible background checks

Health Network

Position Description

- Current experience collaborating with, and ability to reach out, seek input and represent CalOptima Health contracted Health Networks.
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of managed care systems and~~/or~~ CalOptima Health programs
- Minimum three years of experience working directly for a health network
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc PAC meetings
- All appointments to the committee will be appointed by the CalOptima Health Board and are subject to OIG/GSA verification and possible background checks

Hospital

Position Description

- Current experience collaborating with, and ability to reach out, seek input and represent Orange County CalOptima Health contracted Hospitals.
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of managed care systems and CalOptima Health programs
- Minimum three years of experience as a hospital provider for CalOptima Health or representing CalOptima Health hospital providers directly
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc PAC meetings
- All appointments to the committee will be appointed by the CalOptima Health Board and are subject to OIG/GSA verification and possible background checks

Long Term Services and Supports

Position Description

- Current experience collaborating with, and ability to reach out, seek input and represent providers, such as:
  - Intermediate Care Facility – Developmentally Disabled
  - Intermediate Care Facility – Developmentally Disabled – Nursing
  - Intermediate Care Facility -Developmentally Disabled – Habilitative
  - Level B Adult Subacute
  - Level B Pediatric Subacute
  - Level B Skilled Nursing Facility
  - Nursing Facilities – Intermediate Care Facility Level A
  - Skilled Nursing Facilities
  - Skilled Nursing Facilities/Subacute Level B
  - Adult Day Health Care
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of managed care systems and CalOptima Health programs
- Minimum three years of experience as a provider for CalOptima Health or representing CalOptima Health providers directly
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County

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- Availability and willingness to attend regular, special and ad hoc PAC meetings
- All appointments to the committee will be appointed by the CalOptima Health Board and are subject to OIG/GSA verification and possible background checks

Non-Physician Medical Practitioner Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and represent such as: nurse practitioners, nurse midwife, physician assistants, registered psychiatric nurse (Psych RN), chiropractors, dentists, optometrists, and others as appropriate
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Professional Degree (e.g. DC, DDS, DNP MMS, OD) required
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of managed care systems and CalOptima Health programs
- Minimum three years of experience as a provider for CalOptima Health or representing CalOptima Health providers directly
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc PAC meetings
- All appointments to the committee will be appointed by the CalOptima Health Board and are subject to OIG/GSA verification and possible background checks

Nurse Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and represent such as; nurses, nurse Practitioner, nurse midwife, registered nurses, registered psychiatric nurse (Psych RN), nurse anesthetist, advanced practice nurse
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s) and local chapters.
- Knowledge of managed care systems and CalOptima Health programs
- Minimum three years of experience as a provider for CalOptima Health or representing CalOptima Health providers directly
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County

- Availability and willingness to attend regular, special and ad hoc PAC meetings
- All appointments to the committee will be appointed by the CalOptima Health Board and are subject to OIG/GSA verification and possible background checks

Pharmacy Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and represent pharmacies and pharmacy associations
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of managed care systems and CalOptima Health programs
- Minimum three years of experience as a provider for CalOptima Health or representing CalOptima Health providers directly
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc PAC meetings
- All appointments to the committee will be appointed by the CalOptima Health Board and are subject to OIG/GSA verification and possible background checks

Physician Representative (three positions)

Position Description

- Seats will individually be represented by:
  - Adult Primary Care Physician
  - Pediatric Physician
  - Specialist
- Current experience collaborating with, and ability to reach out, seek input, represent and secure input from their physician constituency as well as their community-based physician professional association. When license or credential is required, applicant must have active CA license/credential as appropriate
- Have an active, unrestricted California medical license and board certification as appropriate
- Membership in appropriate medical professional association(s)
- Knowledge of managed care systems and CalOptima Health programs
- Minimum three years of experience as a provider for CalOptima Health
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County

- Familiarity with California and federal health care delivery regulatory requirements and mandates
- Familiarity with provider quality and service requirements and risk adjustment factors
- Availability and willingness to attend regular, special and ad hoc PAC meetings and actively contribute
- All appointments to the committee will be appointed by the CalOptima Health Board and are subject to OIG/GSA verification and possible background checks

Safety Net

Position Description

- Current experience collaborating with, and ability to reach out, seek input and represent safety net providers
  - **Safety-Net Provider** means a provider of comprehensive primary care and/or acute hospital inpatient services that provides these services to a significant total number of Medi-Cal and charity and/or medically indigent patients in relation to the total number of patients served by the provider. Examples of safety net providers include Federally Qualified Health Centers; governmentally operated health systems; community health centers; rural and Indian Health Service facilities; disproportionate share hospitals; and public, university, rural and children's hospitals.
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of managed care systems and CalOptima Health programs
- Minimum three years of experience as a provider for CalOptima Health or representing CalOptima Health providers directly
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc PAC meetings
- All appointments to the committee will be appointed by the CalOptima Health Board and are subject to OIG/GSA verification and possible background checks

Health Care Agency Representative (Standing Seat)

Position Description

- Represent the Orange County Health Care Agency
- No term limits
- All appointments to the committee will be appointed by the CalOptima Health Board and are subject to OIG/GSA verification and possible background checks.

PAC Chair

Position Description

- Availability and willingness to attend regular and special PAC meetings
- Facilitate all PAC meetings using standard meeting rules of order
- Demonstrate leadership and openness, enabling meeting attendees to achieve preset meeting goals
- Liaison between PAC, MAC and the Board of Directors
- Provide PAC Report to CalOptima Health Board of Directors' monthly meetings
- Two-year term
- All appointments to the committee will be appointed by the CalOptima Health Board and are subject to OIG/GSA verification and possible background checks

PAC Vice-Chair

Position Description

- Availability and willingness to attend regular and special PAC meetings
- Facilitate in absence of the PAC Chair all PAC meetings using standard meeting rules of order
- Demonstrate leadership and openness, enabling meeting attendees to achieve preset meeting goals
- Liaison in absence of the PAC Chair between PAC, MAC and the Board of Directors
- Provide PAC Report to CalOptima Health Board of Directors' monthly meetings when PAC Chair is unavailable
- Two-year term
- All appointments to the committee will be appointed by the CalOptima Health Board and are subject to OIG/GSA verification and possible background checks

CalOptima Health

Applicant Name:

Provider Advisory Committee

Applicant Evaluation Tool (use one per applicant)

Position Applying for:

Please rate questions 1 through 5 based on how well the applicant satisfies the following statements where:
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Application is complete and meets minimum qualifications.	YES_____ NO_____	_____
2. Description/explanation of applicant's interest to serve on the PAC plus reasons applicant is qualified to represent constituents and uniquely contribute to the PAC.	1–5	_____
3. List of professional/trade associations related to specific constituency	1–5	_____
4. Ability and specific plan to reach out for input and communication to applicant's constituents including primary professional/trade association(s)	1–5	_____
5. Education and/or licenses	1–3	_____
6. Experience on similar committees or ability to collaborate in a multidisciplinary way	1–3	_____
7. Knowledge/familiarity with California and federal health regulations and requirements	1–5	_____
8. Availability and willingness to attend monthly meetings and serve on subcommittees	1–5	_____
9. Supportive letters of reference (minimum two).	1–2	_____
	Total Possible Points	33
	Total Points Awarded	_____

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PROVIDER ADVISORY COMMITTEE APPLICATION

Instructions: Please answer all questions. You may write or type your answers. Please use a separate sheet if necessary. If you have any questions regarding the application, please call Cheryl Simmons at 714-347-5785.

Name: _____ Work Phone: _____

Address: _____ Cell Phone: _____

City, State, ZIP: _____ Fax: _____

Email: _____ Date: _____

I hereby submit my application for the following Provider Advisory Committee (PAC) seat(s) and I understand that service on the PAC is on a voluntary basis:

- ☐ **Allied Health Services Representative (One seat)**
- ☐ **Behavioral/Mental Health Representative**
- ☐ **Health Network Representative**
- ☐ **Nurse Representative**

Current Position (i.e., employee, student, volunteer, retired, agency, and tenure).

_____

_____

_____

Education and/or licenses (if applicable):

_____

_____

_____

_____

_____

What is your direct or indirect experience working with the CalOptima Health population you wish to represent on PAC? Please include any relevant community experience.

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Explain your ability and specific plan to reach out for input and communicate with the CalOptima Health population you would represent on the PAC (i.e., primary professional/trade association(s), stakeholder involvement, etc.)

Please list similar committees on which you have served or describe your ability to collaborate in a multidisciplinary way.

What is your understanding, experience, and familiarity with the diverse cultural community in Orange County?

What is your current understanding and experience with CalOptima Health programs?

Please explain why you wish to serve on the PAC and how you might uniquely contribute to this advisory committee on behalf of all CalOptima Health members.

Please specify which of CalOptima Health's threshold languages you speak fluently:

☐ English, ☐ Spanish, ☐ Vietnamese, ☐ Farsi, ☐ Korean, ☐ Chinese or ☐ Arabic

Please submit two letters of recommendation along with a biography or resume with this application.

1) Professional
2) Community or Personal

Name: _____

Relationship: _____

Address: _____

City, State, ZIP: _____

Phone: _____

Email: _____

Name: _____

Relationship: _____

Address: _____

City, State, ZIP: _____

Phone: _____

Email: _____

If selected, are you able to commit to a attend all regularly scheduled PAC meetings and volunteer to serve on at least one subcommittee? ☐ Yes ☐ No

Do you agree that you will advocate on behalf of all CalOptima Health members and/or providers during your service on the PAC? ☐ Yes ☐ No

If selected as a representative on PAC, do you agree that you will complete the required compliance courses within the appointed timeframe? ☐ Yes ☐ No

All Advisory Committee Representatives are appointed by the CalOptima Health Board of Directors and are subject to the CalOptima Health Code of Conduct.

Public Records Act Notice

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and resumes, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature **Date**

Submit this application, along with a biography or resume and your two reference letters to:

CalOptima Health
505 City Parkway West
Orange, CA 92868
Attn: Cheryl Simmons

Phone: **714-347-5785** Fax: **714-571-2479** Email: csimmons@caloptima.org

Policy:	AA.1271
Title:	**Whole Child Model Family Advisory Committee**
Department:	Customer Service
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	06/07/2018
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy describes the composition and role of the Family Advisory Committee for Whole-Child Model (WCM) and establishes a process for recruiting, evaluating, and selecting prospective candidates to the Whole-Child Model Family Advisory Committee (WCM FAC).

II. POLICY

A. As directed by ~~CalOptima's~~CalOptima Health's Board of Directors (Board), the WCM FAC shall report to the CalOptima Health Board and shall provide advice and recommendations to the CalOptima Health Board and CalOptima Health staff in regard to California Children's Services (CCS) provided by CalOptima Health Medi-Cal's implementation of the WCM.

B. ~~CalOptima's~~CalOptima Health's Board encourages Member and community involvement in CalOptima Health programs.

C. WCM FAC Members shall recuse themselves from voting or from decisions where a conflict of interest may exist and shall abide by ~~CalOptima's~~CalOptima Health's conflict of interest code and, in accordance with CalOptima Health Policy AA.1204: Gifts, Honoraria, and Travel Payments.

D. CalOptima Health shall provide timely reporting of information pertaining to the WCM FAC as requested by the Department of Health Care Services (DHCS).

E. The composition of the WCM FAC shall reflect the cultural diversity and special needs of the health care consumers within the Whole-Child Model population. WCM FAC members shall have direct or indirect contact with CalOptima Health Members.

F. An organization may have no more than one (1) employee or representative on the WCM MAC at any one time.

G. An individual may participate in no more than one (1) CalOptima Advisory Committee at any one time.

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~~F.~~H. In accordance with CalOptima Health Board Resolution No. 17-1102-01, the WCM FAC shall be comprised of eleven (11) voting members representing CCS family members, as well as consumer advocates representing CCS families. Except as noted below, each voting member shall serve a ~~two~~ three (~~2~~3)-year term with no limits on the number of terms a representative may serve. ~~The initial appointments of WCM FAC members will be divided between one (1) and two (2) year terms to stagger reappointments. In the first year, five (5) committee member seats shall be appointed for a one (1) year term and six (6) committee member seats shall be appointed for a two (2) year term. The WCM FAC members serving a one (1) year term in the first year shall, if reappointed, serve two (2) year terms thereafter.~~

1. Seven (7) to nine (9) of the seats shall be family representatives in one (1) of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):

    a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima Health Member who is a current recipient of CCS services;

    b. CalOptima Health Members eighteen (18) - twenty-one (21) years of age who are current recipients of CCS services; or

    c. Current CalOptima Health Members over the age of twenty-one (21) who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:

    a. Community-based organizations; or

    b. Consumer advocates.

3. While two (2) of the WCM FAC's eleven (11) seats are designated for community-based organizations or consumer advocates, an additional two (2) WCM FAC candidates representing these groups may be considered for these seats in the event that there are not sufficient family representative candidates to fill the family member seats.

4. Interpretive services shall be provided at committee meetings upon request from a WCM FAC member or family member representative.

5. A family representative, in accordance with Section II.H~~F~~.1 of this Policy, may be invited to serve on a statewide stakeholder advisory group. CalOptima Health shall reimburse eligible expenses associated with attending the statewide stakeholder advisory group quarterly meetings in accordance with CalOptima Health Policy GA.5004: Travel Policy.

~~G.~~I. Stipends

1. CalOptima Health may provide a reasonable per diem payment of up to fifty dollars ($50) per meeting to a Member or family representative serving on the WCM FAC. CalOptima Health shall maintain a log of each payment provided to the Member or family representative, including type and value, and shall provide such log to DHCS upon request.

2. Representatives of community-based organizations and consumer advocates are not eligible for stipends.

~~H.~~J. The WCM FAC shall conduct a nomination process to recruit potential candidates for expiring seats, in accordance with this policy.

~~I.~~K. WCM FAC Vacancies

1. If a seat is vacated within two (2) months from the start of the nomination process, the vacated seat shall be filled during the annual recruitment and nomination process.

2. If a seat is vacated after the annual nomination process is complete, the WCM FAC nomination ad hoc subcommittee shall review the applicants from the recent recruitment to see if there is a viable candidate.

    a. If there is no viable candidate among the applicants, CalOptima Health shall conduct recruitment, per S~~s~~ection III.B.2 of this Policy.

3. A new WCM FAC member appointed to fill a mid-term vacancy, shall serve the remainder of the resigning member's term, which may be less than a full two (2) year term.

~~J.~~L. On a~~n~~ bi-annual basis, WCM FAC shall select a chair and vice chair from its membership to coincide with the annual recruitment and nomination process. Candidate recruitment and selection of the chair and vice chair shall be conducted in accordance with Sections III.B-D of this policy.

1. The WCM FAC chair and vice chair may serve one (1) two (2) year term.

2. The WCM FAC chair and/or vice chair may be removed by a majority vote of ~~CalOptima's~~CalOptima Health's Board.

~~K.~~M. The WCM FAC chair or vice chair shall ask for three (3) to four (4) members from the WCM FAC to serve on a nomination ad hoc subcommittee. WCM FAC members who are being considered for reappointment cannot participate in the nomination ad hoc subcommittee.

1. The WCM FAC nomination ad hoc subcommittee shall:

    a. Review, evaluate and select a prospective chair, vice chair and a candidate for each of the open seats, in accordance with Section III.C-D of this policy; and

    b. Forward the prospective ~~chair, vice chair, and~~ slate of candidate(s) to the WCM FAC for review and approval.

2. Following approval from the WCM FAC, the recommended ~~chair, vice chair, and~~ slate of candidate(s) shall be forwarded to ~~CalOptima's~~CalOptima Health's Board for review and approval.

~~L.~~N. ~~CalOptima's~~CalOptima Health's Board shall approve all appointments, reappointments, and chair and vice chair appointments to the WCM FAC.

~~M.~~O. Upon appointment to WCM FAC and annually thereafter, WCM FAC members shall be required to complete all mandatory annual Compliance Training by the given deadline to maintain eligibility standing on the WCM FAC.

~~N.~~P. WCM FAC members shall attend all regularly scheduled meetings, unless they have an excused absence. An absence shall be considered excused if a WCM FAC member provides notification of an absence to CalOptima Health staff prior to the meeting. CalOptima Health staff shall maintain an attendance log of the WCM FAC members' attendance at WCM FAC meetings. As the attendance log is a public record, for any request from a member of the public, the WCM FAC chair, the vice chair, the Chief Executive Officer, or the CalOptima Health Board, CalOptima Health staff shall provide a copy of the attendance log to the requester. In addition, the WCM FAC chair or vice chair shall contact any committee member who has three (3) consecutive unexcused absences.

1. WCM FAC members' attendance shall be considered as a criterion upon reapplication.

III. PROCEDURE

A. WCM FAC meeting frequency

1. WCM FAC shall meet at least quarterly.

2. WCM FAC shall adopt a yearly meeting schedule at the first regularly scheduled meeting in or after January of each year.

3. Attendance by a simple majority of appointed members shall constitute a quorum, and a quorum must be present for any votes to be valid.

B. WCM FAC recruitment process

1. CalOptima Health shall begin recruitment of potential candidates in ~~March~~ February of each year. In the recruitment of potential candidates, the ethnic and cultural diversity and special needs of children and/or families of children in CCS which are or are expected to transition to ~~CalOptima's~~CalOptima Health's Whole-Child Model population shall be considered. Nominations and input from interest groups and agencies shall be given due consideration.

2. CalOptima Health shall recruit for potential candidates using one or more notification methods, which may include, but are not limited to, the following:

   a. Outreach to family representatives and community advocates that represent children receiving CCS;

   b. Placement of vacancy notices on the CalOptima Health website; and/or

   ~~c. Advertisement of vacancies in local newspapers in Threshold Languages.~~
   c. Outreach to community stakeholders

3. Prospective candidates must submit a WCM Family Advisory Committee application, including resume and signed consent forms. Candidates shall be notified at the time of recruitment regarding the deadline to submit their application to CalOptima Health.

4. ~~Except for the initial recruitment,~~
5. During the WCM FAC meeting held before June 30 of a recruitment year for the chair and vice chair, the current chair or vice-chair shall inquire of its membership whether there are interested

candidates who wish to be considered as a chair or vice-chair for the upcoming fiscal year. The candidates are requested to submit a letter of interest for these positions.

~~theThe WCM FAC chair or vice chair shall inquire of its membership whether there are interested candidates who wish to be considered as a chair or vice chair for the upcoming fiscal year.~~

~~4.~~

~~5. CalOptima shall inquire at the first WCM FAC meeting whether there are interested candidates who wish to be considered as a chair for the first year. who will be appointed for a two-year term.~~

C. WCM FAC nomination evaluation process

1. The WCM FAC chair or vice chair shall request three (3) to four (4) members, who are not being considered for reappointment, to serve on the nomination's ad hoc subcommittee. ~~For the first nomination process, Member Advisory Committee (MAC) members shall serve on the nominations ad hoc subcommittee to review candidates for WCM FAC.~~

   a. At the discretion of the nomination ad hoc subcommittee, a subject matter expert (SME), may be included on the subcommittee to provide consultation and advice.

2. Prior to WCM FAC nomination ad hoc subcommittee meeting ~~(including the initial WCM FAC nomination ad hoc subcommittee).~~:

   a. Ad hoc subcommittee members shall individually evaluate and score the application for each of the prospective candidates using the applicant evaluation tool.

   ~~b. Ad hoc subcommittee members shall individually evaluate and select a chair and vice chair from among the interested candidates.~~

   ~~c.~~b. At the discretion of the ad hoc subcommittee, subcommittee members may contact a prospective candidate's references for additional information and background validation.

3. The ad hoc subcommittee shall convene to discuss and select ~~select a chair, vice chair and~~ a candidate for each of the expiring seats by using the findings from the applicant evaluation tool, the attendance record if relevant and the prospective candidate's references.

D. WCM FAC selection and approval process for ~~prospective chair, vice chair, and~~ WCM FAC candidates:

1. The nomination ad hoc subcommittee shall forward its recommendation for ~~a chair, vice chair, and a~~the slate of candidates to WCM FAC ~~(or in the first year, the MAC)~~ for review and approval. Candidates interested in the Chair and Vice Chair positions shall submit a letter of interest to the Staff to the Advisory Committees indicating their interest in the chair and the vice chair seats.

~~1.~~2. Chair and vice chair candidates will be reviewed at the first WCM FAC meeting of the fiscal year ~~a WCM FAC meeting~~ and the members will vote on their candidate of choice for both positions. Candidates must have a quorum of members approving their recommendation in order to be submitted to the Board for appointment. Following WCM FAC's approval ~~(or in the first year, the MAC),~~ the proposed chair, vice chair ~~and slate of candidates~~ shall be submitted to ~~CalOptima's~~CalOptima Health's Board for approval.

~~2.~~3. The WCM FAC members' terms shall be effective upon approval by the CalOptima Health Board.

a. In the case of a selected candidate filling a seat that was vacated mid-term, the new candidate shall attend the ~~immediately following~~next WCM FAC meeting.

~~3.~~4. WCM FAC members shall attend a new advisory committee member orientation.

IV. ATTACHMENT(S)

A. Whole Child Model Member Advisory Committee Application
B. Whole Child Model Member Advisory Committee Applicant Evaluation Tool
C. Whole Child Model Community Advisory Committee Application
D. Whole Child Model Community Advisory Committee Applicant Evaluation Tool

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Board Resolution 17-1102-01
C. CalOptima Health Policy AA.1204: Gifts, Honoraria, and Travel Payments
D. CalOptima Health Policy GA.5004: Travel Policy
E. Welfare and Institutions Code §14094.17(b)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
09/07/2018	Department of Health Care Services (DHCS)	Approved as Submitted
07/19/2019	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
11/02/2017	Regular Meeting of the CalOptima Board of Directors
06/07/2018	Regular Meeting of the CalOptima Board of Directors
05/02/2019	Regular Meeting of the CalOptima Board of Directors
08/06/2020	Regular Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Title	Program(s)
Effective	06/07/2018	AA.1271	Whole Child Model Family Advisory Committee	Medi-Cal Administrative
Revised	05/02/2019	AA.1271	Whole Child Model Family Advisory Committee	Medi-Cal Administrative
Revised	08/06/2020	AA.1271	Whole Child Model Family Advisory Committee	Medi-Cal Administrative

Action	Date	Policy	Title	Program(s)
Revised	TBD	AA.1271	Whole Child Model Family Advisory Committee	Medi-Cal Administrative

IX. GLOSSARY

Term	Definition
California Children's Services Program (CCS)	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
Member	For purposes of this policy, an enrollee-beneficiary of the CalOptima Health Medi-Cal Program receiving California Children's Services through the Whole-Child Model program.
Member Advisory Committee (MAC)	A committee comprised of community advocates and Members, each of whom represents a constituency served by CalOptima Health, which was established by CalOptima Health to advise its Board of Directors on issues impacting Members.
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Population Needs Assessment (PNA).
Whole-Child Model (WCM)	An organized delivery system that will ensure comprehensive, coordinated services through enhanced partnerships among Medi-Cal managed care plans, children's hospitals and specialty care providers.

Policy:	AA.1271
Title:	**Whole Child Model Family Advisory Committee**
Department:	Customer Service
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	06/07/2018
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy describes the composition and role of the Family Advisory Committee for Whole-Child Model (WCM) and establishes a process for recruiting, evaluating, and selecting prospective candidates to the Whole-Child Model Family Advisory Committee (WCM FAC).

II. POLICY

A. As directed by CalOptima Health's Board of Directors (Board), the WCM FAC shall report to the CalOptima Health Board and shall provide advice and recommendations to the CalOptima Health Board and CalOptima Health staff in regard to California Children's Services (CCS) provided by CalOptima Health Medi-Cal's implementation of the WCM.

B. CalOptima Health's Board encourages Member and community involvement in CalOptima Health programs.

C. WCM FAC Members shall recuse themselves from voting or from decisions where a conflict of interest may exist and shall abide by CalOptima Health's conflict of interest code and, in accordance with CalOptima Health Policy AA.1204: Gifts, Honoraria, and Travel Payments.

D. CalOptima Health shall provide timely reporting of information pertaining to the WCM FAC as requested by the Department of Health Care Services (DHCS).

E. The composition of the WCM FAC shall reflect the cultural diversity and special needs of the health care consumers within the Whole-Child Model population. WCM FAC members shall have direct or indirect contact with CalOptima Health Members.

F. An organization may have no more than one (1) employee or representative on the WCM MAC at any one time.

G. An individual may participate in no more than one (1) CalOptima Advisory Committee at any one time.

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H. In accordance with CalOptima Health Board Resolution No. 17-1102-01, the WCM FAC shall be comprised of eleven (11) voting members representing CCS family members, as well as consumer advocates representing CCS families. Except as noted below, each voting member shall serve a three (3)-year term with no limits on the number of terms a representative may serve.

1. Seven (7) to nine (9) of the seats shall be family representatives in one (1) of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):

   a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima Health Member who is a current recipient of CCS services;

   b. CalOptima Health Members eighteen (18) - twenty-one (21) years of age who are current recipients of CCS services; or

   c. Current CalOptima Health Members over the age of twenty-one (21) who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:

   a. Community-based organizations; or

   b. Consumer advocates.

3. While two (2) of the WCM FAC's eleven (11) seats are designated for community-based organizations or consumer advocates, an additional two (2) WCM FAC candidates representing these groups may be considered for these seats in the event that there are not sufficient family representative candidates to fill the family member seats.

4. Interpretive services shall be provided at committee meetings upon request from a WCM FAC member or family member representative.

5. A family representative, in accordance with Section II.H.1 of this Policy, may be invited to serve on a statewide stakeholder advisory group. CalOptima Health shall reimburse eligible expenses associated with attending the statewide stakeholder advisory group quarterly meetings in accordance with CalOptima Health Policy GA.5004: Travel Policy.

I. Stipends

1. CalOptima Health may provide a reasonable per diem payment of up to fifty dollars ($50) per meeting to a Member or family representative serving on the WCM FAC. CalOptima Health shall maintain a log of each payment provided to the Member or family representative, including type and value, and shall provide such log to DHCS upon request.

2. Representatives of community-based organizations and consumer advocates are not eligible for stipends.

J. The WCM FAC shall conduct a nomination process to recruit potential candidates for expiring seats, in accordance with this policy.

K. WCM FAC Vacancies

1. If a seat is vacated within two (2) months from the start of the nomination process, the vacated seat shall be filled during the annual recruitment and nomination process.

2. If a seat is vacated after the annual nomination process is complete, the WCM FAC nomination ad hoc subcommittee shall review the applicants from the recent recruitment to see if there is a viable candidate.

    a. If there is no viable candidate among the applicants, CalOptima Health shall conduct recruitment, per Section III.B.2 of this Policy.

3. A new WCM FAC member appointed to fill a mid-term vacancy, shall serve the remainder of the resigning member's term, which may be less than a full two (2) year term.

L. On a bi-annual basis, WCM FAC shall select a chair and vice chair from its membership to coincide with the annual recruitment and nomination process. Candidate recruitment and selection of the chair and vice chair shall be conducted in accordance with Sections III.B-D of this policy.

1. The WCM FAC chair and vice chair may serve one (1) two (2) year term.

2. The WCM FAC chair and/or vice chair may be removed by a majority vote of CalOptima Health's Board.

M. The WCM FAC chair or vice chair shall ask for three (3) to four (4) members from the WCM FAC to serve on a nomination ad hoc subcommittee. WCM FAC members who are being considered for reappointment cannot participate in the nomination ad hoc subcommittee.

1. The WCM FAC nomination ad hoc subcommittee shall:

    a. Review, evaluate and select a prospective chair, vice chair and a candidate for each of the open seats, in accordance with Section III.C-D of this policy; and

    b. Forward the prospective slate of candidate(s) to the WCM FAC for review and approval.

2. Following approval from the WCM FAC, the recommended slate of candidate(s) shall be forwarded to CalOptima Health's Board for review and approval.

N. CalOptima Health's Board shall approve all appointments, reappointments, and chair and vice chair appointments to the WCM FAC.

O. Upon appointment to WCM FAC and annually thereafter, WCM FAC members shall be required to complete all mandatory annual Compliance Training by the given deadline to maintain eligibility standing on the WCM FAC.

P. WCM FAC members shall attend all regularly scheduled meetings unless they have an excused absence. An absence shall be considered excused if a WCM FAC member provides notification of an absence to CalOptima Health staff prior to the meeting. CalOptima Health staff shall maintain an attendance log of the WCM FAC members' attendance at WCM FAC meetings. As the attendance log is a public record, for any request from a member of the public, the WCM FAC chair, the vice chair, the Chief Executive Officer, or the CalOptima Health Board, CalOptima Health staff shall provide a copy of the attendance log to the requester. In addition, the WCM FAC

chair or vice chair shall contact any committee member who has three (3) consecutive unexcused absences.

1. WCM FAC members' attendance shall be considered as a criterion upon reapplication.

III. PROCEDURE

A. WCM FAC meeting frequency

1. WCM FAC shall meet at least quarterly.

2. WCM FAC shall adopt a yearly meeting schedule at the first regularly scheduled meeting in or after January of each year.

3. Attendance by a simple majority of appointed members shall constitute a quorum, and a quorum must be present for any votes to be valid.

B. WCM FAC recruitment process

1. CalOptima Health shall begin recruitment of potential candidates in February of each year. In the recruitment of potential candidates, the ethnic and cultural diversity and special needs of children and/or families of children in CCS which are or are expected to transition to CalOptima Health's Whole-Child Model population shall be considered. Nominations and input from interest groups and agencies shall be given due consideration.

2. CalOptima Health shall recruit for potential candidates using one or more notification methods, which may include, but are not limited to, the following:

   a. Outreach to family representatives and community advocates that represent children receiving CCS;

   b. Placement of vacancy notices on the CalOptima Health website; and/or

   c. Outreach to community stakeholders

3. Prospective candidates must submit a WCM Family Advisory Committee application, including resume and signed consent forms. Candidates shall be notified at the time of recruitment regarding the deadline to submit their application to CalOptima Health.

4. During the WCM FAC meeting held before June 30 of a recruitment year for the chair and vice chair, the current chair or vice-chair shall inquire of its membership whether there are interested candidates who wish to be considered as a chair or vice-chair for the upcoming fiscal year. The candidates are requested to submit a letter of interest for these positions.

C. WCM FAC nomination evaluation process

1. The WCM FAC chair or vice chair shall request three (3) to four (4) members, who are not being considered for reappointment, to serve on the nomination's ad hoc subcommittee.

   a. At the discretion of the nomination ad hoc subcommittee, a subject matter expert (SME), may be included on the subcommittee to provide consultation and advice.

2. Prior to WCM FAC nomination ad hoc subcommittee meeting:

    a. Ad hoc subcommittee members shall individually evaluate and score the application for each of the prospective candidates using the applicant evaluation tool.

    b. At the discretion of the ad hoc subcommittee, subcommittee members may contact a prospective candidate's references for additional information and background validation.

3. The ad hoc subcommittee shall convene to discuss and select a candidate for each of the expiring seats by using the findings from the applicant evaluation tool, the attendance record if relevant and the prospective candidate's references.

D. WCM FAC selection and approval process for WCM FAC candidates:

1. The nomination ad hoc subcommittee shall forward its recommendation for the slate of candidates to WCM FAC for review and approval. Candidates interested in the Chair and Vice Chair positions shall submit a letter of interest to the Staff to the Advisory Committees indicating their interest in the chair and the vice chair seats.
2. Chair and vice chair candidates will be reviewed at the first WCM FAC meeting of the fiscal year and the members will vote on their candidate of choice for both positions. Candidates must have a quorum of members approving their recommendation in order to be submitted to the Board for appointment. Following WCM FAC's approval the proposed chair, vice chair shall be submitted to CalOptima Health's Board for approval.

3. The WCM FAC members' terms shall be effective upon approval by the CalOptima Health Board.

    a. In the case of a selected candidate filling a seat that was vacated mid-term, the new candidate shall attend the next WCM FAC meeting.

4. WCM FAC members shall attend a new advisory committee member orientation.

IV. ATTACHMENT(S)

A. Whole Child Model Member Advisory Committee Application
B. Whole Child Model Member Advisory Committee Applicant Evaluation Tool
C. Whole Child Model Community Advisory Committee Application
D. Whole Child Model Community Advisory Committee Applicant Evaluation Tool

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Board Resolution 17-1102-01
C. CalOptima Health Policy AA.1204: Gifts, Honoraria, and Travel Payments
D. CalOptima Health Policy GA.5004: Travel Policy
E. Welfare and Institutions Code §14094.17(b)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
09/07/2018	Department of Health Care Services (DHCS)	Approved as Submitted

07/19/2019	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
11/02/2017	Regular Meeting of the CalOptima Board of Directors
06/07/2018	Regular Meeting of the CalOptima Board of Directors
05/02/2019	Regular Meeting of the CalOptima Board of Directors
08/06/2020	Regular Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Title	Program(s)
Effective	06/07/2018	AA.1271	Whole Child Model Family Advisory Committee	Medi-Cal Administrative
Revised	05/02/2019	AA.1271	Whole Child Model Family Advisory Committee	Medi-Cal Administrative
Revised	08/06/2020	AA.1271	Whole Child Model Family Advisory Committee	Medi-Cal Administrative
Revised	TBD	AA.1271	Whole Child Model Family Advisory Committee	Medi-Cal Administrative

IX. GLOSSARY

Term	Definition
California Children's Services Program (CCS)	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
Member	For purposes of this policy, an enrollee-beneficiary of the CalOptima Health Medi-Cal Program receiving California Children's Services through the Whole-Child Model program.
Member Advisory Committee (MAC)	A committee comprised of community advocates and Members, each of whom represents a constituency served by CalOptima Health, which was established by CalOptima Health to advise its Board of Directors on issues impacting Members.
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Population Needs Assessment (PNA).
Whole-Child Model (WCM)	An organized delivery system that will ensure comprehensive, coordinated services through enhanced partnerships among Medi-Cal managed care plans, children's hospitals and specialty care providers.

Whole-Child Model Family Advisory Committee (WCM FAC) Member Application 2023

Instructions: Please type or print clearly. This application is for current California Children's Services (CCS) members and their family members. Please attach a resume or biography listing your qualifications and include signed authorization forms. For questions, please call 714-347-5785.

Name: _____ Primary Phone: _____

Address: _____ Cell Phone: _____

City, State, ZIP: _____ Fax: _____

Date: _____ Email: _____

Please see the eligibility criteria below:*

☐ Authorized representatives, which includes parents, foster parents and caregivers, of a CalOptima Health member who is currently receiving CCS services;

☐ CalOptima Health members ages 18–21 who are currently receiving of CCS services

☐ Current CalOptima Health members over the age of 21 who had received CCS services before

Four seats are available with a term beginning July 1, 2023, and running through June 30, 2025.

One seat is available to fill an existing term through June 30, 2024.

* Interested candidates for the WCM FAC member or family member seats must reside in Orange County and be enrolled in CalOptima Health Medi-Cal and/or California Children's Services/Whole-Child Model or must be a family member of an enrolled CalOptima Health Medi-Cal and California Children's Services/Whole-Child Model member.

CalOptima Health Medi-Cal/CCS status (e.g., member, family member, foster parent, caregiver, etc.):

_____

If you are a family member/foster parent/caregiver, please tell us who the member is and what your relationship is to the member:

Member Name: _____ Relationship: _____

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Please tell us whether you have been a CalOptima Health member (i.e., Medi-Cal) or have any consumer advocacy experience: _____

_____

_____

_____

Please explain why you would be a good representative for diverse cultural and/or special needs of children and/or the families of children in CCS. Include any relevant experience working with these populations: _____

_____

_____

Please provide a brief description of your knowledge or experience with California Children's Services:_____

_____

_____

Please explain why you wish to serve on the WCM FAC:_____

_____

_____

_____

Describe why you would be a qualified representative for service on the WCM FAC:_____

_____

_____

_____

Please specify which of CalOptima Health's threshold languages you speak fluently:

☐ English ☐ Spanish ☐ Vietnamese ☐ Farsi ☐ Korean ☐ Chinese ☐ Arabic

If selected, are you able to commit to attending WCM FAC meetings every other month, as well as serving on at least one subcommittee? ☐ Yes ☐ No

Do you agree that you will advocate on behalf of all CalOptima Health members and/or providers during your service on the WCM FAC? ☐ Yes ☐ No

If selected as a representative on WCM FAC, do you agree that you will complete the required compliance courses within the appointed time frame? ☐ Yes ☐ No

This information is available for free in other languages. Please call our Customer Service department toll-free at **1-888-587-8808** (TTY **711**).

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All advisory committee representatives are appointed by the CalOptima Health Board of Directors and are subject to the CalOptima Health Code of Conduct.

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Please supply two references (professional, community or personal):

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

Please sign the **Public Records Act Notice** below and **Limited Privacy Waiver** on the next page. You also need to sign the attached **Authorization for Use or Disclosure of Protected Health Information** form to enable CalOptima Health to verify current member status.

PUBLIC RECORDS ACT NOTICE

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and resumes, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board materials that are available on CalOptima Health's website, and even if not presented to the Board, will be available on request to members of the public.

Signature: _____ **Date:** _____

Print Name: _____

LIMITED PRIVACY WAIVER

Under state and federal law, the fact that a person is eligible for Medi-Cal and California Children's Services (CCS) is a private matter that may only be disclosed by CalOptima Health as necessary to administer the Medi-Cal and CCS program, unless other disclosures are authorized by the eligible member. Because the position of Member Representative on Whole-Child Model Family Advisory Committee (WCM FAC) requires that the person appointed must be a member or a family member of a member receiving CCS, the member's Medi-Cal and CCS eligibility will be disclosed to the general public. The member or their representative (e.g. parent, foster parent, guardian, etc.) should check the appropriate box below and sign this waiver to allow his or her, or his or her family member or caregiver's name to be nominated for the advisory committee.

☐ **MEMBER APPLICANT — I understand that by signing below and applying to serve on the WCM FAC, I am disclosing my eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

☐ **FAMILY MEMBER APPLICANT — I understand that by applying to serve on the WCM FAC, my status as a family member of a person eligible for Medi-Cal and CCS benefits is likely to become public. I authorize the disclosing of my family member's (insert name of member: _____) eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

Medi-Cal/CCS Member (Printed Name): _____

Applicant Printed Name: _____

Applicant Signature: _____ **Date:** _____

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

The federal Health Insurance Portability and Accountability Act (HIPAA), Privacy Regulations require that you complete this form to authorize CalOptima Health to use or disclose your Protected Health Information (PHI) to another person or organization. Please complete, sign, and return the form to CalOptima Health.

Date of Request: _____ Telephone Number: _____

Member Name: _____ Member CIN: _____

AUTHORIZATION:

I, _____, hereby authorize CalOptima Health, to use or disclose my health information as described below.

Describe the health information that will be used or disclosed under this authorization (please be specific): **Information related to the identity, program administrative activities and/or services provided to {me} {my child} which is disclosed in response to my own disclosures and/or questions related to same.**
Person or organization authorized to receive the health information: **General public**

Describe each purpose of the requested use or disclosure (please be specific): **To allow CalOptima Health staff to respond to questions or issues raised by me that may require reference to my health information that is protected from disclosure by law during public meetings of the CalOptima Health Whole-Child Model Family Advisory Committee**

EXPIRATION DATE:

This authorization shall become effective immediately and shall expire on: **The end of the term of the position applied for.**

Right to Revoke: I understand that I have the right to revoke this authorization in writing at any time. To revoke this authorization, I understand that I must make my request in writing and clearly state that I am revoking this specific authorization. In addition, I must sign my request and then mail or deliver my request to:

CalOptima Health
Customer Service Department
505 City Parkway West
Orange, CA 92868

This information is available for free in other languages. Please call our Customer Service department toll-free at **1-888-587-8808** (TTY **711**).

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I understand that a revocation will not affect the ability of CalOptima Health or any health care provider to use or disclose the health information to the extent that it has acted in reliance on this authorization.

RESTRICTIONS:

I understand that anything that occurs in the context of a public meeting, including the meetings of the Whole-Child Model Family Advisory Committee, is a matter of public record that is required to be disclosed upon request under the California Public Records Act. Information related to, or relevant to, information disclosed pursuant to this authorization that is not disclosed at the public meeting remains protected from disclosure under HIPAA and will not be disclosed by CalOptima Health without separate authorization, unless disclosure is permitted by HIPAA without authorization or is required by law.

MEMBER RIGHTS:

- I understand that I must receive a copy of this authorization.
- I understand that I may receive additional copies of this authorization.
- I understand that I may refuse to sign this authorization.
- I understand that I may withdraw this authorization at any time.
- I understand that neither treatment nor payment will be dependent upon my refusing or agreeing to sign this authorization.

SIGNATURE:

By signing below, I acknowledge receiving a copy of this authorization.

Member Signature: _____ Date: _____

Signature of Parent or Legal Guardian: _____ Date: _____

If Authorized Representative:

Name of Personal Representative: _____

Legal Relationship to Member: _____

Signature of Personal Representative: _____ Date: _____

Basis for legal authority to sign this Authorization by a Personal Representative

(If a personal representative has signed this form on behalf of the member, a copy of the Health Care Power of Attorney, a court order (such as appointment as a conservator, or as the executor or administrator of a deceased member's estate), or other legal documentation demonstrating the authority of the personal representative to act on the individual's behalf must be attached to this form.)

This information is available for free in other languages. Please call our Customer Service department toll-free at **1-888-587-8808** (TTY **711**).

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Submit this application, along with a biography or resume to:

CalOptima Health
Attn: Cheryl Simmons
505 City Parkway West
Orange, CA 92868

Phone: **714-347-5785** Fax: **714-571-2479** Email: csimmons@CalOptima.org

This information is available for free in other languages. Please call our Customer Service department toll-free at **1-888-587-8808** (TTY **711**).

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Whole-Child Model Family Advisory Committee (WCM FAC)
Community Application Fiscal Year 2023

Instructions: Please answer all questions. You may handwrite or type your answers. Attach an additional page if needed.
If you have any questions regarding the application, call 714-347-5785.

Name: _____ Work Phone: _____

Address: _____ Mobile Phone: _____

City, State ZIP: _____ Fax Number: _____

Date: _____ Email: _____

I hereby submit my application for the following Whole-Child Model Family Advisory Committee (WCM FAC) Community Representative seat(s), and I understand that service on the WCM FAC is on a voluntary basis with no stipend:

☐ **Community-based organizations**

☐ **Consumer advocate (two seats)**

All appointments are for a two-year period beginning July 1, 2023, and running through June 30, 2025, with the exception of one consumer advocate representative which will fulfill an existing term through June 30, 2023. These seats are subject to continued eligibility to hold a Community Representative seat.

Current position and/or relation to a community-based organization or consumer advocate(s) (e.g., organization title, student, volunteer, etc.):

_____

1. Please provide a brief description of your direct or indirect experience working with the CalOptima Health population receiving California Children's Services (CCS) services and/or the constituency you wish to represent on the WCM FAC. Include any relevant community experience:

_____

_____

_____

_____

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2. What is your understanding of and familiarity with the diverse cultural and/or special needs of children receiving CCS services in Orange County and/or their families? Include any relevant experience working with such populations:

_____

_____

_____

_____

3. What is your understanding of and experience with California Children's Services, managed care systems and/or CalOptima Health?

_____

_____

_____

_____

4. Please explain why you wish to serve on the WCM FAC:

_____

_____

_____

_____

5. Describe why you would be a qualified representative for service on the WCM FAC:

_____

_____

_____

_____

6. Please specify which of CalOptima Health's threshold languages you speak fluently:

☐ English ☐ Spanish ☐ Vietnamese ☐ Farsi ☐ Korean ☐ Chinese ☐ Arabic

7. If selected, are you able to commit to attending bi-monthly WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

8. Do you agree that you will advocate on behalf of all CalOptima Health members and/or providers during your service on the WCM FAC? ☐ Yes ☐ No

9. If selected as a representative on WCM FAC, do you agree that you will complete the required compliance courses within the appointed time frame? ☐ Yes ☐ No

All advisory committee representatives are appointed by the CalOptima Health Board of Directors and are subject to the CalOptima Health Code of Conduct.

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Please supply two references (professional, community or personal):

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Address: _____ Address: _____

City, State, ZIP: _____ City, State, ZIP: _____

Phone: _____ Phone: _____

Email: _____ Email: _____

Public Records Act Notice

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and resumes, are public records, with the exception of your address, email address and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board materials that are available on CalOptima Health's website, and even if not presented to the Board, will be available on request to members of the public.

_____ _____

Signature **Date**

_____

Print Name

Submit this application, along with a biography or resume to:

CalOptima Health
Attn: Cheryl Simmons
505 City Parkway West
Orange, CA 92868

Phone: **714-347-5785** Fax: **714-571-2479** Email: csimmons@CalOptima Health.org

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CalOptima Health

Applicant Name:

WCM Family Advisory Committee Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat:
Authorized Family Member

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Consumer advocacy experience or Medi-Cal member experience	1–5	_____
2. Good representative for diverse cultural and/or special needs of children and/or families of children in CCS	1–5	_____
Include relevant experience with these populations	1–5	_____
3. Knowledge or experience with California Children's Services	1–5	_____
4. Explanation why applicant wishes to serve on the WCM FAC	1–5	_____
5. Explanation why applicant is a qualified representative for WCM FAC	1–5	_____
6. Ability to speak one of the threshold languages (other than English)	Yes/No	_____
7. Availability and willingness to attend meetings	Yes/No	_____
8. Supportive references	Yes/No	_____
	Total Possible Points	30

_____

Name of Evaluator

Total Points Awarded _____

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CalOptima Health

Applicant Name:

WCM Family Advisory Committee
Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat: Community Based Organization or Consumer Advocate

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Direct or indirect experience working with members the applicant wishes to represent	1–5	_____
Include relevant community involvement	1–5	_____
2. Understanding of and familiarity with the diverse cultural and/or special needs populations in Orange County	1–5	_____
Include relevant experience with diverse populations	1–5	_____
3. Knowledge of managed care systems and/or CalOptima programs	1–5	_____
4. Expressed desire to serve on the WCM FAC	1–5	_____
5. Explanation why applicant is a qualified representative	1–5	_____
6. Ability to speak one of the threshold languages (other than English)	Yes/No	_____
7. Availability and willingness to attend meetings	Yes/No	_____
8. Supportive references	Yes/No	_____
	Total Possible Points	35

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL
Action To Be Taken December 1, 2022
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

13. Adopt Resolution No. 22-1201-02 Approving and Adopting Updated and New CalOptima Health Human Resources Policies

Contacts

Michael Hunn, Chief Executive Officer, (657) 900-1481
Brigette Hoey, Chief Human Resources Officer, (714) 246-8405

Recommended Actions

Adopt Resolution No. 22-1201-02 approving:

1. Updated CalOptima Health policies:
    a. GA. 8018: Paid Time Off (PTO)
    b. GA. 8019: Promotions and Transfers
    c. GA. 8026: Employee Referral Program
    d. GA. 8030: Background Check
    e. GA. 8033: License and Certification Tracking
    f. GA. 8034: Service of Summons, Subpoenas, and Other Legal Documents
    g. GA. 8046: Relocation
    h. GA. 8047: Reduction in Force
    i. GA. 8055: Retiree Health Benefits
    j. GA. 8056: Paid Holidays
    k. GA. 8059: Attendance and Timekeeping
2. New CalOptima Health policy:
    a. GA.8062: Social Media Conduct

Background

Near CalOptima Health's inception, the Board of Directors delegated authority to the Chief Executive Officer (CEO) 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, with emphasis on changes. 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 list of policies and a summary of changes for the updated policies.

GA.8018: Paid Time Off (PTO): This policy provides managers and supervisors with appropriate guidelines to administer CalOptima Health's Paid Time Off (PTO) benefit.

Policy Section	Proposed Change	Rationale	Impact
Throughout	Edited pronouns to gender neutral.	Utilize gender neutral language.	Promotes inclusivity.

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Policy Section	Proposed Change	Rationale	Impact
Throughout	Replaced "Act" with "Paid Sick Leave."	Improve clarity as the California Healthy Workplaces, Healthy Families Act of 2014 is more commonly referred to as "Paid Sick Leave."	Provides clarity.
Throughout	Replaced "years" of service with "months" of service.	Reduce ambiguity related to when employees transition to the next higher tier.	Provides clarity.
II.B	Updated language to allow PTO usage for any reason and specified that CalOptima policies and federal/state law may dictate usage during certain types of leave.	Remove lengthy list of possible reasons employees may use their PTO. Align with applicable policies and laws.	Provides clarity and alignment with current policies.
II.D & II.D.1	Added language to clarify when PTO accrual begins and restructured into sub-bullets. Added statement to allow reinstatement of a former employee's accrual rate when rehired within 90-days of separation and to allow CEO discretion to approve deviations of PTO up to 80 hours per year for rehires after 90-days of separation.	Improve clarity on rehired employees and increases CEO flexibility in approving exceptions that deviate from the standard accrual rates.	Specifies how PTO accrual rate will be determined for reinstated employees.
II.D.2	Changed CEO's authority to approve deviations from the PTO schedule from up to a maximum of 80 hours to up to a maximum of 120 hours.	Encompasses the CEO's deviation approval of employees who transitioned from exempt to non-exempt in 2019 but were approved to maintain their higher exempt accrual rates.	Increases flexibility in rehire process.
II.D. Accrual Schedule	Added language outlining when employees move to a higher tier. Updated accrual schedule to reflect continuous service as "years" instead of "months." Revised the hours of PTO to the fourth decimal place.	Provide clarity for employees on accrual tiers and amounts. Extra decimal point increases accuracy of PTO accrual (upon annual calculation).	Provides clarity and increased precision in PTO accruals.
II.H	Replaced specific definition of "family members" with a reference to GA.8040: Family	Refer to policy GA.8040, which is a more thorough and	Improves alignment with other policies.

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Policy Section	Proposed Change	Rationale	Impact
	Medical and Care Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence.	detailed source of this information.	
II.H	Added the serious health condition of an eligible family member as possible reason for a leave of absence	Improve clarity in the example provided and align with federal/state laws	Expands qualifying reasons for leave.
II.J	Added language clarifying employees on a 9/80 schedule may have PTO deducted an hour when a holiday occurs and added reference to GA.8020: 9/80 Work Schedule.	Align with GA.8020.	Improves alignment with other policies.
II.N	Added the catastrophic illness of a "family member" as a qualifying reason.	Align with Section II.N.1.a of the policy and consistent with practice and existing request form.	Provides alignment within policy.
IX Glossary	Added the term and definition for Paid Sick Leave	Define the term consistently throughout the policy.	Cites applicable California labor codes.
Attachment A	Removed request for description of medical condition.	Align with practice and protect employee privacy. Certification of a catastrophic illness, not specific medical condition is needed.	Protects confidentiality of employees' health, medical, and genetic information.

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
Throughout	Edited pronouns to gender neutral.	Utilize gender neutral language.	Promotes inclusivity.
II.C	Revised language so that all job postings are posted for at least 5 days prior to a job offer being extended.	Provide clarity that minimum posting requirement is for all postings and align with current practice.	Provides clarity and alignment with practice.
II.D	Added language about submitting application and resume to the applicant tracking system.	Align with process.	Aligns with process.

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Policy Section	Proposed Change	Rationale	Impact
II.E., II.E.2 and II.E.4.a	Minor text edits.	Provide clarity.	Provides clarity.
II.F	Reduced required minimum time in current position before an employee can be promoted from 6 to 3 months.	Minimize the limitation placed on internal (vs. external) candidates.	Increases flexibility.
II.G	Minor text edits.	Provide clarity and consistency with this and related policy GA.8030 Background Check.	Provides clarity and alignment within policy and with other policies.
III. Procedure Table - Employee	Minor text revisions. Added statements about courtesy notification to current manager upon applying for an opening and employee responsibility to cooperate with background check and/or medical examinations.	Provide clarity, set expectations, and provide consistency with existing processes.	Provides clarity, expectations, and transparency.
III. Procedure Table – Hiring Manager	Edited details of actions required of the hiring manager from applicant selection through placement.	Provide clarity, set expectations, and provides consistency with existing processes for internal and external applicants.	Provides clarity and sets expectations.
III. Procedure Table - HR	Edited details of actions required of HR from applicant selection through placement, including adding reference to background check process.	Provide clarity, set expectations, and provide consistency.	Provides clarity and sets expectations.
IV.A	Moved Action Form (Sample) to References and renamed Personnel Action Form (Sample).	Allow for updates to action form as needed in business operations.	Provides flexibility for edits to Action Form as needed.
V.A-B	Removed reference to Employee Handbook.	Refer to resources accurately. Since the policy is the source, the Employee Handbook references the policy not the other way around.	Provides clarity, consistency, and accuracy.

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Policy Section	Proposed Change	Rationale	Impact
IX. Glossary	Added definition for Good Standing, and updated definitions for Promotion and Transfer.	Provide consistency with terms used in this and other policies.	Provides alignment within policy.

GA.8026: Employee Referral Program: Employee referrals are a valuable and cost-effective source to find and hire the best new talent. In times of recruiting challenges, CalOptima Health may choose to reward the recruiting efforts of employees by awarding a bonus to employees whose referrals are hired, in accordance with the following guidelines. Exceptions to the policy may be made, in special circumstances, by the Human Resources (HR) Department.

Policy Section	Proposed Change	Rationale	Impact
II.B.1.f.i-iii	Minor text revisions.	Clarify and align with other policies.	Provides clarity and consistency.
II.B.1.f.iv	Added immediate family members to list of ineligible referrals.	Minimize potential for conflict of interest.	Reduces potential conflicts of interest.
V.A	Removed reference to Employee Handbook.	Refer to resources accurately. Since the policy is the source, the Employee Handbook references the policy not the other way around.	Provides clarity, consistency, and accuracy.

GA.8030: Background Check: This policy outlines the process by which CalOptima Health conducts background checks.

Policy Section	Proposed Change	Rationale	Impact
Throughout (II.B, II.F, II.K, III)	Moved portions of text from policy to background check guidelines document.	Provide flexibility in making timely adjustments to guidelines as needed, while maintaining alignment with policy requirements.	Improves flexibility.
II.A	Added, "…this policy provides directives and guidance in the administration of performing background checks in a systematic and fair manner."	Better define the purpose of the policy.	Provides clarity.
II.B-D	Edited text to clarify when initial and post-employment background checks are conducted. Added provisions to	Allow CalOptima Health to conduct post-employment background checks, including criminal checks to exercise	Provides clarity and transparency. Minimizes the

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Policy Section	Proposed Change	Rationale	Impact
	conduct post-employment background checks typically every two years or upon promotion as specified.	due diligence in hiring and retaining employees.	risk of potential employee misconduct.
II.E	Added statement that requirements specific to background check are set out more fully in the Background Check Guidelines.	Refer to the more detailed Background Check Guidelines.	Allows greater flexibility to keep guidelines up to date with best practices and alignment with employment-related laws and statutes.
II.F	Minor text revisions.	Provide clarity.	Provides clarity.
II.G	Clarified that the background check is completed prior to any physical examinations.	Provide clarity and consistency with employment-related laws.	Provides clarity and aligns with employment-related laws and statutes.
II.G.3	Added pre-employment drug testing requirement for employees in safety sensitive classifications.	Align with GA.8052 Drug-Free and Alcohol-Free Workplace.	Improves alignment with other policies.
II.I	Added requirement for employees to notify Human Resources regarding arrests, convictions, and exclusion from Medi-Cal.	Provide CalOptima Health an opportunity to evaluate an employee's suitability to continue employment when off-duty misconduct has a nexus to employee's position with CalOptima Health.	Minimizes the risk of potential employee misconduct in the workplace.
II.K	Added examples of types of action taken on a driver's license that must be reported to Human Resources and added statement prohibiting employees without a valid driver's license from driving.	Provide clarity of employee expectations.	Provides clarity and transparency.
II.M	Added note that CalOptima Health follows Government Code section 12952.	Provide transparency that CalOptima Health will complete an individualized assessment when considering conviction history.	Provides transparency, clarity, and alignment with the Government Code.

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Policy Section	Proposed Change	Rationale	Impact
II.N	Added statement regarding retention of pre-employment checks as required by CalOptima Health's Document Management policy.	Align with GA.3201 Document Management Program.	Improves alignment with other policies.
IV	Attachments moved to Reference section (V).	Allow for timely updating of vendor specific forms if/when vendors change.	Improves flexibility and speed to update forms as needed.
V	Added references for guidelines, Government Codes, Labor Codes, CalOptima Health policies, EEOC regulations and sample forms.	Refer to resources accurately and thoroughly.	Provides accuracy and thoroughness.
IX. Glossary	Added terms and definitions for Safety Sensitive Employee Member.	Provide consistency with terms referenced in policy.	Provides alignment within policy.

GA.8033: License and Certification Tracking: This policy describes how CalOptima Health ensures that all staff required to have active and current licenses and/or certifications have the appropriate and required licensure(s) and/or certification(s) with proper renewal information.

Policy Section	Proposed Change	Rationale	Impact
Throughout	Edited pronouns to gender neutral.	Utilize gender neutral language.	Promotes inclusivity.
Throughout	Updated "Required Licensure and/or Certification" to "Required License or Certification."	Simplify language.	Provides clarity.
II.B	Replaced "reasonable period of time" with "30-calendar-days" and updated language for corrective action/termination.	Clarify the defined period of time and provide accuracy with the corrective action processes.	Provides clarity, accuracy, and transparency.
V	Removed reference to Employee Handbook.	Refer to resources accurately. Since the policy is the source, the Employee Handbook references the policy not the other way around.	Provides clarity, consistency, and accuracy.

GA.8034: Service of Summons, Subpoenas, and Other Legal Documents: This policy clarifies CalOptima Health's responsibility related to receipt of service of legal papers not pertaining to CalOptima Health business.

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Policy Section	Proposed Change	Rationale	Impact
Throughout	Edited pronouns to gender neutral.	Utilize gender neutral language.	Promotes inclusivity.
II.A-C	Split prior section A into 3 sections and made minor text edits.	Provide clarity and conciseness.	Provides clarity and conciseness.
II.E	Updated language referencing work location and keeping personal legal matters separate from professional responsibilities.	Improve clarity due to prevalence of telework, where work location is often the same as the residence.	Provides clarity.
III. Procedure Table	Added language regarding non-acceptance of legal papers "related to personal matters" and updated contact to legal counsel (from Legal Affairs Department).	Improve clarity since legal papers pertaining to business matters are accepted under policy AA.1215 and update who to contact if problems arise (to align with current operations).	Provides clarity and aligns with policies.

GA.8046: Relocation: This policy sets forth CalOptima Health's guidelines for the reimbursement of defined expenses incurred for relocation as a negotiating tool to recruit the most qualified candidates.

Policy Section	Proposed Change	Rationale	Impact
III.C	Updated statement regarding relocation as taxable income.	Align to Internal Revenue Service (IRS) tax code effective 1/1/2018.	Provides alignment with current IRS tax code.
IV.A	Removed "Expense Form" attachment.	Remove from attachments as form is not in use, and Accounting may revise the expense process over time. Added Expense Reporting Reference Guide as a reference.	Aligns with practice.
V	Removed reference to Glossary of Terms and added reference to IRS tax code and CalOptima Health Expense Reporting Reference Guide.	Refer to resources accurately and thoroughly.	Provides clarity, consistency, and accuracy.

GA.8047: Reduction in Force: This policy defines how CalOptima Health administers the Reduction in Force (RIF) program. A RIF occurs when changing priorities, budgetary constraints, or other business conditions require CalOptima Health to eliminate positions.

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Policy Section	Proposed Change	Rationale	Impact
Throughout	Edited pronouns to gender neutral.	Utilize gender neutral language.	Promotes inclusivity.
II.D	Minor text edits.	Reflect current practice.	Aligns with operations.
III.G	Minor text edits.	Reflect current practice.	Aligns with operations.
IV	Removed Severance Agreements as attachments.	Allow severance agreements to be modified by legal counsel on a case-by-case basis as needed.	Allows for legal review of agreements in a timely manner. Allows revisions to agreements as needed and in compliance with related employment laws.

GA.8055: Retiree Health Benefits: This policy provides detailed guidelines on how to administer retiree health benefits for those who qualify for retiree health benefits under this policy.

Policy Section	Proposed Change	Rationale	Impact
Throughout	Edited pronouns to gender neutral.	Utilize gender neutral language.	Promotes inclusivity.
II.A	Added an exception of "Reinstated Eligible Retirees."	Clarify that reinstated eligible retirees may be eligible for retiree health benefits.	Provides clarity and alignment within policy.
III.D.3.b	Changed "another state employer" to "another California public employer."	Specify California public employer (vs any state employer).	Provides clarity.
I.X. Glossary	Updated definition for "Reinstated Eligible Retiree" to state "another California public employer" instead of "another state employer."	Provide consistency with changes in policy.	Provides alignment within policy.

GA.8056: Paid Holidays: This policy establishes the paid holiday schedule for CalOptima Health Employees.

Policy Section	Proposed Change	Rationale	Impact
Throughout	Edited pronouns to gender neutral.	Utilize gender neutral language.	Promotes inclusivity.

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II.A	Removed Presidents' Day; added Lincoln's Birthday, Washington's Birthday, and Indigenous Peoples' Day; minor text revisions.	Remain competitive in attracting and retaining talent.	Enhances ability to attract and retain employees.
III.C	Added language that non-exempt employees will receive holiday premium pay as outlined in GA.8042 Supplemental Compensation.	Align with updated GA.8042 Supplemental Compensation policy.	Eliminates discrepancies between policies.
V.B	Added GA.8042 as a policy reference.	Provide reference to related policy.	Provides clarity.

GA.8059: Attendance and Timekeeping: This policy provides employees and leaders with timekeeping guidelines to manage attendance requirements.

Policy Section	Proposed Change	Rationale	Impact
II.B	Minor text change.	Clarify that meal and breaks are scheduled and employees must observe their time limits.	Provides clarity.
II.D.5	Modified language related to employee breaks in relation to the Fair Labor Standards Act (FLSA). Added statement regarding employee requirement to work within schedule.	Clarify FLSA requirements and that meal breaks included in schedule must be taken.	Provides clarity related to employee expectations related to breaks and schedules.
II.F.1	Added FLSA Workweek to overtime statement.	Clarify overtime is paid by FLSA workweek.	Provides clarity.
II.F.5	Minor text change and consolidation of II.F.4 and II.F.5 statements.	Clarify what can warrant corrective action and made more concise in one bullet.	Provides clarity.
III.B.1.b	Added language that employees need not provide specific health, medical, or genetic information when providing the reason for their unscheduled absence.	Clarify what information employees are not required to provide for an unscheduled absence.	Protects confidentiality of employees' health, medical, and genetic information.
III.C.1.a	Removed bullet.	Remove subjective/vague language.	Provides clarity.
III.D.2	Added when a doctor's note is required.	Align with related policy.	Aligns with other policies.

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Policy Section	Proposed Change	Rationale	Impact
III.G.2.c	Added, "unless otherwise notified by payroll or HR" to the process of approving time worked.	Clarify that payroll or HR may notify a leader when not to approve time worked.	Communicates expectations related to approving time worked.
III.G.3.b	Removed "due to an unforeseen event."	Eliminate unnecessary language.	Provides succinct language and improves clarity.
III.J.4	Removed "Unscheduled/Unauthorized Absence, Tardiness, or Leaving Early occurring because of."	Eliminate unnecessary language.	Provides succinct language and improves clarity.
III.K.2	Changed "Verbal Coaching" to "Coaching Memo." Changed "occurrences" to "points."	Clarify that coaching, in this situation, is documented in memo format. Create consistency with the occurrence and points table in Section III.J.	Increase clarity and align with practice and other policies.
Page 12; V.J	Removed reference to Employee Handbook. Added references to the FLSA and §1630.9 of Title 29 of the California Code of Regulations.	Refer to resources accurately. Since the policy is the source, the Employee Handbook references the policy not the other way around. Provide references to all applicable sources.	Provides clarity, consistency, and accuracy.

GA.8062: Social Media Conduct: This new policy outlines requirements for CalOptima Health employee communication in online communities and compliance with legal and regulatory requirements, including laws concerning privacy and confidentiality.

Fiscal Impact

The recommended action to revise existing Human Resources policies and procedures and adopt new CalOptima Health Policy GA.8062 has no additional fiscal impact in the current year. Staff will include updated administrative expenses in future operating budgets.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Resolution No. 22-1201-02, Approve Updated Human Resources Policies

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2. Revised CalOptima Health Policies

    a. GA.8018: Paid Time Off (PTO) and Attachments A-C
    b. GA.8019: Promotions and Transfers
    c. GA.8026: Employee Referral Program
    d. GA.8030: Background Check
    e. GA.8033: License and Certification Tracking
    f. GA.8034: Service of Summons, Subpoenas, and Other Legal Documents
    g. GA.8046: Relocation
    h. GA.8047: Reduction in Force
    i. GA.8055: Retiree Health Benefits
    j. GA.8056: Paid Holidays
    k. GA.8059: Attendance and Timekeeping

3. New CalOptima Health Policy
    a. GA.8062: Social Media Conduct

/s/ Michael Hunn *11/23/2022*
Authorized Signature **Date**

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RESOLUTION NO. 22-1201-02

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

APPROVE UPDATED AND NEW CALOPTIMA HEALTH POLICIES

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

WHEREAS, in 1994, the Board of Directors designated the Chief Executive Officer as the Appointing Authority with full power to hire and terminate CalOptima 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, California Code of Regulations, Title 2, Section 570.5, requires CalOptima Health to adopt a publicly available pay schedule that identifies the position title and pay rate for every employee position, and CalOptima Health regularly reviews CalOptima Health's salary schedule accordingly.

NOW, THEREFORE, BE IT RESOLVED:

Section 1. That the Board of Directors hereby approves and adopts the attached updated and new CalOptima Health Policies:

- Updated Policy GA. 8018: Paid Time Off (PTO)
- Updated Policy GA. 8019: Promotions and Transfers
- Updated Policy GA. 8026: Employee Referral Program
- Updated Policy GA. 8030: Background Check
- Updated Policy GA. 8033: License and Certification Tracking
- Updated Policy GA. 8034: Service of Summons, Subpoenas, and Other Legal Documents
- Updated Policy GA. 8046: Relocation
- Updated Policy GA. 8047: Reduction in Force
- Updated Policy GA. 8055: Retiree Health Benefits
- Updated Policy GA. 8056: Paid Holidays
- Updated Policy GA. 8059: Attendance and Timekeeping
- New Policy GA.8062: Social Media Conduct

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima Health this 1st day of December 2022.

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AYES:
NOES:
ABSENT:
ABSTAIN:

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

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

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Policy:	GA.8018
Title:	**Paid Time Off (PTO)**
Department:	CalOptima Health Administrative
Section:	Human Resources
CEO Approval:	
Effective Date:	10/27/2011
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy provides managers and supervisors with appropriate guidelines to administer ~~CalOptima's~~CalOptima Health's Paid Time Off (PTO) benefit.

II. POLICY

A. CalOptima Health provides PTO, a work-life balance benefit, to all eligible employees to enable them to take time off from work for activities such as rest, recreation, recovery from injury and illness or other personal activities. CalOptima Health believes this time is valuable for employees in order to enhance productivity and make the work experience more personally satisfying. CalOptima Health provides employees with additional hours of PTO as ~~years~~months of service are accumulated.

B. Full-Time, Part-Time, and Limited Term Employees who are regularly scheduled to work more than twenty (20) hours per week are eligible to accrue PTO. ~~An eligible employee may use PTO hours for vacation, preventative health, or dental care, or care of an existing health condition of the employee, or the employee's family member, short-term illness, family illness, emergencies, religious observances, personal business, Child-Related Activities, or for specified purposes if the employee is a victim of domestic violence, sexual assault, or stalking. CalOptima~~An eligible employee may use accrued PTO hours to take time off from work for any reason ~~that is consistent with CalOptima Health's policies and applicable federal and state laws.~~ CalOptima Health encourages employees to maintain work-life balance by utilizing PTO benefits for rest and recreation throughout the year. ~~-~~Employees who satisfy eligibility requirements set out in CalOptima Health's respective policies and applicable federal and state laws may be granted other types of leaves of absence. Unless otherwise prohibited by law, such leaves may require employees to use accrued PTO before transitioning to unpaid leave.

C. California Healthy Workplaces, Healthy Families Act of 2014 ("~~Act~~Paid Sick Leave"), effective July 1, 2015, requires CalOptima Health to provide paid sick leave to eligible employees. CalOptima Health already provides employees who are eligible to accrue PTO, as specified in Section III.B. above, a sufficient amount of PTO that can be used for sick leave that satisfies the accrual, carryover, and use requirements under the ~~Act.~~Paid Sick Leave law. For all other employees who are not eligible to accrue PTO as specified in Section II.B. above, such as As-

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Needed Employees, who work thirty (30) or more days within one (1) year from the start of their date of employment, the following provisions shall apply:

1. CalOptima Health shall provide the full amount of twenty-four (24) hours or three (3) days, whichever is greater, of paid sick leave to eligible employees on July 1, 2015, and then at the beginning of each calendar year thereafter. For eligible employees hired~~, or engaged,~~ after July 1, 2015, the full amount of twenty-four (24) hours, or three (3) days, whichever is greater, of paid sick leave shall be provided ~~beginning~~ at the commencement of employment ~~or engagement~~ and then at the beginning of each calendar year thereafter. As such, the employee will not accrue any additional paid sick leave and will not carry over any unused sick leave hours to the following year.

2. Upon satisfying a ninety (90) day employment period, employees may use accrued sick leave for preventative care or diagnosis, and care or treatment of an existing health condition of the employee or the employee's family member. The ~~Act~~Paid Sick Leave law defines a "family member" as a child, parent, spouse, registered domestic partner, grandparent, grandchild, or sibling. Eligible employees may also use accrued paid sick leave for specified purposes if the employee is a victim of domestic violence, sexual assault, or stalking.

3. Paid sick leave will not be treated the same as PTO. Upon termination, resignation, retirement, or other separation from employment, CalOptima Health will not ~~payout~~ pay out employees for unused paid sick leave time accrued under the ~~Act~~Paid Sick Leave law. In addition, accrued paid sick leave time is not eligible for cash out. If an employee separates and is then rehired by CalOptima Health within one (1) year from the date of separation, the previously accrued and unused paid sick leave time will be reinstated. An employee rehired within one (1) year from the date of separation may not be subject to the ~~Act's~~Paid Sick Leave law's ninety (90)-day waiting period, if such condition was previously satisfied, and may use their paid sick leave time immediately upon rehire, if eligible.

D. **PTO Accrual**: An eligible employee ~~accrues~~begins accruing PTO ~~hours~~on their hire date, based on ~~his or her~~their classification as exempt or non-exempt, hours paid (excluding overtime) each pay period (non-exempt employees), and ~~years~~months of Continuous Service in accordance with the accrual schedule provided below. ~~PTO begins accruing~~, with the following exceptions:

1. If an employee is rehired by CalOptima Health within ninety (90) calendar days from the date of ~~hire.~~ separation, the employee's PTO accrual rate will include prior months of continuous service. For those employees who are rehired beyond ninety (90) calendar days after separation, the Chief Executive Officer will have the discretion to approve deviations of up to a maximum of eighty (80) accrued hours per year from the date of rehire.

2. On rare occasions and on a case-by-case basis, the Chief Executive Officer may approve deviations of up to a maximum of ~~ten (10) days~~ one hundred twenty (120) hours accrued per year from the accrual schedule below. ~~In addition, the~~

3. The CEO may authorize one-time PTO of up to a maximum of eight (8) hours per employee per incident, in cases of local emergencies or unforeseen circumstances necessitating time off for the immediate protection, welfare and safety of the employee ~~and/~~or CalOptima Health property.

Annual Paid Time Off Benefits Accrual Schedule

In the accrual tables below, the total hours accrued is based on the number of hours paid, prorated for employees who work less than a full-time schedule, and calculated up to a maximum of eighty (80) hours for the biweekly pay period. The increase in PTO accrual will take effect at the end of the pay period following completion of thirty-six (36) months or one hundred twenty (120) months of service as required in the tables below.

Non-Exempt Employees:

~~Years~~Months of Continuous Service	Hours of PTO Accrued (Biweekly pay period)	Annual Hourly Accrual
~~0 – 3~~Up to 36 Months	5.~~54~~5385	~~1~~44
~~4 – 10~~36+ Months to 120 Months	7.~~08~~0769	184
~~11 +~~120+ Months	8.~~62~~6154	224

Note: 36 months = 3 years; 120 months = 10 years

Exempt Employees:

~~Years~~Months of Continuous Service	Hours of PTO Accrued (Biweekly pay period)	Annual Hourly Accrual
~~0 – 3~~Up to 36 Months	7.~~08~~0769	184
~~4 – 10~~36+ Months to 120 Months	8.~~62~~6154	224
~~11 +~~120+ Months	10.~~15~~1538~~8~~	264

Note: 36 Months = 3 years; 120 months = 10 years

~~D.~~E. **Maximum Accrual:** Limits are imposed on the amount of PTO that can be maintained in an employee's PTO account. If available PTO is not used by the end of the benefit year [benefit year is the twelve (12) month period from hire date], employees may carry unused time off into subsequent years, up to the maximum accrual amount specified herein. The maximum amount permitted in an employee's PTO account is equal to two (2) times the employee's Annual Accrual (see chart above). If an employee reaches ~~his or her~~their maximum PTO accrual amount, the employee will stop accruing PTO.

~~E.~~F. **PTO Accrual during Leaves of Absence:** PTO does not accrue when absent from work in connection with an approved or unapproved unpaid Leave of Absence, including, but not limited to, workers' compensation leave, or short/long term disability. PTO accruals recommence when the employee returns to work from an unpaid Leave of Absence.

~~F.~~G. **PTO Scheduling**: Scheduling of PTO is to be done in a manner compatible with ~~CalOptima's~~CalOptima Health's operational requirements. In order to minimize the impact of an employee's absence, planned time off ~~-~~should be submitted by an employee to ~~his or her~~their immediate supervisor for approval at least two (2) weeks before the requested time off. Advance approval by the supervisor is subject to the condition that the employee has sufficient time available in the employee's PTO account at the time the employee uses the PTO. Supervisors have authority to approve or deny PTO requests based on business needs, and CalOptima Health will not be responsible for any expenses incurred by an employee if the request for PTO is not approved. Each department may have special scheduling requirements and procedures for requesting PTO; therefore, employees should check with their immediate supervisor in advance, except for purposes of sick leave. In rare cases, an Executive may authorize the rescission of approved PTO to address

urgent, emergent, or emergency situations. Notification to the employee will be made as soon as the need is known.

~~G.~~H. **PTO for Leaves of Absence Pursuant to Family and Medical Leave Act (FMLA), California Family Rights Act (CFRA), Pregnancy Disability Leave (PDL), Paid Sick Leave, and Other Leaves**: CalOptima Health is required to provide time off to eligible employees in accordance with applicable laws. Accrued PTO will automatically be used to pay employees for any period of time taken off under the FMLA, and/or the CFRA ~~(for their own serious health condition, or that of an immediate family member, unless such health condition qualifies under the PDL).Family member for the purposes of FMLA and CFRA includes a spouse, parent, or child, and includes care for the birth, adoption, or foster care placement of a child, or other qualified next of kin.~~ in accordance with CalOptima Health Policy GA.8040: Family Medical and Care Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence. Use of PTO for any period of time taken off under PDL is at the discretion of the employee. Accrued PTO will ~~also~~ be automatically used towards paid sick leave for preventative care, or care of an existing health condition for the employee, or a family member, which includes the employee's parent, child, spouse, registered domestic partner, grandparent, grandchild, or sibling, or for specified purposes if the employee is a victim of domestic violence, sexual assault, or stalking. In addition, employees may use half of their annual accrued PTO for preventive care, or care of an existing health condition for the employee, or a family member as permitted under Labor Code, ~~Sections~~Section 233. Accrued PTO shall also be automatically used for time-off for Child-Related Activities, subject to the limitations under Labor Code, Section 230.8. At the employee's discretion, PTO may also be used to supplement an employee's income, up to one hundred percent (100~~%),~~%) if an employee is receiving short/long term disability benefits during an approved unpaid Leave of Absence. Leave rights discussed herein may overlap and shall not create greater rights than permitted under applicable laws. For example, the right of an employee on a Leave of Absence for ~~his or her~~their own serious health condition, or the serious health condition of their eligible family member, under FMLA and CFRA may coincide with ~~his or her~~their rights under the ~~Act and Protected~~Paid Sick Leave law , such that ~~he or she~~they shall only be entitled to the maximum amount of time off permitted under FMLA/CFRA~~,~~ or ~~Protected~~the Paid Sick Leave law, whichever is greater. As another example, an employee who has exhausted all of ~~his or her~~their accrued PTO shall not be entitled to additional paid leave under either Acts or under ~~Protected~~the Paid Sick Leave law.

~~H.~~I. **Unscheduled PTO**: Regardless of the reason for an unscheduled absence, an employee shall notify ~~his/her~~their immediate supervisor in accordance with CalOptima Health Policy GA.8059: Attendance and Timekeeping~~.~~. Notification of an unscheduled absence does not make the absence authorized.~~-~~ An employee shall enter the PTO request into the timekeeping system as soon as reasonably possible, and the employee's PTO account will be deducted accordingly. Excessive use of unscheduled PTO above and beyond what is allowed under ~~Protected~~the Paid Sick Leave law may result in discipline, up to and including termination. If an employee is absent for four (4) consecutive days, or more, on personal and unprotected sick time, a doctor's note is required on the first day back.

~~I.~~J. **Holidays Occurring During PTO**: If an observed CalOptima Health holiday occurs during an employee's scheduled PTO, the employee's PTO account will not be deducted for that holiday day~~.~~ , unless the full-time non-exempt employee is on a 9/80 schedule pursuant to CalOptima Health Policy GA.8020: 9/80 Work Schedule. In this case, the employee has the option of using one (1) hour of accrued PTO or making up the time if approved by their supervisor.

~~J.~~K. **Maximum Annual Cash Out**: An election period will be held each year at about the same time as ~~CalOptima's~~CalOptima Health's annual open enrollment period. During this time, each employee

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may elect, for the following year, to convert to cash PTO hours up to the full amount that the employee will be eligible to accrue at the time of cash out in the next calendar year. Once the election period closes, but in no event after December 31 of the year prior to payment of the cash out, the request for PTO cash out cannot be revoked. Requests for cash out will be paid out once per calendar year as determined by the Human Resources Department, provided that all of the following criteria are met: (1) the employee made the election during the applicable open enrollment period, (2) the employee has actually accrued the requested amount of hours in the same year and by the time the cash out is made, and (3) a minimum of one hundred (100) accrued PTO hours remain in the employee's PTO account after cash out. If the employee's election to cash out is for more hours than are eligible, the cash out will be limited to the number of eligible PTO hours at the time the cash out is made. Cashed out PTO will be paid at the employee's current hourly rate at the time the PTO cash out is scheduled to be paid, subject to all applicable taxes and deductions.

~~K.~~L. **Cash Out for Financial Hardship:** If during the year an employee experiences a personal financial hardship, the employee can cash out ~~his or her~~their accrued PTO hours. Cash out for financial hardships are limited to one per calendar year. Documentation verifying the financial hardship must be provided to the Human Resources Department. The number of hours an employee can request for a financial hardship is subject to the requirement that a minimum of one hundred (100) accrued PTO hours remain in the employee's PTO account after cash out. Financial hardships must represent an immediate and heavy financial need and there must be no other resources readily available to handle that financial need. Financial hardships shall be limited to the following reasons:

1. Expenses for, or necessary, to obtain non-reimbursed medical care for employee or immediate family members;

2. Payment for the purchase of a primary residence;

3. Payment of tuition, related education fees, and room and board expenses for postsecondary education for the employee, or the employee's spouse (or registered domestic partner), children, or dependents;

4. Payments necessary to prevent the employee from eviction or foreclosure;

5. Expenses for the repair of damage to an employee's primary residence for damages from natural disasters; or

6. Expenses for the burial, funeral, or memorial for an employee's deceased parent, spouse (or registered domestic partner), children, or dependents.

~~L.~~M. **PTO Pay/Flex Pay on Termination**: Employees are expected to give at least two (2) weeks' written notice prior to resigning from ~~his or her~~their employment. Notice of resignation is expected to be a "working" notice to allow an opportunity for productive work time to complete projects, or train whoever will be assuming the employee's responsibilities. For that reason, employees should avoid using accrued PTO during the two (2) week period preceding their last scheduled day of work and/or coordinate the use of PTO time to provide at least two (2) "working" weeks. In no event shall CalOptima Health permit an employee to use ~~his or her~~their accrued PTO beyond the last day worked by an employee, unless the employee was on an approved Leave of Absence, or unless otherwise required by law. Upon termination of employment, the employee is paid all accrued unused PTO and Flex Holiday time at the employee's base rate of pay, subject to all applicable taxes, at the time of the termination. According to California Labor Code, Section 220(b), as a

public agency, CalOptima Health is not required to pay wages immediately upon termination. CalOptima Health will pay the employee on the next regularly scheduled pay day.

~~M.~~N. **PTO Donation Program**: At the discretion of the Human Resources Department, a PTO Donation Program may be implemented. Employees may donate accrued PTO hours to assist another CalOptima Health employee ("Recipient Employee") when a Recipient Employee, or their family member, qualifies as having a Catastrophic Illness. Donations are completely voluntary, and donors will remain anonymous to the Recipient Employee.

1. To be eligible to receive PTO donations, a Recipient Employee must meet all the following criteria:

   a. Have a Catastrophic Illness, which shall mean a major illness or other medical condition (e.g., heart attack, cancer, etc.) or have a family member with a Catastrophic Illness which requires the employee take a prolonged absence including intermittent absences that are related to the same illness, or condition, and which will result in a substantial loss of income to the employee because the employee will have exhausted all PTO available apart from the PTO Donation Program. Family members referenced above shall include an employee's spouse ~~(~~or registered domestic partner~~);~~, biological, adopted, step, or foster, child under age eighteen (18), or an adult dependent child substantially limited by a physical, or mental, impairment; or biological, adopted, step, or foster, parent;

   b. Have worked for CalOptima Health for at least ninety (90) days and be eligible to accrue PTO hours under this Policy;

   c. Be in Good Standing (no written warnings or corrective action plans within the last six (6) months, and the most recent performance evaluation shows the employee is meeting the performance standards);

   d. Exhausted all of ~~his or her~~their own PTO time;

   e. Completed a written request and authorization form including medical documentation to be approved by the Human Resources Department;

   f. Have the scheduled time off or Leave of Absence, approved by CalOptima Health in accordance with ~~CalOptima's~~CalOptima Health's Leave of Absence and Personal Leave of Absence Policies; and

   g. Have not resigned or been terminated from employment prior to or during the employee's time off or Leave of Absence.

2. To donate, a Donor Employee must meet all the following criteria:

   a. Donate and surrender a minimum of two (2) hours, in increments of one (1) hour.

   b. Maintain a minimum balance of one hundred (100) accrued PTO hours in the Donor Employee's PTO account after donation.

   c. Submit a form authorizing the donation and acknowledging that the donated PTO time has been surrendered to CalOptima Health for the benefit of another employee and is no longer a benefit to the Donor Employee.

3. PTO donation pay rate. PTO hours donated will be transferred to the Recipient Employee on an hour-for-hour basis at the Recipient Employee's rate of pay, without regard to the rate of pay of the Donor Employee. The Recipient Employee is responsible for the tax burden of the donation. Any donated PTO that is not used by the Recipient Employee shall remain in the Recipient Employee's PTO account for future use.

4. Disability or workers' compensation. If a Recipient Employee is receiving short term or long term disability or workers' compensation benefits, the Recipient Employee may coordinate the donated PTO hours with these benefits to supplement the Recipient Employee's income up to one hundred percent (100%) of the employee's salary. For instance, if the Recipient Employee is receiving sixty percent (60%) of ~~his or her~~their income from short term disability, CalOptima Health will allow the Recipient Employee to use the donated PTO hours to supplement up to the forty percent (40%) difference in compensation, bringing the Recipient Employee's total monthly income to one hundred percent (100%) of ~~his or her~~their earnings.

5. The Recipient Employee must submit an application and all necessary documentation to the Human Resources Department to be a recipient of the donated PTO and must give CalOptima Health permission to issue an all-staff email announcing the opportunity to donate PTO. The email will identify the Recipient Employee and any other information expressly authorized by the Recipient Employee.

6. In submitting an application, the Recipient Employee will be required to save, defend, and hold CalOptima Health harmless from any claims, liability, or actions concerning the disclosure of health information authorized by the Recipient Employee.

7. This PTO Donation program is completely voluntary on the part of CalOptima Health and may be amended or terminated by the Human Resources Department at any time at ~~-~~ its sole discretion.

III. PROCEDURE

A. PTO or Paid Sick Leave Time Request for Time Off:

Responsible Party	Action
Employee	• Request PTO or paid sick leave at least two (2) weeks in advance, where possible, using ~~CalOptima's~~CalOptima Health's time-keeping system. If the need for time off is foreseeable, employee must provide reasonable advance notice. If not, the employee must provide notice as soon as practicable. (If using PTO or paid sick leave for illness or preventative treatment, enter time away from work request as PTO Sick).
Supervisor	• Review all requests and approve, or deny, the request.

B. PTO Request to Cash Out:

Responsible Party	Action
Employee	• Request PTO cash out for the following year during the designated election period
Payroll	• Review all requests and approve or deny the request.

C. PTO Request for Donations (Recipient Employee):

Responsible Party	Action
Recipient Employee	• Request a Leave of Absence. • Complete a written request and authorization form including supporting medical documentation to be submitted to the Human Resources Department for approval, if eligible. • Sign a written waiver concerning disclosure of information to CalOptima Health employees.
Human Resources Department	• Receive request and authorization form from Recipient Employee and review for completeness and eligibility. • Within ten (10) days of receipt of all necessary material provide notice to Recipient Employee whether or not Human Resources approves or rejects the employee's request. Where approved, send out email request to all CalOptima Health employees consistent with permissible information provided by the Recipient Employee.

D. PTO Request to Donate (Donor Employee):

Responsible Party	Action
Donor Employee	• Submit a form authorizing the donation and designating the number of hours surrendered to CalOptima Health for the benefit of a Recipient Employee. • Sign an acknowledgement that the donated PTO time has been surrendered to CalOptima Health for the benefit of a Recipient Employee and is no longer a benefit to the Donor Employee.
Human Resources Department	• Receive donation form from Donor Employee and review for completeness and eligibility. • Within ten (10) days of receipt of all necessary material provide notice to Donor Employee whether or not Human Resources approves or rejects the employee's request Where approved, transfer the donated PTO hours to the Recipient Employee on an hour for hour basis at the Recipient Employee's rate of pay.

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IV. ATTACHMENT(S)

A. PTO Donation Program –Request and Authorization Form – Recipient Employee
B. PTO Donation Program –Donation and Authorization Form – Donor Employee
C. Cash Out PTO for Financial Hardship Request Form

V. REFERENCE(S)

A. California Labor Code, §§230.8, 233-234, and ~~246~~245-249 *et seq*.
B. CalOptima Health Employee Handbook
C. CalOptima Health Policy GA.8037: Leave of Absence
D. CalOptima Health Policy GA.8038: Personal Leave of Absence
E. CalOptima Health Policy GA.8040: FMLA and CFRA Leaves of Absence
F. CalOptima Health Policy GA.8041: Workers' Compensation Leave of Absence
G. CalOptima Health Policy GA.8059: Attendance and Timekeeping

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTIONS

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors
08/07/2014	Regular Meeting of the CalOptima Board of Directors
06/04/2015	Regular Meeting of the CalOptima Board of Directors
12/03/2015	Regular Meeting of the CalOptima Board of Directors
02/02/2017	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/27/2011	GA.8018	Paid Time Off (PTO)	Administrative
Revised	03/26/2014	GA.8018	Paid Time Off (PTO)	Administrative
Revised	05/01/2014	GA.8018	Paid Time Off (PTO)	Administrative
Revised	08/07/2014	GA.8018	Paid Time Off (PTO)	Administrative
Revised	06/04/2015	GA.8018	Paid Time Off (PTO)	Administrative
Revised	12/03/2015	GA.8018	Paid Time Off (PTO)	Administrative
Revised	02/02/2017	GA.8018	Paid Time Off (PTO)	Administrative
Revised	12/03/2020	GA.8018	Paid Time Off (PTO)	Administrative
Revised	TBD	GA.8018	Paid Time Off (PTO)	Administrative

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IX. GLOSSARY

Term	Definition
As-Needed	Employees called to work sporadically on an as-needed basis. These employees may not have regularly scheduled hours and do not earn any benefits. As-Needed employees are employed for an indefinite duration and must work less than one thousand (1,000) hours per fiscal year.
Catastrophic Illness	A major illness or other medical condition (e.g., heart attack, cancer, etc.) of the employee or a family member of the employee that requires a prolonged absence of the employee from work, including intermittent absences that are related to the same illness or condition, and will result in a substantial loss of income to the employee because the employee will have exhausted all PTO available apart from the PTO Donation Program.
Child-Related Activities	Participation in activities at child's school or day care facility as permitted under Labor Code, Section 230.8, which includes: finding, enrolling, or reenrolling a child in a school or with a licensed child care provider; child care provider or school, emergency; request for child to be picked up from school/child care, or an attendance policy that prohibits the child from attending or requires the child to be picked up from the school or child care provider; behavioral/discipline problems; closure or unexpected unavailability of school (excluding planned holidays); a natural disaster; or to participate in activities of the school or licensed child care provider of ~~his or her~~their child, if the employee, prior to taking the time off, gives reasonable notice to CalOptima.
Continuous Service	A period of employment with one (1) employer, which begins with the day on which the employee starts work and ends with the date of resignation or dismissal. All service, regardless of hours worked, counts toward calculating continuous service.
Exempt Employee	Exempt status is determined by the Human Resources Department based on the position title and duties and responsibilities of the position and consistent with the ~~federal~~Federal Fair Labor Standards Act (FLSA) regulations. Although an employee's classification may meet applicable federal and/or state exemption criteria, the position may nevertheless be designated as non-exempt. Exempt employees do not earn overtime compensation.
Full-Time Employee	An employee who works sixty (60) to eighty (80) hours ~~a~~per pay period.
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.
Leave of Absence (LOA)	A term used to describe a scheduled period of time off that an employee is to be away from ~~his or her~~their primary job, while maintaining the status of employee.
Limited Term Employee	Employees who are hired to work a full-time schedule on special-assignments that last a period of less than six (6) months. Limited Term employees do not become regular employees as a result of the passage of time.
Non-Exempt Employee	Non-Exempt status applies to all employees who are not identified by Human Resources as exempt. Non-Exempt employees are paid on an hourly basis and are eligible for overtime compensation. Although an employee's classification may qualify for applicable federal exemptions from the FLSA exemption criteria, the position may nevertheless be designated as non-exempt.

Term	Definition
Paid Interns	Paid interns are considered As-Needed employees and should be concurrently enrolled in college or graduate courses.
Paid Sick Leave	Paid Sick Leave covers the provisions of the Healthy Workplaces, Healthy Families Act of 2014 (California Labor Code §245-249) and Kin Care (California Labor Code §233-234)
Part-Time Employees	Employees that regularly work less than thirty (30) hours per week.

1

Policy:	GA.8018
Title:	**Paid Time Off (PTO)**
Department:	CalOptima Health Administrative
Section:	Human Resources
CEO Approval:	
Effective Date:	10/27/2011
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy provides managers and supervisors with appropriate guidelines to administer CalOptima Health's Paid Time Off (PTO) benefit.

II. POLICY

A. CalOptima Health provides PTO, a work-life balance benefit, to all eligible employees to enable them to take time off from work for activities such as rest, recreation, recovery from injury and illness or other personal activities. CalOptima Health believes this time is valuable for employees in order to enhance productivity and make the work experience more personally satisfying. CalOptima Health provides employees with additional hours of PTO as months of service are accumulated.

B. Full-Time, Part-Time, and Limited Term Employees who are regularly scheduled to work more than twenty (20) hours per week are eligible to accrue PTO. An eligible employee may use accrued PTO hours to take time off from work for any reason. CalOptima Health encourages employees to maintain work-life balance by utilizing PTO benefits for rest and recreation throughout the year. Employees who satisfy eligibility requirements set out in CalOptima Health's respective policies and applicable federal and state laws may be granted other types of leaves of absence. Unless otherwise prohibited by law, such leaves may require employees to use accrued PTO before transitioning to unpaid leave.

C. California Healthy Workplaces, Healthy Families Act of 2014 ("Paid Sick Leave"), effective July 1, 2015, requires CalOptima Health to provide paid sick leave to eligible employees. CalOptima Health already provides employees who are eligible to accrue PTO, as specified in Section III.B. above, a sufficient amount of PTO that can be used for sick leave that satisfies the accrual, carryover, and use requirements under the Paid Sick Leave law. For all other employees who are not eligible to accrue PTO as specified in Section II.B. above, such as As-Needed Employees, who work thirty (30) or more days within one (1) year from the start of their date of employment, the following provisions shall apply:

1. CalOptima Health shall provide the full amount of twenty-four (24) hours or three (3) days, whichever is greater, of paid sick leave to eligible employees on July 1, 2015, and then at the beginning of each calendar year thereafter. For eligible employees hired after July 1, 2015, the

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full amount of twenty-four (24) hours, or three (3) days, whichever is greater, of paid sick leave shall be provided at the commencement of employment and then at the beginning of each calendar year thereafter. As such, the employee will not accrue any additional paid sick leave and will not carry over any unused sick leave hours to the following year.

2. Upon satisfying a ninety (90) day employment period, employees may use accrued sick leave for preventative care or diagnosis, and care or treatment of an existing health condition of the employee or the employee's family member. The Paid Sick Leave law defines a "family member" as a child, parent, spouse, registered domestic partner, grandparent, grandchild, or sibling. Eligible employees may also use accrued paid sick leave for specified purposes if the employee is a victim of domestic violence, sexual assault, or stalking.

3. Paid sick leave will not be treated the same as PTO. Upon termination, resignation, retirement, or other separation from employment, CalOptima Health will not pay out employees for unused paid sick leave time accrued under the Paid Sick Leave law. In addition, accrued paid sick leave time is not eligible for cash out. If an employee separates and is then rehired by CalOptima Health within one (1) year from the date of separation, the previously accrued and unused paid sick leave time will be reinstated. An employee rehired within one (1) year from the date of separation may not be subject to the Paid Sick Leave law's ninety (90)-day waiting period, if such condition was previously satisfied, and may use their paid sick leave time immediately upon rehire, if eligible.

D. **PTO Accrual**: An eligible employee begins accruing PTO on their hire date, based on their classification as exempt or non-exempt, hours paid (excluding overtime) each pay period (non-exempt employees), and months of Continuous Service in accordance with the accrual schedule provided below, with the following exceptions:

1. If an employee is rehired by CalOptima Health within ninety (90) calendar days from the date of separation, the employee's PTO accrual rate will include prior months of continuous service. For those employees who are rehired beyond ninety (90) calendar days after separation, the Chief Executive Officer will have the discretion to approve deviations of up to a maximum of eighty (80) accrued hours per year from the date of rehire.

2. On rare occasions and on a case-by-case basis, the Chief Executive Officer may approve deviations of up to a maximum of one hundred twenty (120) hours accrued per year from the accrual schedule below.

3. The CEO may authorize one-time PTO of up to a maximum of eight (8) hours per employee per incident, in cases of local emergencies or unforeseen circumstances necessitating time off for the immediate protection, welfare and safety of the employee or CalOptima Health property.

Annual Paid Time Off Benefits Accrual Schedule

In the accrual tables below, the total hours accrued is based on the number of hours paid, prorated for employees who work less than a full-time schedule, and calculated up to a maximum of eighty (80) hours for the biweekly pay period. The increase in PTO accrual will take effect at the end of the pay period following completion of thirty-six (36) months or one hundred twenty (120) months of service as required in the tables below.

Non-Exempt Employees:

Months of Continuous Service	Hours of PTO Accrued (Biweekly pay period)	Annual Hourly Accrual
Up to 36 Months	5.5385	144
36+ Months to 120 Months	7.0769	184
120+ Months	8.6154	224

Note: 36 months = 3 years; 120 months = 10 years

Exempt Employees:

Months of Continuous Service	Hours of PTO Accrued (Biweekly pay period)	Annual Hourly Accrual
Up to 36 Months	7.0769	184
36+ Months to 120 Months	8.6154	224
120+ Months	10.1538	264

Note: 36 Months = 3 years; 120 months = 10 years

E. **Maximum Accrual:** Limits are imposed on the amount of PTO that can be maintained in an employee's PTO account. If available PTO is not used by the end of the benefit year [benefit year is the twelve (12) month period from hire date], employees may carry unused time off into subsequent years, up to the maximum accrual amount specified herein. The maximum amount permitted in an employee's PTO account is equal to two (2) times the employee's Annual Accrual (see chart above). If an employee reaches their maximum PTO accrual amount, the employee will stop accruing PTO.

F. **PTO Accrual during Leaves of Absence:** PTO does not accrue when absent from work in connection with an approved or unapproved unpaid Leave of Absence, including, but not limited to, workers' compensation leave, or short/long term disability. PTO accruals recommence when the employee returns to work from an unpaid Leave of Absence.

G. **PTO Scheduling**: Scheduling of PTO is to be done in a manner compatible with CalOptima Health's operational requirements. In order to minimize the impact of an employee's absence, planned time off should be submitted by an employee to their immediate supervisor for approval at least two (2) weeks before the requested time off. Advance approval by the supervisor is subject to the condition that the employee has sufficient time available in the employee's PTO account at the time the employee uses the PTO. Supervisors have authority to approve or deny PTO requests based on business needs, and CalOptima Health will not be responsible for any expenses incurred by an employee if the request for PTO is not approved. Each department may have special scheduling requirements and procedures for requesting PTO; therefore, employees should check with their immediate supervisor in advance, except for purposes of sick leave. In rare cases, an Executive may authorize the rescission of approved PTO to address urgent, emergent, or emergency situations. Notification to the employee will be made as soon as the need is known.

H. **PTO for Leaves of Absence Pursuant to Family and Medical Leave Act (FMLA), California Family Rights Act (CFRA), Pregnancy Disability Leave (PDL), Paid Sick Leave, and Other Leaves**: CalOptima Health is required to provide time off to eligible employees in accordance with applicable laws. Accrued PTO will automatically be used to pay employees for any period of time taken off under the FMLA, and/or the CFRA in accordance with CalOptima Health Policy GA.8040: Family Medical and Care Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence. Use of PTO for any period of time taken off under PDL is at the discretion of the employee. Accrued PTO will be automatically used towards paid sick leave for preventative care, or care of an existing health condition for the employee, or a family member, which includes the employee's parent, child, spouse, registered domestic partner, grandparent, grandchild, or sibling, or for specified purposes if the employee is a victim of domestic violence, sexual assault, or stalking. In addition, employees may use half of their annual accrued PTO for preventive care, or care of an existing health condition for the employee, or a family member as permitted under Labor Code, Section 233. Accrued PTO shall also be automatically used for time-off for Child-Related Activities, subject to the limitations under Labor Code, Section 230.8. At the employee's discretion, PTO may also be used to supplement an employee's income, up to one hundred percent (100%) if an employee is receiving short/long term disability benefits during an approved unpaid Leave of Absence. Leave rights discussed herein may overlap and shall not create greater rights than permitted under applicable laws. For example, the right of an employee on a Leave of Absence for their own serious health condition, or the serious health condition of their eligible family member, under FMLA and CFRA may coincide with their rights under the Paid Sick Leave law , such that they shall only be entitled to the maximum amount of time off permitted under FMLA/CFRA or the Paid Sick Leave law, whichever is greater. As another example, an employee who has exhausted all of their accrued PTO shall not be entitled to additional paid leave under either Acts or under the Paid Sick Leave law.

I. **Unscheduled PTO**: Regardless of the reason for an unscheduled absence, an employee shall notify their immediate supervisor in accordance with CalOptima Health Policy GA.8059: Attendance and Timekeeping. Notification of an unscheduled absence does not make the absence authorized. An employee shall enter the PTO request into the timekeeping system as soon as reasonably possible, and the employee's PTO account will be deducted accordingly. Excessive use of unscheduled PTO above and beyond what is allowed under the Paid Sick Leave law may result in discipline, up to and including termination. If an employee is absent for four (4) consecutive days, or more, on personal and unprotected sick time, a doctor's note is required on the first day back.

J. **Holidays Occurring During PTO**: If an observed CalOptima Health holiday occurs during an employee's scheduled PTO, the employee's PTO account will not be deducted for that holiday day, unless the full-time non-exempt employee is on a 9/80 schedule pursuant to CalOptima Health Policy GA.8020: 9/80 Work Schedule. In this case, the employee has the option of using one (1) hour of accrued PTO or making up the time if approved by their supervisor.

K. **Maximum Annual Cash Out**: An election period will be held each year at about the same time as CalOptima Health's annual open enrollment period. During this time, each employee may elect, for the following year, to convert to cash PTO hours up to the full amount that the employee will be eligible to accrue at the time of cash out in the next calendar year. Once the election period closes, but in no event after December 31 of the year prior to payment of the cash out, the request for PTO cash out cannot be revoked. Requests for cash out will be paid out once per calendar year as determined by the Human Resources Department, provided that all of the following criteria are met: (1) the employee made the election during the applicable open enrollment period, (2) the employee has actually accrued the requested amount of hours in the same year and by the time the cash out is made, and (3) a minimum of one hundred (100) accrued PTO hours remain in the employee's PTO account after cash out. If the employee's election to cash out is for more hours than are eligible, the

cash out will be limited to the number of eligible PTO hours at the time the cash out is made. Cashed out PTO will be paid at the employee's current hourly rate at the time the PTO cash out is scheduled to be paid, subject to all applicable taxes and deductions.

L. **Cash Out for Financial Hardship:** If during the year an employee experiences a personal financial hardship, the employee can cash out their accrued PTO hours. Cash out for financial hardships are limited to one per calendar year. Documentation verifying the financial hardship must be provided to the Human Resources Department. The number of hours an employee can request for a financial hardship is subject to the requirement that a minimum of one hundred (100) accrued PTO hours remain in the employee's PTO account after cash out. Financial hardships must represent an immediate and heavy financial need and there must be no other resources readily available to handle that financial need. Financial hardships shall be limited to the following reasons:

1. Expenses for, or necessary, to obtain non-reimbursed medical care for employee or immediate family members;

2. Payment for the purchase of a primary residence;

3. Payment of tuition, related education fees, and room and board expenses for postsecondary education for the employee, or the employee's spouse (or registered domestic partner), children, or dependents;

4. Payments necessary to prevent the employee from eviction or foreclosure;

5. Expenses for the repair of damage to an employee's primary residence for damages from natural disasters; or

6. Expenses for the burial, funeral, or memorial for an employee's deceased parent, spouse (or registered domestic partner), children, or dependents.

M. **PTO Pay/Flex Pay on Termination**: Employees are expected to give at least two (2) weeks' written notice prior to resigning from their employment. Notice of resignation is expected to be a "working" notice to allow an opportunity for productive work time to complete projects, or train whoever will be assuming the employee's responsibilities. For that reason, employees should avoid using accrued PTO during the two (2) week period preceding their last scheduled day of work and/or coordinate the use of PTO time to provide at least two (2) "working" weeks. In no event shall CalOptima Health permit an employee to use their accrued PTO beyond the last day worked by an employee, unless the employee was on an approved Leave of Absence, or unless otherwise required by law. Upon termination of employment, the employee is paid all accrued unused PTO and Flex Holiday time at the employee's base rate of pay, subject to all applicable taxes, at the time of the termination. According to California Labor Code, Section 220(b), as a public agency, CalOptima Health is not required to pay wages immediately upon termination. CalOptima Health will pay the employee on the next regularly scheduled pay day.

N. **PTO Donation Program**: At the discretion of the Human Resources Department, a PTO Donation Program may be implemented. Employees may donate accrued PTO hours to assist another CalOptima Health employee ("Recipient Employee") when a Recipient Employee, or their family member, qualifies as having a Catastrophic Illness. Donations are completely voluntary, and donors will remain anonymous to the Recipient Employee.

1. To be eligible to receive PTO donations, a Recipient Employee must meet all the following criteria:

    a. Have a Catastrophic Illness, which shall mean a major illness or other medical condition (e.g., heart attack, cancer, etc.) or have a family member with a Catastrophic Illness which requires the employee take a prolonged absence including intermittent absences that are related to the same illness, or condition, and which will result in a substantial loss of income to the employee because the employee will have exhausted all PTO available apart from the PTO Donation Program. Family members referenced above shall include an employee's spouse or registered domestic partner; biological, adopted, step, or foster, child under age eighteen (18), or an adult dependent child substantially limited by a physical, or mental, impairment; or biological, adopted, step, or foster, parent;

    b. Have worked for CalOptima Health for at least ninety (90) days and be eligible to accrue PTO hours under this Policy;

    c. Be in Good Standing (no written warnings or corrective action plans within the last six (6) months, and the most recent performance evaluation shows the employee is meeting the performance standards);

    d. Exhausted all of their own PTO time;

    e. Completed a written request and authorization form including medical documentation to be approved by the Human Resources Department;

    f. Have the scheduled time off or Leave of Absence, approved by CalOptima Health in accordance with CalOptima Health's Leave of Absence and Personal Leave of Absence Policies; and

    g. Have not resigned or been terminated from employment prior to or during the employee's time off or Leave of Absence.

2. To donate, a Donor Employee must meet all the following criteria:

    a. Donate and surrender a minimum of two (2) hours, in increments of one (1) hour.

    b. Maintain a minimum balance of one hundred (100) accrued PTO hours in the Donor Employee's PTO account after donation.

    c. Submit a form authorizing the donation and acknowledging that the donated PTO time has been surrendered to CalOptima Health for the benefit of another employee and is no longer a benefit to the Donor Employee.

3. PTO donation pay rate. PTO hours donated will be transferred to the Recipient Employee on an hour-for-hour basis at the Recipient Employee's rate of pay, without regard to the rate of pay of the Donor Employee. The Recipient Employee is responsible for the tax burden of the donation. Any donated PTO that is not used by the Recipient Employee shall remain in the Recipient Employee's PTO account for future use.

4. Disability or workers' compensation. If a Recipient Employee is receiving short term or long term disability or workers' compensation benefits, the Recipient Employee may coordinate the donated PTO hours with these benefits to supplement the Recipient Employee's income up to

one hundred percent (100%) of the employee's salary. For instance, if the Recipient Employee is receiving sixty percent (60%) of their income from short term disability, CalOptima Health will allow the Recipient Employee to use the donated PTO hours to supplement up to the forty percent (40%) difference in compensation, bringing the Recipient Employee's total monthly income to one hundred percent (100%) of their earnings.

5. The Recipient Employee must submit an application and all necessary documentation to the Human Resources Department to be a recipient of the donated PTO and must give CalOptima Health permission to issue an all-staff email announcing the opportunity to donate PTO. The email will identify the Recipient Employee and any other information expressly authorized by the Recipient Employee.

6. In submitting an application, the Recipient Employee will be required to save, defend, and hold CalOptima Health harmless from any claims, liability, or actions concerning the disclosure of health information authorized by the Recipient Employee.

7. This PTO Donation program is completely voluntary on the part of CalOptima Health and may be amended or terminated by the Human Resources Department at any time at its sole discretion.

III. PROCEDURE

A. PTO or Paid Sick Leave Time Request for Time Off:

Responsible Party	Action
Employee	• Request PTO or paid sick leave at least two (2) weeks in advance, where possible, using CalOptima Health's time-keeping system. If the need for time off is foreseeable, employee must provide reasonable advance notice. If not, the employee must provide notice as soon as practicable. (If using PTO or paid sick leave for illness or preventative treatment, enter time away from work request as PTO Sick).
Supervisor	• Review all requests and approve, or deny, the request.

B. PTO Request to Cash Out:

Responsible Party	Action
Employee	• Request PTO cash out for the following year during the designated election period
Payroll	• Review all requests and approve or deny the request.

C. PTO Request for Donations (Recipient Employee):

Responsible Party	Action
Recipient Employee	• Request a Leave of Absence. • Complete a written request and authorization form including supporting medical documentation to be submitted to the Human Resources Department for approval, if eligible. • Sign a written waiver concerning disclosure of information to CalOptima Health employees.
Human Resources Department	• Receive request and authorization form from Recipient Employee and review for completeness and eligibility. • Within ten (10) days of receipt of all necessary material provide notice to Recipient Employee whether or not Human Resources approves or rejects the employee's request. Where approved, send out email request to all CalOptima Health employees consistent with permissible information provided by the Recipient Employee.

D. PTO Request to Donate (Donor Employee):

Responsible Party	Action
Donor Employee	• Submit a form authorizing the donation and designating the number of hours surrendered to CalOptima Health for the benefit of a Recipient Employee. • Sign an acknowledgement that the donated PTO time has been surrendered to CalOptima Health for the benefit of a Recipient Employee and is no longer a benefit to the Donor Employee.
Human Resources Department	• Receive donation form from Donor Employee and review for completeness and eligibility. • Within ten (10) days of receipt of all necessary material provide notice to Donor Employee whether or not Human Resources approves or rejects the employee's request Where approved, transfer the donated PTO hours to the Recipient Employee on an hour for hour basis at the Recipient Employee's rate of pay.

IV. ATTACHMENT(S)

A. PTO Donation Program –Request and Authorization Form – Recipient Employee
B. PTO Donation Program –Donation and Authorization Form – Donor Employee
C. Cash Out PTO for Financial Hardship Request Form

V. REFERENCE(S)

A. California Labor Code, §§230.8, 233-234, and 245-249 *et seq.*
B. CalOptima Health Employee Handbook
C. CalOptima Health Policy GA.8037: Leave of Absence
D. CalOptima Health Policy GA.8038: Personal Leave of Absence
E. CalOptima Health Policy GA.8040: FMLA and CFRA Leaves of Absence
F. CalOptima Health Policy GA.8041: Workers' Compensation Leave of Absence
G. CalOptima Health Policy GA.8059: Attendance and Timekeeping

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTIONS

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors
08/07/2014	Regular Meeting of the CalOptima Board of Directors
06/04/2015	Regular Meeting of the CalOptima Board of Directors
12/03/2015	Regular Meeting of the CalOptima Board of Directors
02/02/2017	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/27/2011	GA.8018	Paid Time Off (PTO)	Administrative
Revised	03/26/2014	GA.8018	Paid Time Off (PTO)	Administrative
Revised	05/01/2014	GA.8018	Paid Time Off (PTO)	Administrative
Revised	08/07/2014	GA.8018	Paid Time Off (PTO)	Administrative
Revised	06/04/2015	GA.8018	Paid Time Off (PTO)	Administrative
Revised	12/03/2015	GA.8018	Paid Time Off (PTO)	Administrative
Revised	02/02/2017	GA.8018	Paid Time Off (PTO)	Administrative
Revised	12/03/2020	GA.8018	Paid Time Off (PTO)	Administrative
Revised	TBD	GA.8018	Paid Time Off (PTO)	Administrative

IX. GLOSSARY

Term	Definition
As-Needed	Employees called to work sporadically on an as-needed basis. These employees may not have regularly scheduled hours and do not earn any benefits. As-Needed employees are employed for an indefinite duration and must work less than one thousand (1,000) hours per fiscal year.
Catastrophic Illness	A major illness or other medical condition (e.g., heart attack, cancer, etc.) of the employee or a family member of the employee that requires a prolonged absence of the employee from work, including intermittent absences that are related to the same illness or condition, and will result in a substantial loss of income to the employee because the employee will have exhausted all PTO available apart from the PTO Donation Program.
Child-Related Activities	Participation in activities at child's school or day care facility as permitted under Labor Code, Section 230.8, which includes: finding, enrolling, or reenrolling a child in a school or with a licensed child care provider; child care provider or school, emergency; request for child to be picked up from school/child care, or an attendance policy that prohibits the child from attending or requires the child to be picked up from the school or child care provider; behavioral/discipline problems; closure or unexpected unavailability of school (excluding planned holidays); a natural disaster; or to participate in activities of the school or licensed child care provider of their child, if the employee, prior to taking the time off, gives reasonable notice to CalOptima.
Continuous Service	A period of employment with one (1) employer, which begins with the day on which the employee starts work and ends with the date of resignation or dismissal. All service, regardless of hours worked, counts toward calculating continuous service.
Exempt Employee	Exempt status is determined by the Human Resources Department based on the position title and duties and responsibilities of the position and consistent with the Federal Fair Labor Standards Act (FLSA) regulations. Although an employee's classification may meet applicable federal and/or state exemption criteria, the position may nevertheless be designated as non-exempt. Exempt employees do not earn overtime compensation.
Full-Time Employee	An employee who works sixty (60) to eighty (80) hours per pay period.
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.
Leave of Absence (LOA)	A term used to describe a scheduled period of time off that an employee is to be away from their primary job, while maintaining the status of employee.
Limited Term Employee	Employees who are hired to work a full-time schedule on special-assignments that last a period of less than six (6) months. Limited Term employees do not become regular employees as a result of the passage of time.
Non-Exempt Employee	Non-Exempt status applies to all employees who are not identified by Human Resources as exempt. Non-Exempt employees are paid on an hourly basis and are eligible for overtime compensation. Although an employee's classification may qualify for applicable federal exemptions from the FLSA exemption criteria, the position may nevertheless be designated as non-exempt.
Paid Interns	Paid interns are considered As-Needed employees and should be concurrently enrolled in college or graduate courses.

Term	Definition
Paid Sick Leave	Paid Sick Leave covers the provisions of the Healthy Workplaces, Healthy Families Act of 2014 (California Labor Code §245-249) and Kin Care (California Labor Code §233-234)
Part-Time Employees	Employees that regularly work less than thirty (30) hours per week.

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PTO DONATION PROGRAM
REQUEST AND AUTHORIZATION FORM
CATASTROPHIC LEAVE REQUEST
Confidential
RECIPIENT EMPLOYEE

CalOptima Health has established a PTO Donation Program under ~~HR~~CalOptima Health Policy GA.8018: Paid Time Off which allows employees to donate portions of their accrued PTO time to CalOptima Health for the benefit of an eligible requesting employee that has a catastrophic illness or has a family member with a Catastrophic Illness. Hours donated will be surrendered to CalOptima Health for the benefit of an eligible recipient employee on an hour for hour basis at the recipient's rate of pay, without regard for the rate of pay of the donor.

Name of Recipient Employee (Print):	**Employee ID #:**	**Date of Request:**
Email:	**Telephone:**	
Recipient Employee Job Title:	**Department:**	
Date Catastrophic Illness Began:	**Date Catastrophic Illness Ended/Expected to End:**	

I, _____ (print Recipient Employee name), hereby request PTO hour donations due to:

☐ my catastrophic illness
☐ my family member's catastrophic illness

~~Describe medical condition: _____.~~

I have read ~~HR~~CalOptima Health Policy GA.8018: Paid Time Off (PTO), understand its contents, agree to the policies and procedures set forth therein, and hereby certify under penalty of perjury to all of the following:

☐	I personally, or a family member, have a catastrophic illness, and am submitting (or have previously submitted) medical ~~verification~~certification confirming the catastrophic illness as defined in ~~HR~~CalOptima Health Policy GA.8018: Paid Time Off (PTO).
☐	I have worked for CalOptima Health for at least 90 days and am eligible to accrue PTO hours.
☐	I am in good standing.
☐	I have or will have exhausted all of my own PTO time.
☐	I have the scheduled time off or leave of absence approved by CalOptima Health.
☐	~~Have~~I have not resigned or been terminated from employment.

It is anticipated that I will have accrued PTO and/or Flex Holiday Time to cover my absence through _____. It is anticipated that I will receive Short Term Disability and/or Long-Term Disability or Workers' Compensation benefits through _____. To ☐ supplement these benefits ☐ cover the balance of the expected absence beyond that time, I am Requesting/Authorizing donations of PTO time from CalOptima Health which may be surrendered by Co-workers from their accrued PTO account. I understand the PTO available for my use under this Program is limited to the number of hours surrendered to CalOptima Health by other employees, that I will be paid only that amount of PTO necessary to obtain 100% of my salary, and that I will receive the PTO as part of the normal payroll cycle.

I understand that my request will be distributed to all CalOptima Health employees and that the request will identify me by name along with the following authorized disclosure concerning the nature of my request:
_____(information authorized by employee).

By submitting this form and signing below, I hereby agree to save, defend, indemnify and hold harmless CalOptima Health (including its Board, officers, employees, and agents) from any claims, liabilities or actions

concerning the disclosure of my information related to this Request and Authorization for PTO donations.

Signed _____Date _____

***If not signed by employee, authorized representative must provide Power of Attorney or other documentation of legal authorization.**

RETURN COMPLETED FORM TO THE HUMAN RESOURCES LEAVE INBOX (leave@caloptima.org)

PTO DONATION PROGRAM
REQUEST AND AUTHORIZATION FORM
CATASTROPHIC LEAVE REQUEST
Confidential
RECIPIENT EMPLOYEE

CalOptima Health has established a PTO Donation Program under CalOptima Health Policy GA.8018: Paid Time Off which allows employees to donate portions of their accrued PTO time to CalOptima Health for the benefit of an eligible requesting employee that has a catastrophic illness or has a family member with a Catastrophic Illness. Hours donated will be surrendered to CalOptima Health for the benefit of an eligible recipient employee on an hour for hour basis at the recipient's rate of pay, without regard for the rate of pay of the donor.

Name of Recipient Employee (Print):	**Employee ID #:**	**Date of Request:**
Email:	**Telephone:**	
Recipient Employee Job Title:	**Department:**	
Date Catastrophic Illness Began:	**Date Catastrophic Illness Ended/Expected to End:**	

I, _____ (print Recipient Employee name), hereby request PTO hour donations due to:

☐ my catastrophic illness
☐ my family member's catastrophic illness

I have read CalOptima Health Policy GA.8018: Paid Time Off (PTO), understand its contents, agree to the policies and procedures set forth therein, and hereby certify under penalty of perjury to all of the following:

☐	I personally, or a family member, have a catastrophic illness, and am submitting (or have previously submitted) medical certification confirming the catastrophic illness as defined in CalOptima Health Policy GA.8018: Paid Time Off (PTO).
☐	I have worked for CalOptima Health for at least 90 days and am eligible to accrue PTO hours.
☐	I am in good standing.
☐	I have or will have exhausted all of my own PTO time.
☐	I have the scheduled time off or leave of absence approved by CalOptima Health.
☐	I have not resigned or been terminated from employment.

It is anticipated that I will have accrued PTO and/or Flex Holiday Time to cover my absence through _____. It is anticipated that I will receive Short Term Disability and/or Long-Term Disability or Workers' Compensation benefits through _____. To ☐ supplement these benefits ☐ cover the balance of the expected absence beyond that time, I am Requesting/Authorizing donations of PTO time from CalOptima Health which may be surrendered by Co-workers from their accrued PTO account. I understand the PTO available for my use under this Program is limited to the number of hours surrendered to CalOptima Health by other employees, that I will be paid only that amount of PTO necessary to obtain 100% of my salary, and that I will receive the PTO as part of the normal payroll cycle. I understand that my request will be distributed to all CalOptima Health employees and that the request will identify me by name along with the following authorized disclosure concerning the nature of my request:
_____(information authorized by employee).

By submitting this form and signing below, I hereby agree to save, defend, indemnify and hold harmless CalOptima Health (including its Board, officers, employees, and agents) from any claims, liabilities or actions concerning the disclosure of my information related to this Request and Authorization for PTO donations.

Signed _____ **Date** _____

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***If not signed by employee, authorized representative must provide Power of Attorney or other documentation of legal authorization.**

RETURN COMPLETED FORM TO THE HUMAN RESOURCES LEAVE INBOX (leave@caloptima.org)

PTO DONATION PROGRAM
DONATION AND AUTHORIZATION FORM
CATASTROPHIC LEAVE DONATION
Confidential

DONATION OF PTO AUTHORIZATION
TO BE GIVEN TO CO-WORKER

CalOptima Health has established a plan under ~~HR~~ CalOptima Health Policy GA.8018: Paid Time Off ~~to allow for~~ allowing employees to donate from their PTO accruals to a requesting employee that has a catastrophic illness or has a family member with a catastrophic illness. Catastrophic illness is defined as a major illness or other medical condition (e.g., heart attack, cancer, etc.) of the employee or a family member of the employee that requires a prolonged absence of the employee from work, including intermittent absences that are related to the same illness or condition, and will result in a substantial loss of income to the employee because the employee will have exhausted all PTO available apart from the PTO Donation Program and Flex Holiday balance.

PTO hours donated will be transferred over on an hour for hour basis to be received as PTO pay at the recipient's rate of pay without regard to the rate of pay of the donor.

PTO hours may be donated to a recipient employee who has a catastrophic illness or has a family member with a catastrophic illness with a minimum donation of two (2) hours, and up to a maximum of eight (8) hours per recipient within a three (3)-month period of time.

To be completed by donating employee.

I, _____ (Name of Donating Employee) am hereby authorizing and voluntarily requesting that _____ hours (not less than 2, not more than 8) of my PTO hours be removed from my accrued balance and transferred to the PTO balance of the recipient employee identified below as of the first day of the current pay period.

Name of Recipient Employee: _____

I understand that the hours I donate will no longer be a benefit to which I am entitled and that all rights to this time off will be transferred and paid to the recipient employee.

Signed _____ **Date** _____

Thank you for participating in this opportunity to help a Coworker in need. Names and amount of time donated will be kept confidential.

RETURN FORM CONFIDENTIALLY TO THE HUMAN RESOURCES LEAVE INBOX (leave@caloptima.org)

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PTO DONATION PROGRAM
DONATION AND AUTHORIZATION FORM
CATASTROPHIC LEAVE DONATION
Confidential

DONATION OF PTO AUTHORIZATION
TO BE GIVEN TO CO-WORKER

CalOptima Health has established a plan under CalOptima Health Policy GA.8018: Paid Time Off allowing employees to donate from their PTO accruals to a requesting employee that has a catastrophic illness or has a family member with a catastrophic illness. Catastrophic illness is defined as a major illness or other medical condition (e.g., heart attack, cancer, etc.) of the employee or a family member of the employee that requires a prolonged absence of the employee from work, including intermittent absences that are related to the same illness or condition, and will result in a substantial loss of income to the employee because the employee will have exhausted all PTO available apart from the PTO Donation Program and Flex Holiday balance.

PTO hours donated will be transferred over on an hour for hour basis to be received as PTO pay at the recipient's rate of pay without regard to the rate of pay of the donor.

PTO hours may be donated to a recipient employee who has a catastrophic illness or has a family member with a catastrophic illness with a minimum donation of two (2) hours, and up to a maximum of eight (8) hours per recipient within a three (3)-month period of time.

To be completed by donating employee.

I, _____ (Name of Donating Employee) am hereby authorizing and voluntarily requesting that _____ hours (not less than 2, not more than 8) of my PTO hours be removed from my accrued balance and transferred to the PTO balance of the recipient employee identified below as of the first day of the current pay period.

Name of Recipient Employee: _____

I understand that the hours I donate will no longer be a benefit to which I am entitled and that all rights to this time off will be transferred and paid to the recipient employee.

Signed _____ **Date** _____

Thank you for participating in this opportunity to help a Coworker in need. Names and amount of time donated will be kept confidential.

RETURN FORM CONFIDENTIALLY TO THE HUMAN RESOURCES LEAVE INBOX (leave@caloptima.org)

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PTO DONATION PROGRAM

CASH OUT PTO FOR FINANCIAL HARDSHIP

REQUEST FORM

Confidential

CalOptima Health has established a PTO cash out for financial hardship option under ~~HR~~ CalOptima Health Policy GA. 8018: Paid Time Off. This allows an employee who experiences a personal financial hardship, to cash out accrued PTO hours. A cash out for financial hardship requires documentation verifying the financial hardship and is subject to limitations. Examples of documentation ~~are~~ include bank statements, "Past Due" invoices, and/or eviction notices.

To be completed by requesting employee~~:~~.

EMPLOYEE NAME: _____

TOTAL HOURS REQUESTED: _____

EMPLOYEE SIGNATURE: _____ **DATE:** _____

APPROVED BY: _____ **DATE:** _____

RETURN FORM TO THE HUMAN RESOURCES LEAVE INBOX (leave@caloptima.org)

FOR OFFICE USE ONLY:

Remaining PTO Balance: _____ Date: _____

Total Time Approved: _____ Date: _____

In accordance with CalOptima Health Policy GA. 8018: Paid Time Off

If during the year an employee experiences a personal financial hardship, the employee can cash out ~~his or her~~their accrued PTO hours. Cash out for financial hardships are limited to one per calendar year. Documentation verifying the financial hardship must be provided to the Human Resources Department. The number of hours an employee can request for a financial hardship is subject to the requirement that a minimum of one hundred (100) accrued PTO hours remain in the employee's PTO account after cash out. Financial hardships must represent an immediate and heavy financial need.

PTO DONATION PROGRAM

CASH OUT PTO FOR FINANCIAL HARDSHIP

REQUEST FORM

Confidential

CalOptima Health has established a PTO cash out for financial hardship option under CalOptima Health Policy GA. 8018: Paid Time Off. This allows an employee who experiences a personal financial hardship, to cash out accrued PTO hours. A cash out for financial hardship requires documentation verifying the financial hardship and is subject to limitations. Examples of documentation include bank statements, "Past Due" invoices, and/or eviction notices.

To be completed by requesting employee:

EMPLOYEE NAME: _____

TOTAL HOURS REQUESTED: _____

EMPLOYEE SIGNATURE: _____ **DATE:** _____

APPROVED BY: _____ **DATE:** _____

RETURN FORM TO THE HUMAN RESOURCES LEAVE INBOX (leave@caloptima.org)

FOR OFFICE USE ONLY:

Remaining PTO Balance: _____ Date: _____

Total Time Approved: _____ Date: _____

In accordance with CalOptima Health Policy GA. 8018: Paid Time Off

If during the year an employee experiences a personal financial hardship, the employee can cash out their accrued PTO hours. Cash out for financial hardships are limited to one per calendar year. Documentation verifying the financial hardship must be provided to the Human Resources Department. The number of hours an employee can request for a financial hardship is subject to the requirement that a minimum of one hundred (100) accrued PTO hours remain in the employee's PTO account after cash out. Financial hardships must represent an immediate and heavy financial need.

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

I. PURPOSE

This policy establishes a consistent method of considering current employees for internal ~~promotions~~Promotions and ~~transfers~~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~~Promotions or ~~transfers~~Transfers to open positions for which they meet the qualifications and minimum job requirements.

C. CalOptima ~~will normally post~~Health posts open positions ~~internally~~ for five (5) business days~~,~~ ~~allowing current employees who possess the necessary education, skills, and experience for the job position and who are in good standing to apply for the open positions~~ before a job offer can be made.

D. To express interest in an open position, current employees must ~~complete and~~ submit ~~an internal~~a job application ~~and attach~~with an updated resume~~.~~ to CalOptima Health's Applicant Tracking System. An employee may also attach a cover letter.

E. An employee may be considered for ~~an internal promotion, or transfer,~~ any position for which they apply only if the following conditions are met:

1. The employee's work performance is in ~~good standing~~Good Standing with a minimum of "Fully Meets Expectations" for the most current review period.

2. The employee ~~must meet~~meets the qualifications and minimum requirements ~~required~~ for the position to which the ~~transfer,~~Transfer or ~~promotion,~~Promotion is sought.

3. The employee is not on a formal Performance Improvement Plan and/or has not received a Performance Improvement Plan~~,~~ or a written~~,~~ or final~~,~~ warning within the last six (6) months.

4. The employee has been employed in ~~his or her~~their current position for a minimum of ~~six (6~~three (3) months.

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

F. On rare occasions, there may be situations where: (1) a position is not posted; or (2) a ~~transfer~~Transfer or ~~promotion~~Promotion is granted due to a sensitive business need, necessitated by other requirements, or implemented prior to the employee being in the position for ~~six (6~~three (3) months. Exceptions to the standard recruitment process may only be made if there is: (1) a substantiated and documented need to ~~transfer~~Transfer or ~~promote~~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.

G. If a job offer is extended and accepted by a current employee, the employee may be subject to ~~the~~a background check in accordance with CalOptima Health Policy GA.8030: Background Check and/or any other required medical examinations, ~~if applicable, the start date and transition~~prior to the effective date of the new position~~.~~. The effective start date will be coordinated between ~~the employee,~~Human Resources (HR), the new supervisor, and the current supervisor. The employee may need to be available to orient and ~~train~~participate in training a replacement.

III. PROCEDURE

Responsible Party	Action
Employee	1. ~~The employee is responsible for reviewing~~Review the job description and/or job posting and ~~ensuring~~ensure that ~~he or she meets~~they meet the qualifications and minimum requirements ~~for the job~~ before submitting an application. 2. In order to express interest in an open position, employees ~~are responsible for taking ownership of their own career by completing an internal job application, attaching~~must apply for the opening through CalOptima Health's Applicant Tracking System and attach an updated resume~~, and submitting the complete package to the Human Resources (HR) Department~~. As a courtesy, it is recommended that employees notify their managers upon applying. 3. ~~Employees participate~~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. ~~3.~~4. Cooperate with any background check and/or any other required medical examinations.
Hiring Manager	~~1. Review internal job application with updated resume and notify HR to schedule an interview if the applicant is qualified.~~ ~~2. Interview the internal applicant.~~ 1. Review 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.

Responsible Party	Action
	~~3.~~2. Once a qualified internal applicant has been identified and the Hiring Manager is interested in selecting that applicant to fill an open position, ~~the Hiring Manager shall speak to internal applicant's immediate supervisor as a reference, and review the internal applicant's personnel files for past and current performance reviews with HR.~~coordinate with HR to complete the hiring process, including but not limited to, compensation review, offer letter creation, background check, educational verification, licensure verification, etc. ~~4. Discuss salary offer~~Coordinate with HR~~.~~ 3. ~~The Hiring Manager will work with~~ and the ~~selected employee's~~ current ~~manager~~supervisor to ~~establish~~agree upon a ~~fair~~ start date ~~for both departments.~~. ~~5.~~4. Complete the new hire/internal transfer form for HR to initiate the internal transfer eTicket.

HR	~~1.~~ Review ~~internal applicant~~ applications and resumes~~.~~ ~~2.~~1. ~~Review personnel files~~ for ~~rating of employee for the most current review period and verify if the employee received a Performance Improvement Plan, or a written or final warning within the last six (6) months.~~minimum and preferred qualifications. 2. Determine Good Standing status of internal applicants. 3. If the internal applicant ~~appears to meet~~meets the qualifications and minimum requirements, ~~HR will~~ send the application and/or resume to the Hiring Manager. At the request of the Hiring Manager, ~~HR shall schedule an interview with~~move the internal ~~applicant. If appropriate,~~candidate forward in the ~~Hiring Manager will conduct a second interview with additional staff members.~~selection process. If the internal applicant is not selected, ~~HR will~~ notify the internal applicant of the decision. 4. If an internal applicant is selected to fill an open position, ~~HR will~~ extend an offer, ~~in consultation with the Hiring Manager,~~ based on ~~the employee's experience and skill level, current pay, classification~~application of ~~the open position, and CalOptima's~~CalOptima Health's Compensation Program, Compensation Administration Guidelines, and Salary Schedule. 5. ~~HR will~~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. ~~5.~~6. Submit the internal transfer eTicket and process ~~an~~a Personnel Action Form~~, which is an internal~~ to document ~~used by HR in a form similar to the sample form attached hereto and which may be updated from time to time~~the action taking place.

IV. ATTACHMENT(S)

~~A. Action Form (Sample)~~
Not Applicable

V. REFERENCE(S)

A. Personnel Action Form (Sample)
~~A.~~B. CalOptima ~~Employee Handbook~~Health Policy GA.8030: Background Check

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
TBD	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	TBD	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	~~Person~~The supervisor or manager responsible for making final hiring decision.
Performance Improvement Plan	A developmental coaching tool used to document performance and behavioral deficiencies or issues and create an action plan with goals and due dates to help employees correct and/or improve performance and behavior while still holding them accountable for past performance.
Promotion	Occurs when ~~a current~~an employee ~~advances to an open position at~~is selected for a job with a higher ~~classification and salary range from the employee's previous position.~~pay grade.
Transfer	Occurs when an employee moves ~~into a new position that is equivalent in its classification and salary range~~ to a different job title having the ~~employee's previous position.~~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:	TBD
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 days before a job offer can be made.

D. To express interest in an open position, current employees must submit a job application with an updated resume 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 performance is in Good Standing with a minimum of "Fully Meets Expectations" for the most current 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 Performance Improvement Plan or a written or final warning within the last six (6) months.

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

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

F. 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.

G. 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. The employee may need to be available to orient and participate in training a replacement.

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. 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 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, compensation review, offer letter creation, background check, educational verification, licensure verification, etc. 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. Personnel Action Form (Sample)
B. CalOptima Health Policy GA.8030: Background Check

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
TBD	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

Action	Date	Policy	Policy Title	Program(s)
Revised	TBD	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 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.8026
Title:	**Employee Referral Program**
Department:	CalOptima Health Administrative
Section:	Human Resources
CEO Approval:	*/s/*
Effective Date:	01/05/2012
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy provides for an opportunity for employees to receive compensation for individuals referred to and hired by CalOptima Health.

II. POLICY

A. Employee referrals are a valuable and cost-effective source to find and hire the best new talent. In times of recruiting challenges, CalOptima Health may choose to reward the recruiting efforts of employees by awarding a bonus to employees whose referrals are hired, in accordance with the following guidelines. Exceptions to the policy may be made, in special circumstances, by the Human Resources (HR) Department.

B. Eligibility

1. Employees will be eligible to receive bonuses for referrals if all of the following conditions are met:

   a. The employee making the referral is a regular full-time or part-time employee;

   b. The referred applicant is hired for a regular full-time or part-time position at CalOptima Health;

   c. The referred applicant remains continuously employed by CalOptima Health and is in Good Standing for a minimum of four (4) months;

   d. The employee making the referral is employed by CalOptima Health at the conclusion of the four (4) month period; and

   e. The applicant was not already identified through another source.

   f. All regular full-time or part-time employees are eligible to receive a referral bonus, except:

      i. ~~Members of~~Employees in the ~~HR~~Human Resources Department; or

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ii. Employees in ~~supervisory~~leadership positions who refer applicants for employment within their own work units; or

iii. ~~Members of the~~Employees in Executive ~~Staff~~Level Positions; or

iv. Employees, when referring a member of their immediate family including: current spouse; registered domestic partner; biological, adopted, step or foster child; biological, adopted, step or foster parent; legal guardian; siblings, including step brother and step sister; grandparent; grandchild; parents-in-law; siblings-in-law; or child-in-law.

g. A referral from an eligible employee will be considered for the referral bonus except if the person being referred is~~:~~:

i. A former or current employee of CalOptima Health;

ii. A former or current consultant to CalOptima Health; or

iii. A temporary worker who currently works or worked for CalOptima Health in the past, unless the temporary employee meets all of the following: (1) was referred to CalOptima Health by an eligible employee; (2) was then referred by CalOptima Health to a temporary staffing agency; (3) worked as a temporary employee at CalOptima Health; and (4) was then subsequently hired immediately following work as a temporary employee at CalOptima Health and remains continuously employed as a CalOptima Health employee for a minimum or four (4) months.

C. Awards

1. There is no limit to the number of applicants an employee may refer. For each referred applicant who is hired under the terms of this policy, the employee may receive a bonus of a specified amount before taxes. The bonus amount, which will be set in a fair and consistent manner, is dependent on the position and at the discretion of the HR Department. If the referred applicant indicates more than one (1) employee name as a referral, the HR Department will select the first employee listed to receive the referral bonus. Employees will receive bonuses with their paychecks (in a separate check) within two (2) to four (4) weeks after the four (4) month minimum employment period.

D. The Employee Referral Program is provided only to the extent that budgeted funds are available. CalOptima Health is under no obligation to fund or continue the Employee Referral Program.

III. PROCEDURE

Responsible Party	Action
Employee	1. Employee's name needs to be entered by the applicant at time of completing the online application through the CalOptima Health website, under "How did you hear about us?"
Human Resources	1. Determine the amount of the bonus payment appropriate to the position prior to advertising for the open position; 2. If the referred applicant indicates more than one (1) employee name as a referral, the first employee listed will receive the referral bonus;

Responsible Party	Action
	3. Notify referring employees of candidates who were hired; 4. Track all hired referrals through the waiting period; 5. ~~Certify~~Verify that both employees are still employed at the end of the four (4) month waiting period; 6. Ensure sufficient funds in budget for bonus payment; 7. Approve the bonus payment; and 8. Send Action Form to the Payroll Department.
Payroll Department	1. Upon receipt of HR's request for payment, the Payroll Department will issue the bonus payment to the referring employee.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

~~A. CalOptima Employee Handbook~~
Not applicable

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
04/06/2017	Regular Meeting of the CalOptima Board of Directors
06/04/2015	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
TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/05/2012	GA.8026	Employee Referral Program	Administrative
Revised	06/04/2015	GA.8026	Employee Referral Program	Administrative
Revised	04/06/2017	GA.8026	Employee Referral Program	Administrative
Revised	12/03/2020	GA.8026	Employee Referral Program	Administrative
Revised	TBD	GA.8026	Employee Referral Program	Administrative

IX. GLOSSARY

Term	Definition
Employee	Any and all employees of CalOptima Health, including all permanent and temporary employees, volunteers, and other employed personnel.
Employee Referral Program	A bonus program for employees whose applicant referrals are hired, and the eligibility conditions are met.
Executive ~~Staff~~Level Position	~~Any CalOptima employee whose~~The position ~~title is~~of Executive Director or ~~Chief Officer of one (1) or more departments~~above.
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.

Policy:	GA.8026
Title:	**Employee Referral Program**
Department:	CalOptima Health Administrative
Section:	Human Resources
CEO Approval:	*/s/*
Effective Date:	01/05/2012
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy provides for an opportunity for employees to receive compensation for individuals referred to and hired by CalOptima Health.

II. POLICY

A. Employee referrals are a valuable and cost-effective source to find and hire the best new talent. In times of recruiting challenges, CalOptima Health may choose to reward the recruiting efforts of employees by awarding a bonus to employees whose referrals are hired, in accordance with the following guidelines. Exceptions to the policy may be made, in special circumstances, by the Human Resources (HR) Department.

B. Eligibility

1. Employees will be eligible to receive bonuses for referrals if all of the following conditions are met:

   a. The employee making the referral is a regular full-time or part-time employee;

   b. The referred applicant is hired for a regular full-time or part-time position at CalOptima Health;

   c. The referred applicant remains continuously employed by CalOptima Health and is in Good Standing for a minimum of four (4) months;

   d. The employee making the referral is employed by CalOptima Health at the conclusion of the four (4) month period; and

   e. The applicant was not already identified through another source.

   f. All regular full-time or part-time employees are eligible to receive a referral bonus, except:

      i. Employees in the Human Resources Department; or

ii. Employees in leadership positions who refer applicants for employment within their own work units; or

iii. Employees in Executive Level Positions; or

iv. Employees, when referring a member of their immediate family including: current spouse; registered domestic partner; biological, adopted, step or foster child; biological, adopted, step or foster parent; legal guardian; siblings, including step brother and step sister; grandparent; grandchild; parents-in-law; siblings-in-law; or child-in-law.

g. A referral from an eligible employee will be considered for the referral bonus except if the person being referred is:

i. A former or current employee of CalOptima Health;

ii. A former or current consultant to CalOptima Health; or

iii. A temporary worker who currently works or worked for CalOptima Health in the past, unless the temporary employee meets all of the following: (1) was referred to CalOptima Health by an eligible employee; (2) was then referred by CalOptima Health to a temporary staffing agency; (3) worked as a temporary employee at CalOptima Health; and (4) was then subsequently hired immediately following work as a temporary employee at CalOptima Health and remains continuously employed as a CalOptima Health employee for a minimum or four (4) months.

C. Awards

1. There is no limit to the number of applicants an employee may refer. For each referred applicant who is hired under the terms of this policy, the employee may receive a bonus of a specified amount before taxes. The bonus amount, which will be set in a fair and consistent manner, is dependent on the position and at the discretion of the HR Department. If the referred applicant indicates more than one (1) employee name as a referral, the HR Department will select the first employee listed to receive the referral bonus. Employees will receive bonuses with their paychecks (in a separate check) within two (2) to four (4) weeks after the four (4) month minimum employment period.

D. The Employee Referral Program is provided only to the extent that budgeted funds are available. CalOptima Health is under no obligation to fund or continue the Employee Referral Program.

III. PROCEDURE

Responsible Party	Action
Employee	1. Employee's name needs to be entered by the applicant at time of completing the online application through the CalOptima Health website, under "How did you hear about us?"
Human Resources	1. Determine the amount of the bonus payment appropriate to the position prior to advertising for the open position; 2. If the referred applicant indicates more than one (1) employee name as a referral, the first employee listed will receive the referral bonus;

Responsible Party	Action
	3. Notify referring employees of candidates who were hired; 4. Track all hired referrals through the waiting period; 5. Verify that both employees are still employed at the end of the four (4) month waiting period; 6. Ensure sufficient funds in budget for bonus payment; 7. Approve the bonus payment; and 8. Send Action Form to the Payroll Department.
Payroll Department	1. Upon receipt of HR's request for payment, the Payroll Department will issue the bonus payment to the referring employee.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

Not applicable

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
04/06/2017	Regular Meeting of the CalOptima Board of Directors
06/04/2015	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
TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/05/2012	GA.8026	Employee Referral Program	Administrative
Revised	06/04/2015	GA.8026	Employee Referral Program	Administrative
Revised	04/06/2017	GA.8026	Employee Referral Program	Administrative
Revised	12/03/2020	GA.8026	Employee Referral Program	Administrative
Revised	TBD	GA.8026	Employee Referral Program	Administrative

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IX. GLOSSARY

Term	Definition
Employee	Any and all employees of CalOptima Health, including all permanent and temporary employees, volunteers, and other employed personnel.
Employee Referral Program	A bonus program for employees whose applicant referrals are hired, and the eligibility conditions are met.
Executive Level Position	The position of Executive Director or above.
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.

Policy:	GA.8030
Title:	**Background Check**
Department:	CalOptima Health Administrative~~Human Resources~~
Section:	Human Resources~~Not Applicable~~
CEO Approval:	*/s/*
Effective Date:	04/01/2013
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ PACE ☒ Administrative

I. PURPOSE

This policy outlines the process by which CalOptima Health conducts background checks.

II. POLICY

A. CalOptima Health ~~believes that hiring qualified individuals contributes~~is committed to ~~CalOptima's overall strategic success. Background checks serve~~protecting the health, well-being, and safety of its employees and ~~m~~Members. To accomplish these goals, a background check serves as an important part of the selection process~~.~~ and ~~the~~this policy provides directives and guidance in the administration of performing background checks in a systematic and fair manner. Through the background check process, CalOptima Health ~~employees have access to confidential private and protected health information. Through comprehensive background checks, CalOptima can obtain~~obtains additional applicant information that ~~helps~~will help determine the applicant's overall employability~~,~~ and ensures the protection of the people, property, and information of the organization.

B. CalOptima Health shall conduct background checks on all external job applicants after a contingent offer of employment ~~is made~~has been accepted by the applicant and prior to commencement of employment.

C. For promotions~~,~~ or transfers~~,~~ of ~~internal~~ employees ~~to certain positions~~, a post-employment background check, including criminal background ~~may~~will~~be~~may be required depending on the job duties or if not conducted within the past twelve (12) months.

D. Post-employment ~~criminal~~ background checks will be conducted, typically every two years or upon promotion into positions that ~~, for employees in positions with~~ have access to personal health information (PHI), ~~with~~ direct member ~~contact~~access, ~~which~~ provide healthcare services, any position that may have access to personally identifiable information (PII) for any member or employee, any position authorized to enter into financial contracts on behalf of CalOptima Health, or any ~~role~~position with ~~has~~ fiduciary responsibilities.
~~. Types of positions included would be those who if not completed within the past twelve (12) months~~CalOptima Health may also require the third-party background provider to provide ~~continuous monitoring in a timely manner.~~

~~B.~~E. Requirements specific to ~~B~~background checks are ~~safety sensitive, have health risk, or exposure and/or financial exposure.~~set out more fully in the Employment Related Background Check

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Guidelines. CalOptima Health ~~shall~~ may use a third~~-~~party agency to conduct the background checks and prepare a report~~, which may include, but is not limited to, information pertaining to an applicant's:~~.

~~1. Past employment;~~

~~2. Criminal background;~~

~~3. Highest level of education, whether required for the position or not; if highest education completed is greater than a Master's degree, check all education levels from Master's degree and higher (i.e., MD, PhD, etc.);~~

~~4. Department of Motor Vehicles (DMV) record, where applicable;~~

~~5. Credit record, where applicable;~~

~~6. Professional and personal references, where applicable;~~

~~7. Character; and~~

~~8. Reputation.~~

~~C.~~F. The background check is conducted~~, in part,~~ to verify the accuracy of the information provided by the applicant, including~~-~~, but not limited to, the applicant's social security number, education obtained, employment experience, etc. Some positions may require additional background screening, depending on the job requirements, duties, and responsibilities.

~~D.~~G. For positions that require physical examinations, drug testing, and/or tuberculosis testing, CalOptima Health shall perform the background check first, ~~and if an employment offer is made after the background check is completed, but prior to the commencement of employment duties, CalOptima may then condition employment on the passing of~~then may commence with a physical examination, drug testing, and/or tuberculosis testing provided that:

1. The examination~~,~~ or inquiry~~,~~ is job-related and consistent with business necessity~~.~~;~~ and~~

2. ~~That all~~All new employees in the same job classification are subject to the same examination~~,~~ or screening.

3. Pre-Employment Testing: All employees in Safety Sensitive classifications are required to pass a pre-employment drug test as a condition of employment in the classification as defined in CalOptima Health Policy GA.8052: Drug-Free and Alcohol-Free Workplace.

H. The Human Resources Department shall also be responsible for conducting exclusion monitoring for all CalOptima Health employees upon hire and monthly thereafter~~. The Human Resources Department shall conduct exclusion monitoring through the Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE), the General Services Administration's (GSA) System for Award Management (SAM), and the Medi-Cal Suspended & Ineligible (S&I) Website, as outlined in the Human Resources exclusions desktop procedure. Any applicant or existing employee found on the Office of Inspector General (OIG), System for Award Management (SAM), and/or Medi-Cal (S&I) Website and verified according to the Human Resources procedure cannot be hired by or continue employment with CalOptima.~~ as outlined in the Employment Related Background Check Guidelines.

~~E.~~

~~F.~~I. Employees shall notify the Human Resources Department upon hire or immediately any time thereafter, if the employee knows, or has reason to know that the employee has 1) an arrest for which the employee is out on bail, or out on their own recognizance, and pending trial pursuant to Labor Code section 432.7(a)(1); or 2) post-hire felony criminal convictions that are not more than seven (7) years old and that have not been or are not in the process of being expunged, dismissed, pardoned or sealed by judicial order; or 3)~~has been convicted of a crime or~~ is excluded from a federally funded healthcare program and/or may be listed on the Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE), the General Services Administration's (GSA) System for Award Management (SAM), and the Medi-Cal Suspended & Ineligible (S&I) Website~~OIG List~~LEIE, SAM, and/or Medi-Cal (S&I) Websites.

~~G.~~J. CalOptima Health shall ensure that all background checks are held confidentially~~,~~ by the Human Resources Department in compliance with all federal and state statutes, such as the California Investigative Consumer Reporting Act and the Fair Credit Reporting Act.

~~H.~~K. For positions that require an employee to drive as part of their work duties, CalOptima Health may check the applicant/employee's department of motor vehicles (DMV) records, which includes verification of car insurance and status of the ~~driver~~driver's license. Employees shall notify the Human Resources Department upon hire or immediately any time thereafter, if the employee knows or has reason to know of any action to be taken on the employee's driver's license, including, but not limited to, suspension, revocation, restriction, or other action, or an event that occurs that could lead to such actions, including, but not limited to, accidents, citations for driving under the influence (DUI), etc. Employee's without a valid driver's license will be prohibited from driving CalOptima Health vehicles, driving for CalOptima Health business, and parking on CalOptima Health premises. Failure to report such incidents to Human Resources may lead to ~~disciplinary~~corrective action, up to and including termination.

~~I.~~L. Falsification of information on the employment application~~,~~ or providing false information for the purpose of hiring~~,~~ may result in ~~disciplinary~~ corrective action, up to and including termination of employment.

M. CalOptima Health follows Government Code section 12952, which requires that employers that intend to deny an applicant a position of employment solely or in in part because of the applicant's conviction history, must "make an individualized assessment of whether the applicant's conviction history has a direct and adverse relationship with the specific duties of the job that justify denying the applicant the position. In making the assessment described in this paragraph, the employer shall consider all of the following:

~~1.~~ ~~(i)~~ The nature and gravity of the offense or conduct;~~;~~
1.

~~2.~~ ~~(ii)~~ The time that has passed since the offense or conduct and completion of the sentence; and~~.~~
2.

~~(iii)~~ The nature of the job held or sought."
3.

~~J.~~N.The Human Resources Department~~, with the assistance of Legal Counsel, may revise the sample attachments,~~ will maintain all pre and post-employment background check documents and pre and post-employment drug screening documents as ~~appropriate, to reflect individual circumstances and to be consistent with applicable laws.~~notated in CalOptima Health Policy GA.3201: Document Management Program.

~~III.~~

~~IV.~~III. PROCEDURE

Not Applicable

~~V. Responsible Party~~	~~VI. Action~~
~~VII. Applicant~~	~~VIII. Complete application on Open Hire.~~ ~~IX.~~ ~~X. Submit a copy of references.~~ ~~XI.~~ ~~XII. Complete the Background Check Consent Form.~~
~~XIII. Human Resources~~	~~XIV. Provide notice and disclosure to the applicant about the purpose of the report and how the Background Check report will be used as required pursuant to Federal and State laws.~~ ~~XV.~~ ~~XVI. Complete a Background Check Order Form.~~ ~~XVII.~~ ~~XVIII. Facsimile Order Form to vendor.~~ ~~XIX.~~ ~~XX. If the applicant wishes to receive a copy of the report, a copy shall be sent to the applicant within three (3) business days of the date that the report was provided to CalOptima.~~ ~~XXI.~~ ~~XXII. Send Pre-Adverse Action Form to the candidate, if applicable.~~ ~~XXIII.~~ ~~XXIV. Notify candidate of the results of the background check in general terms (i.e., passed, unable to locate, etc. within forty-eight (48) hours of receiving results).~~

~~XXV.~~IV. ATTACHMENT(S)

Not Applicable~~Sample Background Check Disclosure, Authorization and Consent Form~~
~~Sample Pre-Adverse Action – Full Disclosure~~
~~Sample Adverse Action Notice – Denial & Withdrawal~~

~~XXVI.~~V. REFERENCE(S)

A. California Consumer Credit Reporting Agencies Act, California Civil Code §1785.1 *et seq*.
B. California Investigative Consumer Reporting Act, California Civil Code §1786 *et seq*.
C. California ~~Labor~~Government Code~~, §1024.5~~ section 12952
D. California Labor Code section 432.7

E. California Labor Code, §1024.5
~~D.~~F. CalOptima Employee Handbook
~~E.~~G. CalOptima Health Policy GA.~~8000: Glossary of Terms~~3201: Document Management Program
H. CalOptima Health Policy GA.8052: Drug-Free and Alcohol-Free Workplace
I. Employment Related Background Check Guidelines
~~F.~~J. Fair Credit Reporting Act [15, USC, §1681 *et seq*.]
K. Equal Employment Opportunity Commission (EEOC) Regulation 29, C.F.R. Section §1602.14
L. Pre-Employment Background Authorization and Release
M. Sample Pre-Adverse Action Letter - Full Disclosure
N. Sample Adverse Action Notice – Denial and Withdrawal
O. Sample Background Check Disclosure, Authorization and Consent Form

~~XXVII.~~VI. REGULATORY AGENCY APPROVAL(S)

None to Date

~~XXVIII.~~VII. BOARD ACTION(S)

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors
11/06/2014	Regular Meeting of the CalOptima Board of Directors
04/06/2017	Regular Meeting of the CalOptima Board of Directors

~~XXIX.~~VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/01/2013	GA.8030	Background Check	Administrative
Revised	05/01/2014	GA.8030	Background Check	Administrative
Revised	10/01/2014	GA.8030	Background Check	Administrative
Revised	04/06/2017	GA.8030	Background Check	Administrative
Revised	TBD	GA.8030	Background Check	Administrative

~~XXX.~~IX. GLOSSARY

~~Not Applicable~~

Term	Definition
Member	A beneficiary who is enrolled in a CalOptima Health program.
Safety Sensitive Employee	A position where the employee has the responsibility for their own safety or other people's safety, such as administering medication, handling of controlled substances and/or providing health care services or personal care services to CalOptima Health Members. This shall include any employee who operates a CalOptima Health owned or leased motor vehicle.

Policy:	GA.8030
Title:	**Background Check**
Department:	CalOptima Health Administrative
Section:	Human Resources
CEO Approval:	*/s/*
Effective Date:	04/01/2013
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ PACE ☒ Administrative

I. PURPOSE

This policy outlines the process by which CalOptima Health conducts background checks.

II. POLICY

A. CalOptima Health is committed to protecting the health, well-being, and safety of its employees and Members. To accomplish these goals, a background check serves as an important part of the selection process and this policy provides directives and guidance in the administration of performing background checks in a systematic and fair manner. Through the background check process, CalOptima Health obtains additional applicant information that will help determine the applicant's overall employability and ensures the protection of the people, property, and information of the organization.

B. CalOptima Health shall conduct background checks on all external job applicants after a contingent offer of employment has been accepted by the applicant and prior to commencement of employment.

C. For promotions or transfers of employees, a post-employment background check, including criminal background may be required depending on the job duties or if not conducted within the past twelve (12) months.

D. Post-employment background checks will be conducted, typically every two years or upon promotion into positions that have access to personal health information (PHI), direct member access, provide healthcare services, any position that may have access to personally identifiable information (PII) for any member or employee, any position authorized to enter into financial contracts on behalf of CalOptima Health, or any position with fiduciary responsibilities.

E. Requirements specific to background checks are set out more fully in the Employment Related Background Check Guidelines. CalOptima Health may use a third-party agency to conduct the background checks and prepare a report.

F. The background check is conducted to verify the accuracy of the information provided by the applicant, including, but not limited to, the applicant’s social security number, education obtained, employment experience, etc. Some positions may require additional background screening, depending on the job requirements, duties, and responsibilities.

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G. For positions that require physical examinations, drug testing, and/or tuberculosis testing, CalOptima Health shall perform the background check first, then may commence with a physical examination, drug testing, and/or tuberculosis testing provided that:

1. The examination or inquiry is job-related and consistent with business necessity.

2. All new employees in the same job classification are subject to the same examination or screening.

3. Pre-Employment Testing: All employees in Safety Sensitive classifications are required to pass a pre-employment drug test as a condition of employment in the classification as defined in CalOptima Health Policy GA.8052: Drug-Free and Alcohol-Free Workplace.

H. The Human Resources Department shall also be responsible for conducting exclusion monitoring for all CalOptima Health employees upon hire and monthly thereafter as outlined in the Employment Related Background Check Guidelines.

I. Employees shall notify the Human Resources Department upon hire or immediately any time thereafter, if the employee knows, or has reason to know that the employee has 1) an arrest for which the employee is out on bail, or out on their own recognizance, and pending trial pursuant to Labor Code section 432.7(a)(1); or 2) post-hire felony criminal convictions that are not more than seven (7) years old and that have not been or are not in the process of being expunged, dismissed, pardoned or sealed by judicial order; or 3) is excluded from a federally funded healthcare program and/or may be listed on the Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE), the General Services Administration's (GSA) System for Award Management (SAM), and the Medi-Cal Suspended & Ineligible (S&I) Website.

J. CalOptima Health shall ensure that all background checks are held confidentially by the Human Resources Department in compliance with all federal and state statutes, such as the California Investigative Consumer Reporting Act and the Fair Credit Reporting Act.

K. For positions that require an employee to drive as part of their work duties, CalOptima Health may check the applicant/employee's department of motor vehicles (DMV) records, which includes verification of car insurance and status of the driver's license. Employees shall notify the Human Resources Department upon hire or immediately any time thereafter, if the employee knows or has reason to know of any action to be taken on the employee's driver's license, including, but not limited to, suspension, revocation, restriction, or other action, or an event that occurs that could lead to such actions, including, but not limited to, accidents, citations for driving under the influence (DUI), etc. Employee's without a valid driver's license will be prohibited from driving CalOptima Health vehicles, driving for CalOptima Health business, and parking on CalOptima Health premises. Failure to report such incidents to Human Resources may lead to corrective action, up to and including termination.

L. Falsification of information on the employment application or providing false information for the purpose of hiring may result in corrective action, up to and including termination of employment.

M. CalOptima Health follows Government Code section 12952, which requires that employers that intend to deny an applicant a position of employment solely or in in part because of the applicant's conviction history, must make an individualized assessment of whether the applicant's conviction history has a direct and adverse relationship with the specific duties of the job that justify denying the applicant the position. In making the assessment described in this paragraph, the employer shall consider all of the following:

1. The nature and gravity of the offense or conduct;

2. The time that has passed since the offense or conduct and completion of the sentence; and

3. The nature of the job held or sought.

N. The Human Resources Department will maintain all pre and post-employment background check documents and pre and post-employment drug screening documents as notated in CalOptima Health Policy GA.3201: Document Management Program.

III. PROCEDURE

Not Applicable

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. California Consumer Credit Reporting Agencies Act, California Civil Code §1785.1 *et seq.*
B. California Investigative Consumer Reporting Act, California Civil Code §1786 *et seq.*
C. California Government Code section 12952
D. California Labor Code section 432.7
E. California Labor Code, §1024.5
F. CalOptima Employee Handbook
G. CalOptima Health Policy GA.3201: Document Management Program
H. CalOptima Health Policy GA.8052: Drug-Free and Alcohol-Free Workplace
I. Employment Related Background Check Guidelines
J. Fair Credit Reporting Act [15, USC, §1681 *et seq.*]
K. Equal Employment Opportunity Commission (EEOC) Regulation 29, C.F.R. Section §1602.14
L. Pre-Employment Background Authorization and Release
M. Sample Pre-Adverse Action Letter - Full Disclosure
N. Sample Adverse Action Notice – Denial and Withdrawal
O. Sample Background Check Disclosure, Authorization and Consent Form

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors
11/06/2014	Regular Meeting of the CalOptima Board of Directors
04/06/2017	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/01/2013	GA.8030	Background Check	Administrative
Revised	05/01/2014	GA.8030	Background Check	Administrative
Revised	10/01/2014	GA.8030	Background Check	Administrative
Revised	04/06/2017	GA.8030	Background Check	Administrative
Revised	TBD	GA.8030	Background Check	Administrative

IX. GLOSSARY

Term	Definition
Member	A beneficiary who is enrolled in a CalOptima Health program.
Safety Sensitive Employee	A position where the employee has the responsibility for their own safety or other people's safety, such as administering medication, handling of controlled substances and/or providing health care services or personal care services to CalOptima Health Members. This shall include any employee who operates a CalOptima Health owned or leased motor vehicle.

Policy:	GA.8033
Title:	**License and Certification Tracking**
Department:	CalOptima Health Administrative
Section:	Human Resources
CEO Approval:	*/s/*
Effective Date:	01/05/2012
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy describes how CalOptima Health ensures that all staff, required to have active and current licenses and/or certifications, have the appropriate and required licensure(s) and/or certification(s) with proper renewal information.

II. POLICY

A. When a Required ~~Licensure~~License and/or Certification is/are mandated as part of a job position, or in the performance of an employee's job duties, or where an employee receives supplemental pay for having a particular license and/or certification, the applicant/employee shall have, maintain, and provide proof of the applicable active and current license(s) and/or certification(s). The Human Resources (HR) Department shall verify the license(s) and/or certification(s) of each applicant, including the license/certification number(s) and expiration date(s), through the appropriate licensing/certifying board to ensure primary source verification. A new hire employee who fails to provide proof of the Required ~~Licensure~~License and/or Certification prior to ~~his or her~~their start date ~~shall~~will not be permitted to begin work until such proof has been submitted and verified by HR. All Required ~~Licensures~~Licenses and Certifications are verified at the time of hire and prior to their expiration date.

B. An employee whose job description specifies a Required ~~Licensure~~License and/or Certification, and/or an employee who receives supplemental pay for having a particular license and/or certification, is responsible for maintaining an active and current license and/or certification for the duration of ~~his/her~~their employment at CalOptima Health. If CalOptima Health does **not** receive proof of license and/or certification renewal prior to the expiration date, the employee may be subject to suspension without pay effective the following business day. CalOptima Health will remove the employment suspension when it has obtained proof of an active and current licensure and/or certification. ~~If an employee fails~~Failure to provide verification of ~~Required Licensure and/or Certification~~ renewal to CalOptima Health, within ~~a reasonable period of time~~ thirty (30) calendar days following the expiration date, ~~the employee~~ may ~~be terminated from employment with CalOptima.~~result in corrective action, up to and including termination.

C. Employees shall notify the Human Resources Department immediately any time the employee knows, or has reason to know, of any action to be taken on the employee's Required

~~Licensure~~License and/or Certification, or an event that occurs that could lead to such actions, including, but not limited to, pending, active, or resolved licensing board investigations, restrictions, allegations, revocations, suspensions, probation, disciplinary actions, accidents, driving under the influence (DUI), etc. Employees shall also notify the Human Resources Department of any professional licenses that they hold or held in other states that have been revoked, suspended, or restricted due to misconduct or disciplinary action. CalOptima Health may place the employee on "limited work assignment," suspend the employee without pay or terminate the employee depending on the circumstances. Failure to provide timely notification of such action(s) will be grounds for discipline, up to and including, termination.

III. PROCEDURE

Responsible Party	Action
Employee	1. Provide proof of active and current license(s) and/or certification(s) upon hire. 2. Renew all Required Licensures and/or Certifications on time. 3. Provide HR with documentation of renewed license(s) and/or certification(s) before license and/or certification expiration date. 4. Notify HR immediately if the employee knows, or has reason to know, of any actual, pending, or potential adverse action, or event, impacting the employee's license and/or certification, including but not limited to, pending, active, or resolved investigations, restrictions, allegations, revocations, suspensions, probations, disciplinary actions, accidents, DUIs, etc.
Human Resources	1. Verify the validity and date of expiration of the license(s) and/or certification(s) prior to the employee's start date, and prior to the expiration date, then place a copy in the employee's HR file. 2. Track licensures and/or certifications to ensure all required licenses and/or certifications are up to date. 3. Where an employee receives supplemental pay for having a particular license and/or certification, verify and track such license and/or certification to ensure the employee continues to qualify for such supplemental pay. 4. When CalOptima Health becomes aware that an employee's license and/or certification has been or has the potential to be placed on probation, restriction, revocation, suspension or other disciplinary action, CalOptima Health may place the employee on "limited work assignment," suspension without pay, or proceed with termination, as appropriate based on the circumstances determined by HR in conjunction with the employee's Executive Director or Chief. If the probation or restriction of a license and/or certification cannot be cleared in a reasonable period of time, not to exceed a thirty (30)-day period, the employee may be terminated from employment with CalOptima Health.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

~~A. CalOptima Employee Handbook~~
Not Applicable

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Regulatory Agency
01/05/2012	Regular Meeting of the CalOptima Board of Directors
11/06/2014	Regular Meeting of the CalOptima Board of Directors
12/01/2016	Regular Meeting of the CalOptima Board of Directors
04/05/2018	Regular Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/05/2012	GA.8033	Professional License Tracking, changed to License and Certification	Administrative
Revised	11/06/2014	GA.8033	License and Certification Tracking	Administrative
Revised	12/01/2016	GA.8033	License and Certification Tracking	Administrative
Revised	04/05/2018	GA.8033	License and Certification Tracking	Administrative
Revised	08/01/2020	GA.8033	License and Certification Tracking	Administrative
Revised	TBD	GA.8033	License and Certification Tracking	Administrative

IX. GLOSSARY

Term	Definition
Required ~~Licensure~~License and/or Certification	Licenses and/or certificates deemed "required" in the applicable job description and/or required in the performance of an employee's job duties, including, but not limited to, professional licenses, driver licenses, etc.

Policy:	GA.8033
Title:	**License and Certification Tracking**
Department:	CalOptima Health Administrative
Section:	Human Resources
CEO Approval:	*/s/*
Effective Date:	01/05/2012
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy describes how CalOptima Health ensures that all staff, required to have active and current licenses and/or certifications, have the appropriate and required licensure(s) and/or certification(s) with proper renewal information.

II. POLICY

A. When a Required License and/or Certification is/are mandated as part of a job position, or in the performance of an employee's job duties, or where an employee receives supplemental pay for having a particular license and/or certification, the applicant/employee shall have, maintain, and provide proof of the applicable active and current license(s) and/or certification(s). The Human Resources (HR) Department shall verify the license(s) and/or certification(s) of each applicant, including the license/certification number(s) and expiration date(s), through the appropriate licensing/certifying board to ensure primary source verification. A new hire employee who fails to provide proof of the Required License and/or Certification prior to their start date will not be permitted to begin work until such proof has been submitted and verified by HR. All Required Licenses and Certifications are verified at the time of hire and prior to their expiration date.

B. An employee whose job description specifies a Required License and/or Certification, and/or an employee who receives supplemental pay for having a particular license and/or certification, is responsible for maintaining an active and current license and/or certification for the duration of their employment at CalOptima Health. If CalOptima Health does **not** receive proof of license and/or certification renewal prior to the expiration date, the employee may be subject to suspension without pay effective the following business day. CalOptima Health will remove the employment suspension when it has obtained proof of an active and current licensure and/or certification. Failure to provide verification of renewal to CalOptima Health, within thirty (30) calendar days following the expiration date, may result in corrective action, up to and including termination.

C. Employees shall notify the Human Resources Department immediately any time the employee knows, or has reason to know, of any action to be taken on the employee's Required License and/or Certification, or an event that occurs that could lead to such actions, including, but not limited to, pending, active, or resolved licensing board investigations, restrictions, allegations, revocations, suspensions, probation, disciplinary actions, accidents, driving under the influence (DUI), etc.

Employees shall also notify the Human Resources Department of any professional licenses that they hold or held in other states that have been revoked, suspended, or restricted due to misconduct or disciplinary action. CalOptima Health may place the employee on "limited work assignment," suspend the employee without pay or terminate the employee depending on the circumstances. Failure to provide timely notification of such action(s) will be grounds for discipline, up to and including, termination.

III. PROCEDURE

Responsible Party	Action
Employee	1. Provide proof of active and current license(s) and/or certification(s) upon hire. 2. Renew all Required Licensures and/or Certifications on time. 3. Provide HR with documentation of renewed license(s) and/or certification(s) before license and/or certification expiration date. 4. Notify HR immediately if the employee knows, or has reason to know, of any actual, pending, or potential adverse action, or event, impacting the employee's license and/or certification, including but not limited to, pending, active, or resolved investigations, restrictions, allegations, revocations, suspensions, probations, disciplinary actions, accidents, DUIs, etc.
Human Resources	1. Verify the validity and date of expiration of the license(s) and/or certification(s) prior to the employee's start date, and prior to the expiration date, then place a copy in the employee's HR file. 2. Track licensures and/or certifications to ensure all required licenses and/or certifications are up to date. 3. Where an employee receives supplemental pay for having a particular license and/or certification, verify and track such license and/or certification to ensure the employee continues to qualify for such supplemental pay. 4. When CalOptima Health becomes aware that an employee's license and/or certification has been or has the potential to be placed on probation, restriction, revocation, suspension or other disciplinary action, CalOptima Health may place the employee on "limited work assignment," suspension without pay, or proceed with termination, as appropriate based on the circumstances determined by HR in conjunction with the employee's Executive Director or Chief. If the probation or restriction of a license and/or certification cannot be cleared in a reasonable period of time, not to exceed a thirty (30)-day period, the employee may be terminated from employment with CalOptima Health.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

Not Applicable

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Regulatory Agency
01/05/2012	Regular Meeting of the CalOptima Board of Directors
11/06/2014	Regular Meeting of the CalOptima Board of Directors
12/01/2016	Regular Meeting of the CalOptima Board of Directors
04/05/2018	Regular Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/05/2012	GA.8033	Professional License Tracking, changed to License and Certification	Administrative
Revised	11/06/2014	GA.8033	License and Certification Tracking	Administrative
Revised	12/01/2016	GA.8033	License and Certification Tracking	Administrative
Revised	04/05/2018	GA.8033	License and Certification Tracking	Administrative
Revised	08/01/2020	GA.8033	License and Certification Tracking	Administrative
Revised	TBD	GA.8033	License and Certification Tracking	Administrative

IX. GLOSSARY

Term	Definition
Required License and/or Certification	Licenses and/or certificates deemed "required" in the applicable job description and/or required in the performance of an employee's job duties, including, but not limited to, professional licenses, driver licenses, etc.

Policy:	GA.8034
Title:	**Service of Summons, Subpoenas, and Other Legal Documents**
Department:	CalOptima Health Administrative
Section:	Human Resources
CEO Approval:	*/s/*
Effective Date:	01/05/2012
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy clarifies ~~CalOptima's~~CalOptima Health's responsibility related to receipt of service of legal papers not pertaining to CalOptima Health business.

II. POLICY

A. CalOptima Health shall not accept, or facilitate, service of legal papers, such as subpoenas, summons, or complaints, except for those which are directed to CalOptima Health, or its agents, and which relate to the business of CalOptima~~.~~ Health.

~~A.~~B. Most documents entitled Summons, Subpoena, Court Orders, Notices to Appear, etc., whether for civil, criminal, or administrative matters, require personal service to the individual. CalOptima Health has no obligation to accept, or facilitate, such service to employees or others when the legal papers are related to personal ~~and not CalOptima business~~ matters. ~~Consistent with CalOptima Policy AA.1215: Public Records Requests and Subpoenas, CalOptima should not accept legal documents that are not directly related to CalOptima business, or CalOptima Members.~~

C. Consistent with CalOptima Health Policy AA.1215: Public Records Requests and Subpoenas, CalOptima Health should not accept legal documents that are not directly related to CalOptima Health business or Members.

~~B.~~D. In the event a notice is left at the place of employment (e.g., with the ~~receptionist~~Front Desk Reception/Security), it will be forwarded on to the employee. However, this may not constitute proper service and the employee would need to discuss such a matter with ~~his or her~~their own legal counsel.

~~C.~~E. Employees are advised to keep personal legal matters away from CalOptima Health premises and separate from their ~~work location~~professional responsibilities to avoid any interference with the proper conduct of ~~CalOptima's~~CalOptima Health's business.

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III. PROCEDURE

Responsible Party	Action
~~Receptionist~~ Front Desk Reception/ Security (Admin Building and PACE)	1. Inform the process server that it is ~~CalOptima's~~CalOptima Health's policy not to accept or facilitate service of legal papers related to personal matters at the work site. 2. If a problem arises, contact ~~the Legal Affairs Department~~CalOptima Health's legal counsel immediately.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Policy AA.1215: Public Records Requests and Subpoenas
B. CalOptima Health Policy AA.1217: Legal Claims and Judicial Review

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
01/05/2012	Regular Meeting of the CalOptima Board of Directors
11/03/2016	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	01/05/2012	GA.8034	Service of Summons	Administrative
Revised	11/03/2016	GA.8034	Service of Summons, Subpoenas, and Other Legal Documents	Administrative
Revised	09/01/2018	GA.8034	Service of Summons, Subpoenas, and Other Legal Documents	Administrative
Revised	10/01/2020	GA.8034	Service of Summons, Subpoenas, and Other Legal Documents	Administrative
Revised	TBD	GA.8034	Service of Summons, Subpoenas, and Other Legal Documents	Administrative

IX. GLOSSARY

~~Not Applicable~~

Term	Definition
Member	A beneficiary who is enrolled in a CalOptima Health program.

Policy:	GA.8034
Title:	**Service of Summons, Subpoenas, and Other Legal Documents**
Department:	CalOptima Health Administrative
Section:	Human Resources
CEO Approval:	*/s/*
Effective Date:	01/05/2012
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy clarifies CalOptima Health's responsibility related to receipt of service of legal papers not pertaining to CalOptima Health business.

II. POLICY

A. CalOptima Health shall not accept, or facilitate, service of legal papers, such as subpoenas, summons, or complaints, except for those which are directed to CalOptima Health, or its agents, and which relate to the business of CalOptima Health.

B. Most documents entitled Summons, Subpoena, Court Orders, Notices to Appear, etc., whether for civil, criminal, or administrative matters, require personal service to the individual. CalOptima Health has no obligation to accept, or facilitate, such service to employees or others when the legal papers are related to personal matters.

C. Consistent with CalOptima Health Policy AA.1215: Public Records Requests and Subpoenas, CalOptima Health should not accept legal documents that are not directly related to CalOptima Health business or Members.

D. In the event a notice is left at the place of employment (e.g., with the Front Desk Reception/Security), it will be forwarded on to the employee. However, this may not constitute proper service and the employee would need to discuss such a matter with their own legal counsel.

E. Employees are advised to keep personal legal matters away from CalOptima Health premises and separate from their professional responsibilities to avoid any interference with the proper conduct of CalOptima Health's business.

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III. PROCEDURE

Responsible Party	Action
Front Desk Reception/ Security (Admin Building and PACE)	1. Inform the process server that it is CalOptima Health's policy not to accept or facilitate service of legal papers related to personal matters at the work site. 2. If a problem arises, contact CalOptima Health's legal counsel immediately.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Policy AA.1215: Public Records Requests and Subpoenas
B. CalOptima Health Policy AA.1217: Legal Claims and Judicial Review

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
01/05/2012	Regular Meeting of the CalOptima Board of Directors
11/03/2016	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	01/05/2012	GA.8034	Service of Summons	Administrative
Revised	11/03/2016	GA.8034	Service of Summons, Subpoenas, and Other Legal Documents	Administrative
Revised	09/01/2018	GA.8034	Service of Summons, Subpoenas, and Other Legal Documents	Administrative
Revised	10/01/2020	GA.8034	Service of Summons, Subpoenas, and Other Legal Documents	Administrative
Revised	TBD	GA.8034	Service of Summons, Subpoenas, and Other Legal Documents	Administrative

IX. GLOSSARY

Term	Definition
Member	A beneficiary who is enrolled in a CalOptima Health program.

Policy:	GA.8046
Title:	**Relocation**
Department:	CalOptima Health Administrative
Section:	Human Resources
CEO Approval:	*/s/*
Effective Date:	02/01/2014
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy sets forth CalOptima Health's guidelines for the reimbursement of defined expenses incurred for relocation as a negotiating tool to recruit the most qualified candidates.

II. POLICY

A. CalOptima Health may provide relocation expenses for new employees if funds are available in the hiring department's budget on a case-by-case basis and in full compliance with Federal Internal Revenue Service (IRS) regulations.

B. CalOptima Health shall comply with all applicable laws and regulations in administering relocation expenses.

C. Reimbursement for relocation expenses should be consistent with CalOptima Health Policy GA.5004: Travel Policy.

III. PROCEDURE

A. All or part of a new employee's relocation expenses may be paid for or reimbursed by CalOptima Health when such an incentive assists the organization in the attraction and retention of qualified new hires.

1. ELIGIBILITY – Eligibility for payment of relocation expenses is determined and approved by the Chief Executive Officer (CEO), Chief Financial Officer (CFO), and Executive Director of Human Resources based on guidelines managed by the Human Resources Department. CalOptima Health does not base eligibility on position or title, but on the department's need to use relocation as a recruiting tool. A candidate that is offered relocation benefits shall not be eligible to receive payment of relocation expenses until after the candidate has accepted a position, which is defined herein as the point when (i) the candidate has returned to CalOptima Health the countersigned employment offer letter and all other required employment documents and (ii) the candidate has successfully completed the pre-employment screening and background check, and the candidate has commenced work with CalOptima Health.

2. AMOUNTS AND PACKAGE – Individual departments may provide relocation expenses to new employees based on the amount of funds available in the department's budget and consistent with the guidelines managed by the Human Resources Department. The offer letter of employment should specify the approved relocation expenses and define the maximum amount allowable. Relocation expenses are limited to actual and necessary approved relocation expenses, and CalOptima Health shall not pay for any amounts in excess of the actual and necessary approved relocation expenses, even if the new employee's relocation expenses are below the maximum amount allowable. A request for reimbursement of relocation expense must be submitted within a reasonable period of time to the Accounting Department, and must be supported by original receipts or equivalent electronic receipts that contain the same level of detail as an acceptable paper receipt or invoice and evidence the purchase of qualifying expenditures.

3. APPROVALS – CalOptima Health's CEO, CFO, and the Executive Director of Human Resources must approve relocation eligibility, amounts, and package.

B. A department offering payment of relocation expenses to a new employee should use the expense form maintained by the Accounting Department Accounts Payable. Levels of approval must be completed prior to payment. The form must:

1. Identify which relocation expenses will be covered by the hiring department; and

2. Explain how to process payment for relocation expenses.

C. Relocation Tax Implications ~~(IRS Distance and Time Tests)~~

1. ~~In order for CalOptima's payment or reimbursement of certain relocation expenses to be non-taxable to a new employee, the move must meet both the IRS' distance and time tests as outlined in guidelines provided by the IRS, as may be amended from time to time.~~Under the Tax Cuts and Jobs Act, all employer-paid relocation expenses must be reported as taxable income. Relocation expenses may be covered through a lump sum payment or through reimbursement up to a specific dollar amount. Both allowances are taxable and will be issued through Payroll. CalOptima Health should advise new employees eligible for relocation to consult their own tax consultants regarding relocation tax implications.

D. Common Relocation Expense

1. Below are common relocation expenses which may be offered to new employees. Expenses are outlined in guidelines provided by the IRS, as may be amended from time to time.

a. Packing, crating, and transporting household goods and personal effects and those of the members of the new employee's household from the new employee's former home to the new home;

b. Storing household goods or personal affects en route within any period of thirty (30) consecutive days;

c. Storing household goods or personal effects once at CalOptima Health;

d. Searching for housing or consulting about relocation;

e. Lodging en route for new employee and members of new employee's household;

f. Lodging once in Orange County (other than first day of arrival);

g. Dining en route and dining once in Orange County;

h. Using personal vehicle; and/or

i. Using commercial transportation.

2. Use of Personal Vehicles –Post-acceptance expenses for use of personal vehicles, such as travel expenses (one (1) trip) to find a new home or moving expenses to transfer to the new location, are considered relocation expenses and shall be reimbursed consistent with CalOptima Health Policy GA.5004: Travel Policy.

3. Use of Commercial Transportation – Use of commercial transportation (i.e., airlines, trains, etc.) when relocating may be reimbursed by CalOptima Health, including transportation for family members. However, only one-way trips, without side excursions, are reimbursable by CalOptima Health.

IV. ATTACHMENTS

~~A. Expense Form~~
Not Applicable

V. REFERENCE(S)

~~A. CalOptima Policy GA.8000: Glossary of Terms~~
~~B.~~A. CalOptima Health Policy GA.5004: Travel Policy
B. 26 U.S.C. §132(g)
C. CalOptima Health Expense Reporting Reference Guide

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors
04/06/2017	Regular Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

~~Version~~	Date	Policy ~~Number~~	Policy Title	~~Line(s) of~~
Effective	02/01/2014	GA.8046	Relocation	Administrative
Revised	04/06/2017	GA.8046	Relocation	Administrative
Revised	TBD	GA.8046	Relocation	Administrative

IX. GLOSSARY

Not Applicable

Policy:	GA.8046
Title:	**Relocation**
Department:	CalOptima Health Administrative
Section:	Human Resources
CEO Approval:	*/s/*
Effective Date:	02/01/2014
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy sets forth CalOptima Health's guidelines for the reimbursement of defined expenses incurred for relocation as a negotiating tool to recruit the most qualified candidates.

II. POLICY

A. CalOptima Health may provide relocation expenses for new employees if funds are available in the hiring department's budget on a case-by-case basis and in full compliance with Federal Internal Revenue Service (IRS) regulations.

B. CalOptima Health shall comply with all applicable laws and regulations in administering relocation expenses.

C. Reimbursement for relocation expenses should be consistent with CalOptima Health Policy GA.5004: Travel Policy.

III. PROCEDURE

A. All or part of a new employee's relocation expenses may be paid for or reimbursed by CalOptima Health when such an incentive assists the organization in the attraction and retention of qualified new hires.

1. ELIGIBILITY – Eligibility for payment of relocation expenses is determined and approved by the Chief Executive Officer (CEO), Chief Financial Officer (CFO), and Executive Director of Human Resources based on guidelines managed by the Human Resources Department. CalOptima Health does not base eligibility on position or title, but on the department's need to use relocation as a recruiting tool. A candidate that is offered relocation benefits shall not be eligible to receive payment of relocation expenses until after the candidate has accepted a position, which is defined herein as the point when (i) the candidate has returned to CalOptima Health the countersigned employment offer letter and all other required employment documents and (ii) the candidate has successfully completed the pre-employment screening and background check, and the candidate has commenced work with CalOptima Health.

2. AMOUNTS AND PACKAGE – Individual departments may provide relocation expenses to new employees based on the amount of funds available in the department's budget and consistent with the guidelines managed by the Human Resources Department. The offer letter of employment should specify the approved relocation expenses and define the maximum amount allowable. Relocation expenses are limited to actual and necessary approved relocation expenses, and CalOptima Health shall not pay for any amounts in excess of the actual and necessary approved relocation expenses, even if the new employee's relocation expenses are below the maximum amount allowable. A request for reimbursement of relocation expense must be submitted within a reasonable period of time to the Accounting Department and must be supported by original receipts or equivalent electronic receipts that contain the same level of detail as an acceptable paper receipt or invoice and evidence the purchase of qualifying expenditures.

3. APPROVALS – CalOptima Health's CEO, CFO, and the Executive Director of Human Resources must approve relocation eligibility, amounts, and package.

B. A department offering payment of relocation expenses to a new employee should use the expense form maintained by the Accounting Department Accounts Payable. Levels of approval must be completed prior to payment. The form must:

1. Identify which relocation expenses will be covered by the hiring department; and

2. Explain how to process payment for relocation expenses.

C. Relocation Tax Implications

1. Under the Tax Cuts and Jobs Act, all employer-paid relocation expenses must be reported as taxable income. Relocation expenses may be covered through a lump sum payment or through reimbursement up to a specific dollar amount. Both allowances are taxable and will be issued through Payroll. CalOptima Health should advise new employees eligible for relocation to consult their own tax consultants regarding relocation tax implications.

D. Common Relocation Expense

1. Below are common relocation expenses which may be offered to new employees. Expenses are outlined in guidelines provided by the IRS, as may be amended from time to time.

a. Packing, crating, and transporting household goods and personal effects and those of the members of the new employee's household from the new employee's former home to the new home;

b. Storing household goods or personal affects en route within any period of thirty (30) consecutive days;

c. Storing household goods or personal effects once at CalOptima Health;

d. Searching for housing or consulting about relocation;

e. Lodging en route for new employee and members of new employee's household;

f. Lodging once in Orange County (other than first day of arrival);

g. Dining en route and dining once in Orange County;

h. Using personal vehicle; and/or

i. Using commercial transportation.

2. Use of Personal Vehicles –Post-acceptance expenses for use of personal vehicles, such as travel expenses (one (1) trip) to find a new home or moving expenses to transfer to the new location, are considered relocation expenses and shall be reimbursed consistent with CalOptima Health Policy GA.5004: Travel Policy.

3. Use of Commercial Transportation – Use of commercial transportation (i.e., airlines, trains, etc.) when relocating may be reimbursed by CalOptima Health, including transportation for family members. However, only one-way trips, without side excursions, are reimbursable by CalOptima Health.

IV. ATTACHMENTS

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Policy GA.5004: Travel Policy
B. 26 U.S.C. §132(g)
C. CalOptima Health Expense Reporting Reference Guide

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors
04/06/2017	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	02/01/2014	GA.8046	Relocation	Administrative
Revised	04/06/2017	GA.8046	Relocation	Administrative
Revised	TBD	GA.8046	Relocation	Administrative

IX. GLOSSARY

Not Applicable

Policy:	GA.8047
Title:	**Reduction in Force**
Department:	CalOptima Health Administrative
Section:	Human Resources
CEO Approval:	*/s/*
Effective Date:	02/01/2014
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy defines how CalOptima Health shall administer a Reduction in Force (RIF) program. A RIF occurs when changing priorities, budgetary constraints, or other business conditions require CalOptima Health to eliminate positions.

II. POLICY

A. All CalOptima Health employees are At-Will employees. An employee is terminated as part of the RIF program through no fault of ~~his or her~~their own. The RIF is considered an involuntary separation of employment that is intended to be permanent as a result of:

1. Lack of work, changing priorities, budgetary constraints, or other business reasons; or

2. A determination by management that, due to business reasons, an employee's performance, or contribution to the business (although satisfactory), does not meet the needs of the business.

B. As part of the RIF program, CalOptima Health shall evaluate the business needs of the organization and the need for particular positions. CalOptima Health shall take into account the relative value of work performed by specific employees, including, but not limited to, performance, qualifications, discipline, attendance, and length of service, so that CalOptima Health can continue to provide the highest level of service possible with a reduced work force. In implementing ~~an~~a RIF program, CalOptima Health may consider, depending on the circumstances, various factors, including, but not limited to, the following (which are not presented in any order of importance):

1. ~~CalOptima's~~CalOptima Health's need, or lack thereof, for the position occupied by the employee;

2. The contributions which the employee has made to the success of the organization, and the perceived likelihood of contributions to the success of the business in the foreseeable future;

3. Demonstrated high quality performance on the same, or related, assignments;

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4. Versatility and ability in applying pertinent skills and experience to current and expected business requirements;

5. The employee's length of service in the particular position to be retained;

6. The employee's length of service with CalOptima Health;

7. ~~CalOptima's~~CalOptima Health's need to maintain continuity with respect to a particular project or team; and

8. The more recent performance of the employee compared to others in the same classification.

C. In cases where management determines the various factors considered are essentially equal between two (2) or more employees, length of service in the position and/or length of service at CalOptima Health may be the deciding factor in determining which employee, or employees, shall be retained. In the event an employee who is being laid off has greater length of service in the position and/or length of service at CalOptima Health than an employee, or employees, being retained within the same classification and specialty in the impacted department, CalOptima Health must document the basis, in the judgment of management, the employee with less length of service is better suited for retention.

D. The Human Resources Department shall ~~work closely~~consult with ~~the Legal Affairs Department~~legal counsel to implement the RIF program to ensure compliance with all applicable federal, state, and local laws and regulations.

E. An employee terminated as part of the RIF program must continue to perform ~~his or her~~their duties satisfactorily until the Separation Date. ~~-~~ Otherwise, the employee may be subject to disciplinary action, up to and including termination, prior to the specified Separation Date, consistent with CalOptima Health Policy GA.8022: Performance and Behavior Standards. ~~-~~ An employee terminated as a result of failure to perform duties satisfactorily until the Separation Date shall not be qualified to receive any benefits administered as part of the RIF program.

F. Limitations to Eligibility

1. An employee terminated as part of the RIF program will not be eligible to receive benefits under the plan if the employee:

   a. Is terminated for cause, including but not limited to, failure to meet the performance requirements of the position, policy violation, theft, gross misconduct, etc.; or

   b. Fails, or refuses, to return all CalOptima Health property in the employee's possession, and/or fails to clear all expense and other financial accounts, as of the date of termination. (Examples of CalOptima Health property include, but are not limited to: CalOptima Health Security badges, office keys any and all CalOptima Health documents, files, and computers. Examples of accounts to be cleared include, but are not limited to, the completion and reconciliation of expense accounts); or

   c. Resigns, or otherwise voluntarily terminates, ~~his or her~~their employment; or

   d. Is terminated by temporary layoff, or furlough, except that if CalOptima Health elects to convert the temporary layoff, or furlough, into a permanent layoff, severance pay may then

be payable as of the effective date of permanent layoff, if the employee otherwise is eligible for benefits under the RIF program; or,

e. Is on a leave of absence, except that if an employee is released to return to work from an approved leave of absence and CalOptima Health has no assignment for the employee, ~~he/she~~they may be eligible for benefits under the RIF program; or

f. Is offered a comparable position within CalOptima Health in lieu of termination, but fails, or refuses, to accept it; or

g. Is terminated because of ~~CalOptima's~~CalOptima Health's sale, or transfer, of all, or part, of its assets and ~~his/her~~their employment continues with the agency, or transferee organization, after the transfer has been completed; or

h. Is terminated in connection with the "outsourcing" of operational functions, and ~~he/she is~~they are offered comparable employment by the outsourcing vendor. For this purpose, comparable employment shall be defined as a position with substantially the same duties, at the same, or greater, compensation and comparable benefits, which does not require relocation, as defined by the IRS; or

i. Is terminated from employment for failure to return to work following a leave of absence; or

j. Retires; or

k. Is deceased, at which time eligibility for benefits under the RIF program will end and all such benefit payments, if any, will cease; or

l. Is separated from CalOptima Health because ~~he or she is~~they are no longer able to perform the essential functions of ~~his/her~~their job ~~(~~with or without reasonable accommodation~~)~~ because of a disability; or

m. Is a temporary employee, intern/volunteer, independent contractor or consultant; or

n. Is an employee employed by CalOptima Health pursuant to a written contract containing provisions for severance benefits; or

o. Is convicted of a crime involving an abuse of ~~his or her~~their office, or position.

G. This policy sets forth general guidelines to observe in the event of a RIF; however, this policy may be subject to change, deviation, or modification, without notice, depending on the circumstances. Any decision to deviate from this policy in any particular case shall be subject to the discretion of the Chief Executive Officer (CEO).

H. Applicable provisions of this policy may also be used to address employee separations or terminations, other than a RIF, where appropriate, at the discretion of the CEO.

III. PROCEDURE

A. Affected Positions: ~~-~~Following an evaluation of ~~CalOptima's~~CalOptima Health's business needs, CalOptima Health, through appropriate Executive Officers and the Human Resources (HR) Department (hereinafter referred to as the "management"), will identify and determine the positions that will be eliminated and/or affected by a RIF. Management also has the discretion to determine

the manner in which the RIF will occur; however, notification to the HR Department should precede the implementation of the RIF.

B. Determinations:~~-~~ Determinations concerning the evaluation of employees, the considerations evaluated, and final recommendations should be made by the employee's immediate supervisor and/or manager with the next higher management level. ~~-~~Documentation of all considerations evaluated should be furnished to HR and approved by management prior to any notification to the employee affected by the RIF.

C. Transfers or Downgrades: ~~-~~Depending on ~~CalOptima's~~CalOptima Health's business needs, an employee impacted by the RIF may be offered a downgrade (a lower position and/or reduction in base pay) or lateral transfer (an equivalent position and/or equivalent base pay) to another open job position for which ~~he or she is~~they are, in the judgment of management, most qualified even though it is a job position or classification that the employee has not previously held. An employee impacted by the RIF who is offered a lateral transfer, or downgrade, may be provided the option of layoff. HR shall determine, on a case-by-case basis, the time period appropriate to accept, or decline, such job offer.

D. Employee Notices: ~~-~~Employees who are to be laid off as a result of the RIF should be notified of such reduction only after all necessary approvals have been obtained. ~~-~~An employee notified of a lay off must continue to work up to the Separation Date specified in the notice, unless management decides otherwise. An employee notified of ~~his or her~~their lay off, as a result of the RIF, may not subsequently be placed on a leave of absence (LOA) without prior approval of the Executive Director of HR.

E. Severance: Severance pay may be offered, if approved by the CEO and HR, upon an employee's separation from service when it is deemed appropriate due to special circumstances. If severance pay is authorized and offered, it will be paid in accordance with the following, unless otherwise defined in a separate employee agreement, or approved by the CEO:

1. Two (2) weeks of pay at the rate of the Annual Earnings for employees with less than two (2) years of service and more than ninety (90) days; or

2. One (1) week of pay at the rate of the Annual Earnings for each completed year of service, with a maximum of sixteen (16) weeks, for employees with two (2) years or more of service.

F. Employees on a Leave of Absence: ~~-~~If an employee is on a Leave of Absence (LOA), and ~~his or her~~their position is terminated as part of the RIF, CalOptima Health will not terminate the LOA early to implement the RIF program. ~~-~~The employee will be laid off at the scheduled, or required, conclusion of the LOA. ~~-~~This paragraph does not apply to employees on Personal LOA, pursuant to CalOptima Health Policy GA.8038: Personal Leave of Absence.

G. Release Agreement: In order to be eligible for the severance pay, if offered, an eligible employee must fully complete and execute a ~~Separation Agreement~~separation agreement provided by CalOptima Health, in a form approved by ~~the Legal Affairs Department~~legal counsel, at, or near the time of, termination. This ~~Separation Agreement~~separation agreement includes a release of all known and unknown claims the employee has, or may have, against CalOptima Health, as well as an agreement of confidentiality, non-disparagement, and non-solicitation. To be eligible for the severance pay, the ~~Separation Agreement~~separation agreement must be signed by the employee and must become irrevocable, in accordance with applicable law.

H. Payment Method: All wages earned and unpaid, including paid time off (PTO) and flex holidays, on the specified Separation Date will be paid to the employee in accordance with ~~CalOptima's~~CalOptima Health's pay schedule and not necessarily on the employee's Separation Date. ~~-~~CalOptima Health may make payment of severance pay, if an employee is eligible, in accordance with the CalOptima Health payroll schedule as if the recipient were still employed or in a lump sum payment, following a seven (7) day waiting period, where applicable, and after receipt of the fully executed and irrevocable ~~Separation Agreement~~separation agreement and/or any other agreement. Payment in installments will be equal to the employee's bi-weekly Annual Earnings wages, less applicable taxes and deductions, including benefits, if applicable, until the agreed upon sum has been distributed. Eligible employees receiving payment in installments shall be required to remain reasonably available during the time period the employee is receiving periodic severance payments to respond to questions from CalOptima Health and address work related matters. Payment by lump sum will be distributed on ~~CalOptima's~~CalOptima Health's next regularly scheduled payday and will be equal to the amount the employee would have made in wages for the applicable number of weeks of severance pay offered, less applicable taxes and deductions.

I. Taxes: CalOptima Health shall reduce all severance pay by all applicable federal, state, or local tax withholdings.

J. Termination of Severance Pay: If a former employee is receiving severance pay through periodic payments as described in Section III.H., severance pay will immediately cease if CalOptima Health discovers that the employee:

1. Has failed to return all CalOptima Health property; or

2. Has disclosed or used confidential information about CalOptima Health for the benefit of a third party; or

3. Has defamed CalOptima Health; or

4. Has been hired on a full-time basis by another employer; or

5. Has failed to remain reasonably available to respond to CalOptima Health questions, or work-related matters.

6. Has attempted to entice other employees of CalOptima Health to work for a competitor; or

7. Has been convicted of a crime involving an abuse of ~~his or her~~their office, or position.

K. Death: If a former employee dies before all payments have been made, severance payments will cease. No benefits will continue to a beneficiary.

L. Returning to Work: If an employee is eligible for and receives benefits under this ~~Policy~~policy, and that employee later returns to work for CalOptima Health before receiving all payments under this ~~Policy~~policy, further severance payments will cease effective on the rehire date. If the employee later becomes eligible for benefits under this ~~Policy~~policy, the subsequent severance payment calculated based on the total years of service will be reduced by the amount of severance payments previously paid.

M. Retirement Benefits: The receipt of severance pay under this ~~Policy~~policy shall have no effect on the employee's right, if any, to retiree benefits under any other employee pension, or welfare benefit plan.

N. Other Benefits: Other than severance pay, employees shall not be offered, or provided, any other benefits (health, dental, vision, life insurance, or CalPERS/PARS payments). If the employee is being paid by lump sum as described in Section III.H., medical, dental, and vision benefits shall cease on the last day of the month in the same month as the Separation Date, unless otherwise determined by the CEO. ~~-~~All other benefits, including, but not limited to, life insurance and payment towards CalPERS and PARS ends on the Separation Date. If the employee is receiving severance pay through periodic payments as described in Section III.H. above, medical, dental, vision, and other applicable benefits, as determined solely by HR, may cease on the last day of the month in the same month the employee receives ~~his or her~~their last periodic severance payment, unless otherwise determined by the CEO.

O. Time Limits: All time limits herein refer to calendar days. ~~-~~If the expiration of any time limits of this policy falls on a weekend, or a holiday observed by CalOptima Health, the time limit will be deemed to end on the next workday.

P. Source of Benefits: The benefits provided under this policy shall be unfunded and payable solely from the ~~CalOptima's~~CalOptima Health's general fund.

Q. No Individual Liability: It is the express purpose and intention of CalOptima Health that no individual liability whatsoever shall attach to, or be incurred by, any director, officer, Board Member, executive, employee, representative, or agent of CalOptima~~.~~ Health. This Policy does not guarantee a right to any employee for severance pay, and such benefit shall be offered at the sole discretion of CalOptima Health.

R. No Employment References:~~-~~ If an employee terminated as part of the RIF program requests an employment reference from CalOptima ~~Health~~, CalOptima Health shall only provide the employee's date(s) of employment and position in response to such requests.~~-~~ All reference requests must be directed to HR.

S. No Vested Right: ~~-~~This ~~Policy~~policy does not guarantee a right to any employee for severance pay, and such benefit, if offered, shall be at the sole discretion of CalOptima Health.

IV. ATTACHMENT(S)

~~A. Severance Agreement Under 40~~
~~B. Severance Agreement Over 40~~
Not Applicable

V. REFERENCE(S)

A. Age Discrimination in Employment Act, 29 U.S.C. §621 *et seq.*
B. California Labor Code §1400 *et seq.*
C. Government Code §12964.5
D. CalOptima Health Employee Handbook
E. CalOptima Health Policy GA.8022: Performance and Behavior Standards
F. CalOptima Health Policy GA.8038: Personal Leave of Absence
G. Older Workers Benefit Protection Act, 29 U.S.C. §§623, 626 & 630
H. Worker Adjustment and Retraining Notification Act (WARN), 29 U.S.C. §2101 *et seq.*

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors
08/07/2014	Regular Meeting of the CalOptima Board of Directors
12/01/2016	Regular Meeting of the CalOptima Board of Directors
04/05/2018	Regular Meeting of the CalOptima Board of Directors
12/03/2020	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	02/01/2014	GA.8047	Reduction In Force	Administrative
Revised	08/07/2014	GA.8047	Reduction In Force	Administrative
Revised	12/01/2016	GA.8047	Reduction In Force	Administrative
Revised	04/05/2018	GA.8047	Reduction In Force	Administrative
Revised	12/03/2020	GA.8047	Reduction In Force	Administrative
Revised	TBD	GA.8047	Reduction In Force	Administrative

IX. GLOSSARY

Term	Definition
Annual Earnings	The annualized base salary of the employee as of the Separation Date, without regard to overtime, car allowances, bonus, incentive payments or commission payments.
At-Will	An employment, having no specified term, may be terminated at the will of employees or ~~employers~~the employer at any time and with or without cause.
Service	All periods of employment with CalOptima Health, provided that service does not include periods in which an employee is on a Personal leave of absence pursuant to CalOptima Health Policy GA.8038: Personal Leave of Absence, and service shall not include any period of employment for which the employee has received severance pay under the RIF program or under any similar plan of ~~CalOptima's.~~CalOptima Health's.
Separation Date	The last day of employment with CalOptima Health.

Policy:	GA.8047
Title:	**Reduction in Force**
Department:	CalOptima Health Administrative
Section:	Human Resources
CEO Approval:	*/s/*
Effective Date:	02/01/2014
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy defines how CalOptima Health shall administer a Reduction in Force (RIF) program. A RIF occurs when changing priorities, budgetary constraints, or other business conditions require CalOptima Health to eliminate positions.

II. POLICY

A. All CalOptima Health employees are At-Will employees. An employee is terminated as part of the RIF program through no fault of their own. The RIF is considered an involuntary separation of employment that is intended to be permanent as a result of:

1. Lack of work, changing priorities, budgetary constraints, or other business reasons; or

2. A determination by management that, due to business reasons, an employee's performance, or contribution to the business (although satisfactory), does not meet the needs of the business.

B. As part of the RIF program, CalOptima Health shall evaluate the business needs of the organization and the need for particular positions. CalOptima Health shall take into account the relative value of work performed by specific employees, including, but not limited to, performance, qualifications, discipline, attendance, and length of service, so that CalOptima Health can continue to provide the highest level of service possible with a reduced work force. In implementing a RIF program, CalOptima Health may consider, depending on the circumstances, various factors, including, but not limited to, the following (which are not presented in any order of importance):

1. CalOptima Health's need, or lack thereof, for the position occupied by the employee;

2. The contributions which the employee has made to the success of the organization, and the perceived likelihood of contributions to the success of the business in the foreseeable future;

3. Demonstrated high quality performance on the same, or related, assignments;

4. Versatility and ability in applying pertinent skills and experience to current and expected business requirements;

5. The employee's length of service in the particular position to be retained;

6. The employee's length of service with CalOptima Health;

7. CalOptima Health's need to maintain continuity with respect to a particular project or team; and

8. The more recent performance of the employee compared to others in the same classification.

C. In cases where management determines the various factors considered are essentially equal between two (2) or more employees, length of service in the position and/or length of service at CalOptima Health may be the deciding factor in determining which employee, or employees, shall be retained. In the event an employee who is being laid off has greater length of service in the position and/or length of service at CalOptima Health than an employee, or employees, being retained within the same classification and specialty in the impacted department, CalOptima Health must document the basis, in the judgment of management, the employee with less length of service is better suited for retention.

D. The Human Resources Department shall consult with legal counsel to implement the RIF program to ensure compliance with all applicable federal, state, and local laws and regulations.

E. An employee terminated as part of the RIF program must continue to perform their duties satisfactorily until the Separation Date. Otherwise, the employee may be subject to disciplinary action, up to and including termination, prior to the specified Separation Date, consistent with CalOptima Health Policy GA.8022: Performance and Behavior Standards. An employee terminated as a result of failure to perform duties satisfactorily until the Separation Date shall not be qualified to receive any benefits administered as part of the RIF program.

F. Limitations to Eligibility

1. An employee terminated as part of the RIF program will not be eligible to receive benefits under the plan if the employee:

   a. Is terminated for cause, including but not limited to, failure to meet the performance requirements of the position, policy violation, theft, gross misconduct, etc.; or

   b. Fails, or refuses, to return all CalOptima Health property in the employee's possession, and/or fails to clear all expense and other financial accounts, as of the date of termination. (Examples of CalOptima Health property include, but are not limited to: CalOptima Health Security badges, office keys any and all CalOptima Health documents, files, and computers. Examples of accounts to be cleared include, but are not limited to, the completion and reconciliation of expense accounts); or

   c. Resigns, or otherwise voluntarily terminates, their employment; or

   d. Is terminated by temporary layoff, or furlough, except that if CalOptima Health elects to convert the temporary layoff, or furlough, into a permanent layoff, severance pay may then be payable as of the effective date of permanent layoff, if the employee otherwise is eligible for benefits under the RIF program; or,

e. Is on a leave of absence, except that if an employee is released to return to work from an approved leave of absence and CalOptima Health has no assignment for the employee, they may be eligible for benefits under the RIF program; or

f. Is offered a comparable position within CalOptima Health in lieu of termination, but fails, or refuses, to accept it; or

g. Is terminated because of CalOptima Health's sale, or transfer, of all, or part, of its assets and their employment continues with the agency, or transferee organization, after the transfer has been completed; or

h. Is terminated in connection with the "outsourcing" of operational functions, and they are offered comparable employment by the outsourcing vendor. For this purpose, comparable employment shall be defined as a position with substantially the same duties, at the same, or greater, compensation and comparable benefits, which does not require relocation, as defined by the IRS; or

i. Is terminated from employment for failure to return to work following a leave of absence; or

j. Retires; or

k. Is deceased, at which time eligibility for benefits under the RIF program will end and all such benefit payments, if any, will cease; or

l. Is separated from CalOptima Health because they are no longer able to perform the essential functions of their job with or without reasonable accommodation because of a disability; or

m. Is a temporary employee, intern/volunteer, independent contractor or consultant; or

n. Is an employee employed by CalOptima Health pursuant to a written contract containing provisions for severance benefits; or

o. Is convicted of a crime involving an abuse of their office, or position.

G. This policy sets forth general guidelines to observe in the event of a RIF; however, this policy may be subject to change, deviation, or modification, without notice, depending on the circumstances. Any decision to deviate from this policy in any particular case shall be subject to the discretion of the Chief Executive Officer (CEO).

H. Applicable provisions of this policy may also be used to address employee separations or terminations, other than a RIF, where appropriate, at the discretion of the CEO.

III. PROCEDURE

A. Affected Positions: Following an evaluation of CalOptima Health's business needs, CalOptima Health, through appropriate Executive Officers and the Human Resources (HR) Department (hereinafter referred to as the "management"), will identify and determine the positions that will be eliminated and/or affected by a RIF. Management also has the discretion to determine the manner in which the RIF will occur; however, notification to the HR Department should precede the implementation of the RIF.

B. Determinations: Determinations concerning the evaluation of employees, the considerations evaluated, and final recommendations should be made by the employee's immediate supervisor and/or manager with the next higher management level. Documentation of all considerations evaluated should be furnished to HR and approved by management prior to any notification to the employee affected by the RIF.

C. Transfers or Downgrades: Depending on CalOptima Health's business needs, an employee impacted by the RIF may be offered a downgrade (a lower position and/or reduction in base pay) or lateral transfer (an equivalent position and/or equivalent base pay) to another open job position for which they are, in the judgment of management, most qualified even though it is a job position or classification that the employee has not previously held. An employee impacted by the RIF who is offered a lateral transfer, or downgrade, may be provided the option of layoff. HR shall determine, on a case-by-case basis, the time period appropriate to accept, or decline, such job offer.

D. Employee Notices: Employees who are to be laid off as a result of the RIF should be notified of such reduction only after all necessary approvals have been obtained. An employee notified of a lay off must continue to work up to the Separation Date specified in the notice unless management decides otherwise. An employee notified of their lay off, as a result of the RIF, may not subsequently be placed on a leave of absence (LOA) without prior approval of the Executive Director of HR.

E. Severance: Severance pay may be offered, if approved by the CEO and HR, upon an employee's separation from service when it is deemed appropriate due to special circumstances. If severance pay is authorized and offered, it will be paid in accordance with the following, unless otherwise defined in a separate employee agreement, or approved by the CEO:

1. Two (2) weeks of pay at the rate of the Annual Earnings for employees with less than two (2) years of service and more than ninety (90) days; or

2. One (1) week of pay at the rate of the Annual Earnings for each completed year of service, with a maximum of sixteen (16) weeks, for employees with two (2) years or more of service.

F. Employees on a Leave of Absence: If an employee is on a Leave of Absence (LOA), and their position is terminated as part of the RIF, CalOptima Health will not terminate the LOA early to implement the RIF program. The employee will be laid off at the scheduled, or required, conclusion of the LOA. This paragraph does not apply to employees on Personal LOA, pursuant to CalOptima Health Policy GA.8038: Personal Leave of Absence.

G. Release Agreement: In order to be eligible for the severance pay, if offered, an eligible employee must fully complete and execute a separation agreement provided by CalOptima Health, in a form approved by legal counsel, at, or near the time of, termination. This separation agreement includes a release of all known and unknown claims the employee has, or may have, against CalOptima Health, as well as an agreement of confidentiality, non-disparagement, and non-solicitation. To be eligible for the severance pay, the separation agreement must be signed by the employee and must become irrevocable, in accordance with applicable law.

H. Payment Method: All wages earned and unpaid, including paid time off (PTO) and flex holidays, on the specified Separation Date will be paid to the employee in accordance with CalOptima Health's pay schedule and not necessarily on the employee's Separation Date. CalOptima Health may make payment of severance pay, if an employee is eligible, in accordance with the CalOptima Health payroll schedule as if the recipient were still employed or in a lump sum payment, following a seven (7) day waiting period, where applicable, and after receipt of the fully executed and irrevocable

separation agreement and/or any other agreement. Payment in installments will be equal to the employee's bi-weekly Annual Earnings wages, less applicable taxes and deductions, including benefits, if applicable, until the agreed upon sum has been distributed. Eligible employees receiving payment in installments shall be required to remain reasonably available during the time period the employee is receiving periodic severance payments to respond to questions from CalOptima Health and address work related matters. Payment by lump sum will be distributed on CalOptima Health's next regularly scheduled payday and will be equal to the amount the employee would have made in wages for the applicable number of weeks of severance pay offered, less applicable taxes and deductions.

I. Taxes: CalOptima Health shall reduce all severance pay by all applicable federal, state, or local tax withholdings.

J. Termination of Severance Pay: If a former employee is receiving severance pay through periodic payments as described in Section III.H., severance pay will immediately cease if CalOptima Health discovers that the employee:

1. Has failed to return all CalOptima Health property; or

2. Has disclosed or used confidential information about CalOptima Health for the benefit of a third party; or

3. Has defamed CalOptima Health; or

4. Has been hired on a full-time basis by another employer; or

5. Has failed to remain reasonably available to respond to CalOptima Health questions, or work-related matters.

6. Has attempted to entice other employees of CalOptima Health to work for a competitor; or

7. Has been convicted of a crime involving an abuse of their office, or position.

K. Death: If a former employee dies before all payments have been made, severance payments will cease. No benefits will continue to a beneficiary.

L. Returning to Work: If an employee is eligible for and receives benefits under this policy, and that employee later returns to work for CalOptima Health before receiving all payments under this policy, further severance payments will cease effective on the rehire date. If the employee later becomes eligible for benefits under this policy, the subsequent severance payment calculated based on the total years of service will be reduced by the amount of severance payments previously paid.

M. Retirement Benefits: The receipt of severance pay under this policy shall have no effect on the employee's right, if any, to retiree benefits under any other employee pension, or welfare benefit plan.

N. Other Benefits: Other than severance pay, employees shall not be offered, or provided, any other benefits (health, dental, vision, life insurance, or CalPERS/PARS payments). If the employee is being paid by lump sum as described in Section III.H., medical, dental, and vision benefits shall cease on the last day of the month in the same month as the Separation Date, unless otherwise determined by the CEO. All other benefits, including, but not limited to, life insurance and payment towards CalPERS and PARS ends on the Separation Date. If the employee is receiving severance

pay through periodic payments as described in Section III.H. above, medical, dental, vision, and other applicable benefits, as determined solely by HR, may cease on the last day of the month in the same month the employee receives their last periodic severance payment, unless otherwise determined by the CEO.

O. Time Limits: All time limits herein refer to calendar days. If the expiration of any time limits of this policy falls on a weekend, or a holiday observed by CalOptima Health, the time limit will be deemed to end on the next workday.

P. Source of Benefits: The benefits provided under this policy shall be unfunded and payable solely from the CalOptima Health's general fund.

Q. No Individual Liability: It is the express purpose and intention of CalOptima Health that no individual liability whatsoever shall attach to, or be incurred by, any director, officer, Board Member, executive, employee, representative, or agent of CalOptima Health. This Policy does not guarantee a right to any employee for severance pay, and such benefit shall be offered at the sole discretion of CalOptima Health.

R. No Employment References: If an employee terminated as part of the RIF program requests an employment reference from CalOptima Health, CalOptima Health shall only provide the employee's date(s) of employment and position in response to such requests. All reference requests must be directed to HR.

S. No Vested Right: This policy does not guarantee a right to any employee for severance pay, and such benefit, if offered, shall be at the sole discretion of CalOptima Health.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. Age Discrimination in Employment Act, 29 U.S.C. §621 *et seq.*
B. California Labor Code §1400 *et seq.*
C. Government Code §12964.5
D. CalOptima Health Employee Handbook
E. CalOptima Health Policy GA.8022: Performance and Behavior Standards
F. CalOptima Health Policy GA.8038: Personal Leave of Absence
G. Older Workers Benefit Protection Act, 29 U.S.C. §§623, 626 & 630
H. Worker Adjustment and Retraining Notification Act (WARN), 29 U.S.C. §2101 *et seq.*

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors
08/07/2014	Regular Meeting of the CalOptima Board of Directors
12/01/2016	Regular Meeting of the CalOptima Board of Directors

04/05/2018	Regular Meeting of the CalOptima Board of Directors
12/03/2020	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	02/01/2014	GA.8047	Reduction In Force	Administrative
Revised	08/07/2014	GA.8047	Reduction In Force	Administrative
Revised	12/01/2016	GA.8047	Reduction In Force	Administrative
Revised	04/05/2018	GA.8047	Reduction In Force	Administrative
Revised	12/03/2020	GA.8047	Reduction In Force	Administrative
Revised	TBD	GA.8047	Reduction In Force	Administrative

IX. GLOSSARY

Term	Definition
Annual Earnings	The annualized base salary of the employee as of the Separation Date, without regard to overtime, car allowances, bonus, incentive payments or commission payments.
At-Will	An employment, having no specified term, may be terminated at the will of employees or the employer at any time and with or without cause.
Service	All periods of employment with CalOptima Health, provided that service does not include periods in which an employee is on a Personal leave of absence pursuant to CalOptima Health Policy GA.8038: Personal Leave of Absence, and service shall not include any period of employment for which the employee has received severance pay under the RIF program or under any similar plan of CalOptima Health's.
Separation Date	The last day of employment with CalOptima Health.

Policy:	GA.8055
Title:	**Retiree Health Benefit**
Department:	CalOptima Health Administrative
Section:	Human Resources
CEO Approval:	*/s/*
Effective Date:	05/01/2014
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy provides detailed guidelines on how to administer retiree health benefits for those who qualify for retiree health benefits under this policy.

II. POLICY

A. Retiree health benefits are available to Current Retirees, Eligible Employees, and Eligible ~~Employees~~Retirees. Retiree health benefits are not available to employees who: (1) were initially hired on or after January 1, 2004, or (2) employees who were hired or rehired on or after December 1, 2013~~.~~ (with the exception of Reinstated Eligible Retirees).

B. Eligible Retirees and, if elected and paid for by the Eligible Retirees, the Eligible Dependents of Current Retirees, Retired Eligible Employees, or Reinstated Eligible Retirees, will, until the CalOptima Health Board of Directors ("Board") decides that CalOptima Health will no longer continue the program or otherwise modifies it, be eligible to receive retiree health benefits as follows:

1. *Not Medicare Eligible*: If the Eligible Retiree and/or the Eligible Dependent(s) is/are not yet eligible for Medicare, then the Eligible Retiree and/or the Eligible Dependent(s) will receive the same health insurance coverage as active employees and their dependents subject to the limitations below. The Eligible Retiree's share of premiums for the Eligible Retiree's health insurance coverage will be the same as those paid by active employees for similar coverage. In the event CalOptima Health is unable to reasonably obtain health insurance coverage for the Eligible Dependent(s) who are not Medicare eligible, CalOptima Health may provide a stipend to the Eligible Dependent(s) in lieu of health insurance coverage in an amount calculated based on the proportional amount CalOptima Health pays for the most closely analogous active employee health insurance coverage for active employees and their dependent(s), but in no event shall the total dollar amount for the stipend be more than the amount CalOptima Health would have paid for the most closely analogous health insurance coverage for the Eligible Dependent(s). Proof of coverage, along with evidence of payments for health care coverage, must be submitted to CalOptima Health in order for the stipend to be paid.

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~~1.~~2. *Medicare Eligible*: If the Eligible Retiree and/or the Eligible Dependent(s) is/are Medicare eligible, then the Eligible Retiree and/or the Eligible Dependent(s) will be required to enroll, at the Eligible Retiree's expense, in Medicare Part A and/or Part B, as a condition of receiving retiree health benefits under this policy. Proof of Medicare coverage must be submitted to Human Resources. The Eligible Retiree may select one (1) of the Medicare supplemental coverage options offered by CalOptima Health for the Medicare Eligible Retiree and/or the Eligible Dependent(s). The Eligible Retiree's share of the Medicare supplemental coverage premium will be calculated based on the same proportional amount active employees pay for the most closely analogous active employee health insurance coverage for the active employee and their dependents. In the event CalOptima Health is unable to reasonably obtain Medicare Supplemental coverage for the Eligible Dependent(s) who are Medicare eligible, CalOptima Health may provide a stipend to the Eligible Dependent(s) in lieu of Medicare Supplemental coverage in an amount calculated based on the proportional amount CalOptima Health pays for the most closely analogous Medicare supplemental coverage for Eligible Retirees and their dependent(s), but in no event shall the total dollar amount for the stipend be more than the amount CalOptima Health would have paid for the most closely analogous Medicare Supplemental coverage for the Eligible Dependent(s). Proof of coverage, along with evidence of payments for Medicare Supplemental coverage, must be submitted to CalOptima Health in order for the stipend to be paid.

C. This retiree health benefit policy is completely voluntary on the part of CalOptima Health and may be amended, or terminated, by the CalOptima Health Board at any time in its sole discretion. This policy shall not create any vested benefits for any person, or categories of persons.

D. The Chief Executive Officer of CalOptima Health is charged with administering and interpreting this policy. When addressing any issue that is not dealt with in the Policy, the Chief Executive Officer shall consider and give weight to what the result would have been if CalOptima Health were still providing its employee health insurance through CalPERS.

E. This policy shall supersede any and all prior Board actions or policies concerning retiree health benefits.

III. PROCEDURE

A. The following provisions set forth the enrollment requirements for an Eligible Retiree to receive Retiree Health Benefits:

1. A Retired Eligible Employee must enroll ~~him/herself~~themself and ~~his/her~~their Eligible Dependents within sixty (60) calendar days of the Retired Eligible Employee's Retirement Date or must wait to enroll during the annual open enrollment period applicable to active employees.

2. An Eligible Retiree must elect the Medicare coverage option ~~he or she wants~~they want within sixty (60) calendar days of the Eligible Retiree and/or the Eligible Dependent becoming Medicare eligible and provide proof of Medicare coverage to Human Resources.

3. A Reinstated Eligible Employee must enroll within sixty (60) calendar days of ~~his or her~~their Subsequent Retirement Date.

4. A Survivor Dependent may continue coverage without interruption or enroll for Survivor Dependent coverage by submitting all necessary documentation within sixty (60) calendar days of the death of the Eligible Retiree.

5. Health insurance coverage options may be changed by an Eligible Retiree during the annual open enrollment period and for defined qualifying events applicable for active employees who are covered under ~~CalOptima's~~CalOptima Health's employee health plan.

B. Retiree health benefits coverage will begin upon one (1) of the following:

1. If an Eligible Employee enrolls within sixty (60) calendar days of separation from CalOptima Health and ~~his or her~~their Retirement Date, then the retiree health benefits coverage for the Retired Eligible Employee and the Eligible Dependent(s) will begin on the first day of the month following the date CalOptima Health timely receives the completed health enrollment forms from the Eligible Employee.

2. If the Retired Eligible Employee fails to enroll within sixty (60) calendar days of ~~his or her~~their Retirement Date, but subsequently enrolls during any future open enrollment period applicable for active employees, retiree health benefits coverage will begin on the following January 1.

3. Retiree health benefits coverage for an Eligible Survivor Dependent will continue uninterrupted upon submission of all required documentation or begin on the first day of the month following timely enrollment for coverage as a Survivor Dependent.

4. If a Reinstated Eligible Employee timely enrolls within sixty (60) calendar days of ~~his or her~~their Subsequent Retirement Date, then the retiree health benefits coverage for the Reinstated Eligible Employee and the Eligible Dependent(s) will begin on the first day of the month following the date CalOptima Health timely receives the completed health enrollment forms from the Reinstated Eligible Employee.

C. If an Eligible Employee separates from CalOptima Health before CalOptima Health receives notice from CalPERS that the Eligible Employee has/will become an annuitant, the Eligible Employee will be offered termination of health coverage information and a COBRA health plan continuation packet. After CalOptima Health receives notice from CALPERS of the Eligible Employee's retirement effective date, CalOptima Health will forward a packet to the Retired Eligible Employee concerning retiree health benefits. The Retired Eligible Employee must enroll ~~him/herself~~themself and ~~his/her~~their Eligible Dependents within sixty (60) calendar days of the Retired Eligible Employee's Retirement Date or must wait to enroll during the next annual open enrollment period applicable to active employees. (NOTE: If the retirement effective date indicated by CalPERS is postdated to the date of separation or other earlier date, and CalOptima Health does not receive notice from CalPERS until more than sixty (60) calendar days after such date, the Retired Eligible Employee must wait to enroll during the next annual open enrollment period.). If the Retired Eligible Employee needs access to health coverage before the retiree health benefits coverage will begin, the Retired Eligible Employee will need to elect and pay for COBRA health plan continuation or pay for an alternative health plan until then.

D. Retiree health benefit coverage will terminate upon the following:

1. For Eligible Retirees, upon death of the Eligible Retiree.

2. For Eligible Dependents, upon death of the Eligible Retiree, unless the Eligible Dependent is an Eligible Survivor Dependent.

3. For Current Retirees and Retired Eligible Employees who are reinstated from retirement:

a. During the period of reinstatement that ends CalPERS retirement annuity payments; and

b. During and after the Subsequent Retirement Date if the Current Retiree and/or Retired Eligible Employee subsequently terminates employment from another ~~state~~California public employer who provides retiree health benefits with a retiree share premium that is less than, or equal to, that being charged by CalOptima Health under this policy.

4. Upon the failure of an Eligible Retiree or Eligible Survivor Dependent to pay any required premiums within ninety (90) calendar days of payment due date.

5. When the CalOptima Health Board elects to terminate retiree health benefits, in part, or in its entirety.

6. Upon the failure to obtain and certify Medicare coverage within ninety (90) calendar days upon the Eligible Retiree or the Eligible Dependent(s) becoming Medicare eligible.

7. Upon the failure of an Eligible Retiree or Eligible Dependent to maintain the required Medicare coverage.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

Not Applicable

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
08/07/2014	Regular Meeting of the CalOptima Board of Directors
06/02/2016	Regular Meeting of the CalOptima Board of Directors
11/03/2016	Regular Meeting of the CalOptima Board of Directors
06/04/2020	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	05/01/2014	GA.8055	Retiree Health Benefit Policy	Administrative
Revised	08/07/2014	GA.8055	Retiree Health Benefit Policy	Administrative
Revised	06/02/2016	GA.8055	Retiree Health Benefit	Administrative
Revised	11/03/2016	GA.8055	Retiree Health Benefit	Administrative
Revised	11/07/2019	GA.8055	Retiree Health Benefit	Administrative
Revised	06/04/2020	GA.8055	Retiree Health Benefit	Administrative
Revised	TBD	GA.8055	Retiree Health Benefit	Administrative

IX. GLOSSARY

Term	Definition
Current Retiree	Former employee of CalOptima Health who: 1. Was hired before January 1, 2004; 2. Completed at least five (5) years of pensionable service (with CalOptima Health and/or combined with other service with a public agency that participates in CalPERS); and 3. Was already receiving retiree health benefits from CalOptima Health on January 1, 2014.
Eligible Dependent	The current spouse, registered domestic partner, dependent child up to age 26, and/or certified disabled dependent child over age 26, of a Current Retiree, Retired Eligible Employee, or Reinstated Eligible Retiree, who: 1. Meets the definition of a dependent who is eligible for coverage under the employee health plan then maintained by CalOptima Health for its active employees; and 2. Has been timely enrolled for coverage under this retiree health policy by the Eligible Retiree.
Eligible Employee	A current active employee of CalOptima Health meeting the following criteria: 1. The most recent date of hire was before January 1, 2004, or whose initial date of hire was before January 1, 2004, and whose most recent rehire date was before December 1, 2013; 2. Completes at least five (5) years of pensionable service (with CalOptima Health and/or combined with other service with a public agency that participates in CalPERS).
Eligible Retiree	Current Retiree, Retired Eligible Employee, Reinstated Eligible Retiree or Eligible Survivor Dependent.
Eligible Survivor Dependent	A Survivor Dependent who timely enrolls for Survivor Dependent health coverage within sixty (60) calendar days of the death of the Eligible Retiree.
Reinstated Eligible Retiree	A Current Retiree or Retired Eligible Employee whose CalPERS retirement annuity and benefits under this Policy ended due to a reinstatement from retirement as defined in Government Code §§22838 and 21190 et.seq., or successor sections, and who (i) subsequently terminates employment from another ~~state~~California public employer who does not provide retiree health benefits with a retiree share premium that is less than or equal to that being charged by CalOptima Health under this Policy; (ii) once again begins collecting retirement annuity payments from CalPERS within one hundred twenty (120) calendar days of such subsequent separation from employment; and (iii) timely enrolls for resumption of coverage under this Policy.

Term	Definition
Retired Eligible Employee	Eligible Employee who: 1. Retires within one hundred twenty (120) calendar days of such Eligible Employee's separation from employment with CalOptima Health and receives a monthly retirement allowance from CalPERS; and 2. Timely applies for retiree health benefits in accordance with this policy on and after January 1, 2014.
Retirement Date	Date Eligible Employee becomes an annuitant with CalPERS within one hundred twenty (120) calendar days of such Eligible Employee's separation from employment with CalOptima Health.
Subsequent Retirement Date	Date Reinstated Eligible Retiree again begins collecting retirement annuity payments from CalPERS within one hundred twenty (120) calendar days of separating from employment with the subsequent state employer described in that definition.
Survivor Dependent	Eligible Dependent who: 1. Survives an Eligible Retiree; and 2. Is collecting monthly survivor benefits from CalPERS that is attributable to a deceased Current Retiree, Retired Eligible Employee, or Reinstated Eligible Employee.

Policy:	GA.8055
Title:	**Retiree Health Benefit**
Department:	CalOptima Health Administrative
Section:	Human Resources
CEO Approval:	*/s/*
Effective Date:	05/01/2014
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy provides detailed guidelines on how to administer retiree health benefits for those who qualify for retiree health benefits under this policy.

II. POLICY

A. Retiree health benefits are available to Current Retirees, Eligible Employees, and Eligible Retirees. Retiree health benefits are not available to employees who: (1) were initially hired on or after January 1, 2004, or (2) employees who were hired or rehired on or after December 1, 2013 (with the exception of Reinstated Eligible Retirees).

B. Eligible Retirees and, if elected and paid for by the Eligible Retirees, the Eligible Dependents of Current Retirees, Retired Eligible Employees, or Reinstated Eligible Retirees, will, until the CalOptima Health Board of Directors ("Board") decides that CalOptima Health will no longer continue the program or otherwise modifies it, be eligible to receive retiree health benefits as follows:

1. *Not Medicare Eligible*: If the Eligible Retiree and/or the Eligible Dependent(s) is/are not yet eligible for Medicare, then the Eligible Retiree and/or the Eligible Dependent(s) will receive the same health insurance coverage as active employees and their dependents subject to the limitations below. The Eligible Retiree's share of premiums for the Eligible Retiree's health insurance coverage will be the same as those paid by active employees for similar coverage. In the event CalOptima Health is unable to reasonably obtain health insurance coverage for the Eligible Dependent(s) who are not Medicare eligible, CalOptima Health may provide a stipend to the Eligible Dependent(s) in lieu of health insurance coverage in an amount calculated based on the proportional amount CalOptima Health pays for the most closely analogous active employee health insurance coverage for active employees and their dependent(s), but in no event shall the total dollar amount for the stipend be more than the amount CalOptima Health would have paid for the most closely analogous health insurance coverage for the Eligible Dependent(s). Proof of coverage, along with evidence of payments for health care coverage, must be submitted to CalOptima Health in order for the stipend to be paid.

2. *Medicare Eligible*: If the Eligible Retiree and/or the Eligible Dependent(s) is/are Medicare eligible, then the Eligible Retiree and/or the Eligible Dependent(s) will be required to enroll, at

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the Eligible Retiree's expense, in Medicare Part A and/or Part B, as a condition of receiving retiree health benefits under this policy. Proof of Medicare coverage must be submitted to Human Resources. The Eligible Retiree may select one (1) of the Medicare supplemental coverage options offered by CalOptima Health for the Medicare Eligible Retiree and/or the Eligible Dependent(s). The Eligible Retiree's share of the Medicare supplemental coverage premium will be calculated based on the same proportional amount active employees pay for the most closely analogous active employee health insurance coverage for the active employee and their dependents. In the event CalOptima Health is unable to reasonably obtain Medicare Supplemental coverage for the Eligible Dependent(s) who are Medicare eligible, CalOptima Health may provide a stipend to the Eligible Dependent(s) in lieu of Medicare Supplemental coverage in an amount calculated based on the proportional amount CalOptima Health pays for the most closely analogous Medicare supplemental coverage for Eligible Retirees and their dependent(s), but in no event shall the total dollar amount for the stipend be more than the amount CalOptima Health would have paid for the most closely analogous Medicare Supplemental coverage for the Eligible Dependent(s). Proof of coverage, along with evidence of payments for Medicare Supplemental coverage, must be submitted to CalOptima Health in order for the stipend to be paid.

C. This retiree health benefit policy is completely voluntary on the part of CalOptima Health and may be amended, or terminated, by the CalOptima Health Board at any time in its sole discretion. This policy shall not create any vested benefits for any person, or categories of persons.

D. The Chief Executive Officer of CalOptima Health is charged with administering and interpreting this policy. When addressing any issue that is not dealt with in the Policy, the Chief Executive Officer shall consider and give weight to what the result would have been if CalOptima Health were still providing its employee health insurance through CalPERS.

E. This policy shall supersede any and all prior Board actions or policies concerning retiree health benefits.

III. PROCEDURE

A. The following provisions set forth the enrollment requirements for an Eligible Retiree to receive Retiree Health Benefits:

1. A Retired Eligible Employee must enroll themself and their Eligible Dependents within sixty (60) calendar days of the Retired Eligible Employee's Retirement Date or must wait to enroll during the annual open enrollment period applicable to active employees.

2. An Eligible Retiree must elect the Medicare coverage option they want within sixty (60) calendar days of the Eligible Retiree and/or the Eligible Dependent becoming Medicare eligible and provide proof of Medicare coverage to Human Resources.

3. A Reinstated Eligible Employee must enroll within sixty (60) calendar days of their Subsequent Retirement Date.

4. A Survivor Dependent may continue coverage without interruption or enroll for Survivor Dependent coverage by submitting all necessary documentation within sixty (60) calendar days of the death of the Eligible Retiree.

5. Health insurance coverage options may be changed by an Eligible Retiree during the annual open enrollment period and for defined qualifying events applicable for active employees who are covered under CalOptima Health's employee health plan.

B. Retiree health benefits coverage will begin upon one (1) of the following:

1. If an Eligible Employee enrolls within sixty (60) calendar days of separation from CalOptima Health and their Retirement Date, then the retiree health benefits coverage for the Retired Eligible Employee and the Eligible Dependent(s) will begin on the first day of the month following the date CalOptima Health timely receives the completed health enrollment forms from the Eligible Employee.

2. If the Retired Eligible Employee fails to enroll within sixty (60) calendar days of their Retirement Date, but subsequently enrolls during any future open enrollment period applicable for active employees, retiree health benefits coverage will begin on the following January 1.

3. Retiree health benefits coverage for an Eligible Survivor Dependent will continue uninterrupted upon submission of all required documentation or begin on the first day of the month following timely enrollment for coverage as a Survivor Dependent.

4. If a Reinstated Eligible Employee timely enrolls within sixty (60) calendar days of their Subsequent Retirement Date, then the retiree health benefits coverage for the Reinstated Eligible Employee and the Eligible Dependent(s) will begin on the first day of the month following the date CalOptima Health timely receives the completed health enrollment forms from the Reinstated Eligible Employee.

C. If an Eligible Employee separates from CalOptima Health before CalOptima Health receives notice from CalPERS that the Eligible Employee has/will become an annuitant, the Eligible Employee will be offered termination of health coverage information and a COBRA health plan continuation packet. After CalOptima Health receives notice from CALPERS of the Eligible Employee's retirement effective date, CalOptima Health will forward a packet to the Retired Eligible Employee concerning retiree health benefits. The Retired Eligible Employee must enroll themself and their Eligible Dependents within sixty (60) calendar days of the Retired Eligible Employee's Retirement Date or must wait to enroll during the next annual open enrollment period applicable to active employees. (NOTE: If the retirement effective date indicated by CalPERS is postdated to the date of separation or other earlier date, and CalOptima Health does not receive notice from CalPERS until more than sixty (60) calendar days after such date, the Retired Eligible Employee must wait to enroll during the next annual open enrollment period.). If the Retired Eligible Employee needs access to health coverage before the retiree health benefits coverage will begin, the Retired Eligible Employee will need to elect and pay for COBRA health plan continuation or pay for an alternative health plan until then.

D. Retiree health benefit coverage will terminate upon the following:

1. For Eligible Retirees, upon death of the Eligible Retiree.

2. For Eligible Dependents, upon death of the Eligible Retiree, unless the Eligible Dependent is an Eligible Survivor Dependent.

3. For Current Retirees and Retired Eligible Employees who are reinstated from retirement:

   a. During the period of reinstatement that ends CalPERS retirement annuity payments; and

   b. During and after the Subsequent Retirement Date if the Current Retiree and/or Retired Eligible Employee subsequently terminates employment from another California public

employer who provides retiree health benefits with a retiree share premium that is less than, or equal to, that being charged by CalOptima Health under this policy.

4. Upon the failure of an Eligible Retiree or Eligible Survivor Dependent to pay any required premiums within ninety (90) calendar days of payment due date.

5. When the CalOptima Health Board elects to terminate retiree health benefits, in part, or in its entirety.

6. Upon the failure to obtain and certify Medicare coverage within ninety (90) calendar days upon the Eligible Retiree or the Eligible Dependent(s) becoming Medicare eligible.

7. Upon the failure of an Eligible Retiree or Eligible Dependent to maintain the required Medicare coverage.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

Not Applicable

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
08/07/2014	Regular Meeting of the CalOptima Board of Directors
06/02/2016	Regular Meeting of the CalOptima Board of Directors
11/03/2016	Regular Meeting of the CalOptima Board of Directors
06/04/2020	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	05/01/2014	GA.8055	Retiree Health Benefit Policy	Administrative
Revised	08/07/2014	GA.8055	Retiree Health Benefit Policy	Administrative
Revised	06/02/2016	GA.8055	Retiree Health Benefit	Administrative
Revised	11/03/2016	GA.8055	Retiree Health Benefit	Administrative
Revised	11/07/2019	GA.8055	Retiree Health Benefit	Administrative
Revised	06/04/2020	GA.8055	Retiree Health Benefit	Administrative
Revised	TBD	GA.8055	Retiree Health Benefit	Administrative

IX. GLOSSARY

Term	Definition
Current Retiree	Former employee of CalOptima Health who: 1. Was hired before January 1, 2004; 2. Completed at least five (5) years of pensionable service (with CalOptima Health and/or combined with other service with a public agency that participates in CalPERS); and 3. Was already receiving retiree health benefits from CalOptima Health on January 1, 2014.
Eligible Dependent	The current spouse, registered domestic partner, dependent child up to age 26, and/or certified disabled dependent child over age 26, of a Current Retiree, Retired Eligible Employee, or Reinstated Eligible Retiree, who: 1. Meets the definition of a dependent who is eligible for coverage under the employee health plan then maintained by CalOptima Health for its active employees; and 2. Has been timely enrolled for coverage under this retiree health policy by the Eligible Retiree.
Eligible Employee	A current active employee of CalOptima Health meeting the following criteria: 1. The most recent date of hire was before January 1, 2004, or whose initial date of hire was before January 1, 2004, and whose most recent rehire date was before December 1, 2013; 2. Completes at least five (5) years of pensionable service (with CalOptima Health and/or combined with other service with a public agency that participates in CalPERS).
Eligible Retiree	Current Retiree, Retired Eligible Employee, Reinstated Eligible Retiree or Eligible Survivor Dependent.
Eligible Survivor Dependent	A Survivor Dependent who timely enrolls for Survivor Dependent health coverage within sixty (60) calendar days of the death of the Eligible Retiree.
Reinstated Eligible Retiree	A Current Retiree or Retired Eligible Employee whose CalPERS retirement annuity and benefits under this Policy ended due to a reinstatement from retirement as defined in Government Code §§22838 and 21190 et.seq., or successor sections, and who (i) subsequently terminates employment from another California public employer who does not provide retiree health benefits with a retiree share premium that is less than or equal to that being charged by CalOptima Health under this Policy; (ii) once again begins collecting retirement annuity payments from CalPERS within one hundred twenty (120) calendar days of such subsequent separation from employment; and (iii) timely enrolls for resumption of coverage under this Policy.

Term	Definition
Retired Eligible Employee	Eligible Employee who: 1. Retires within one hundred twenty (120) calendar days of such Eligible Employee's separation from employment with CalOptima Health and receives a monthly retirement allowance from CalPERS; and 2. Timely applies for retiree health benefits in accordance with this policy on and after January 1, 2014.
Retirement Date	Date Eligible Employee becomes an annuitant with CalPERS within one hundred twenty (120) calendar days of such Eligible Employee's separation from employment with CalOptima Health.
Subsequent Retirement Date	Date Reinstated Eligible Retiree again begins collecting retirement annuity payments from CalPERS within one hundred twenty (120) calendar days of separating from employment with the subsequent state employer described in that definition.
Survivor Dependent	Eligible Dependent who: 1. Survives an Eligible Retiree; and 2. Is collecting monthly survivor benefits from CalPERS that is attributable to a deceased Current Retiree, Retired Eligible Employee, or Reinstated Eligible Employee.

1

Policy:	GA.8056
Title:	**Paid Holidays**
Department:	CalOptima Health Administrative
Section:	Human Resources
CEO Approval:	/s/
Effective Date:	04/01/2014
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy establishes the paid holiday schedule for CalOptima Health Employees.

II. POLICY

A. The following holidays shall be observed by CalOptima Health:

1. New Year's Day
2. Martin Luther King ~~Jr. Day~~Jr's Birthday
~~3. Presidents' Day~~
3. Lincoln's Birthday
4. Washington's Birthday
~~4.~~5. Memorial Day
~~5.~~6. Independence Day
~~6.~~7. Labor Day
8. Indigenous Peoples' Day
~~7.~~9. Veteran's Day
10. Thanksgiving Day ~~and the Friday~~
~~8.~~11. Day after Thanksgiving
~~9.~~12. Christmas Day
~~10.~~13. One Flex Holiday (credited on January 1)

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B. A holiday that falls on a Saturday or Sunday can be observed on the preceding Friday or the following Monday. Holiday observances will be noted on the annual payroll schedule. Employees will be provided notice of any changes to the published schedule.

C. Regular full-time and regular part-time Employees who are regularly scheduled to work twenty (20) or more hours per week are eligible to receive a maximum of one (1) Flex Holiday (maximum of eight (8) hours, prorated based on scheduled work hours) each calendar year on January 1st. Limits are imposed on the number of Flex Holiday hours that can be maintained in an Employee's Flex Holiday account. A maximum of twelve (12) hours, prorated based on scheduled work hours, may be maintained in an Employee's Flex Holiday account as of January 1st of each year. In the event that available Flex Holiday hours are not used by the last pay period of the calendar year, Employees may carry unused Flex Holiday hours into subsequent years and may accrue additional hours up to the maximum of eight (8) hours, prorated based on scheduled work hours. If an Employee reached the maximum amount of twelve (12) hours on January 1st, prorated based on scheduled work hours, the Employee will stop accruing Flex Holiday hours. Flex Holiday hours are not eligible for annual cash out applicable to Paid Time Off (PTO) hours. The Chief Executive Officer (CEO) may assign a specific date for the Flex Holiday for business reasons and/or needs. Assignment of the Flex Holiday will be announced in advance. Otherwise, Employees may take the Flex Holiday on any day elected by the Employee, subject to approval by the Employee's manager. If an Employee separates from CalOptima Health and has unused Flex Holiday hours, the unused Flex Holiday hours will be paid out at the same time and in the same manner as unused PTO hours upon termination.

D. Regular full-time and regular part-time Employees shall be paid ~~his or her~~their regular rate of pay for the holidays specified in this Policy.

E. CalOptima Health may, in its discretion, amend the list of paid holidays and/or require an Employee to work on one or more of the observed holidays.

F. From time to time, at the discretion of the CEO, the CEO, or ~~his/her~~their Designee, may authorize managers, at their discretion, to release Employees early, up to a maximum of two (2) hours, with pay, on the ~~work day~~workday immediately preceding a holiday, as long as departments ensure critical areas are covered for the entire business day. The release of Employees early as provided herein is intended to benefit only those Employees who are working on the ~~work day~~workday immediately preceding a holiday. Employees who are on PTO on the day Employees are permitted to leave early are not entitled to any credit or future early release.

III. PROCEDURE

A. CalOptima Health will note holiday observances annually on its payroll schedule. In the event of a change to the published schedule, CalOptima Health will provide prompt notice to all Employees.

B. When a holiday falls on a regular nine (9) hour ~~work day~~workday for a full-time non-exempt Employee on a 9/80 schedule pursuant to CalOptima Health Policy GA.8020: 9/80 Work Schedule, the Employee has the option of using one (1) hour of accrued PTO or making up the time if approved by ~~his or her~~their supervisor. For Employees on the 9/80 Work Schedule, should a holiday fall on an Employee's scheduled day off, the Employee will be permitted to take another day off in the same workweek.

C. ~~If a~~All regular, non-exempt, full-time employees who are eligible for paid holidays but who may be required to work on a holiday observed by CalOptima Health will receive Holiday Premium Pay in accordance with CalOptima Health Policy GA.8042: Supplemental Compensation. If a regular, non-exempt part-time Employee is required to work a scheduled holiday, ~~he or she~~they will receive ~~his~~

~~or her~~their regular rate of pay for the holiday, in addition to ~~his or her~~their regular compensation for the hours of actual work performed.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Policy GA.8020: 9/80 Work Schedule
B. CalOptima Health Policy GA.8042: Supplemental Compensation

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors
04/07/2016	Regular Meeting of the CalOptima Board of Directors
04/05/2018	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	04/01/2014	GA.8056	Paid Holidays	Administrative
Revised	04/07/2016	GA.8056	Paid Holidays	Administrative
Revised	04/05/2018	GA.8056	Paid Holidays	Administrative
Revised	02/01/2021	GA.8056	Paid Holidays	Administrative
Revised	TBD	GA.8056	Paid Holidays	Administrative

IX. GLOSSARY

Term	Definition
Employee	For the purposes of this policy, employees include regular full-time and regular part-time employees of CalOptima Health.

Policy:	GA.8056
Title:	**Paid Holidays**
Department:	CalOptima Health Administrative
Section:	Human Resources
CEO Approval:	*/s/*
Effective Date:	04/01/2014
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy establishes the paid holiday schedule for CalOptima Health Employees.

II. POLICY

A. The following holidays shall be observed by CalOptima Health:

1. New Year's Day
2. Martin Luther King Jr's Birthday
3. Lincoln's Birthday
4. Washington's Birthday
5. Memorial Day
6. Independence Day
7. Labor Day
8. Indigenous Peoples' Day
9. Veteran's Day
10. Thanksgiving Day
11. Day after Thanksgiving
12. Christmas Day
13. One Flex Holiday (credited on January 1)

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B. A holiday that falls on a Saturday or Sunday can be observed on the preceding Friday or the following Monday. Holiday observances will be noted on the annual payroll schedule. Employees will be provided notice of any changes to the published schedule.

C. Regular full-time and regular part-time Employees who are regularly scheduled to work twenty (20) or more hours per week are eligible to receive a maximum of one (1) Flex Holiday (maximum of eight (8) hours, prorated based on scheduled work hours) each calendar year on January 1st. Limits are imposed on the number of Flex Holiday hours that can be maintained in an Employee's Flex Holiday account. A maximum of twelve (12) hours, prorated based on scheduled work hours, may be maintained in an Employee's Flex Holiday account as of January 1st of each year. In the event that available Flex Holiday hours are not used by the last pay period of the calendar year, Employees may carry unused Flex Holiday hours into subsequent years and may accrue additional hours up to the maximum of eight (8) hours, prorated based on scheduled work hours. If an Employee reached the maximum amount of twelve (12) hours on January 1st, prorated based on scheduled work hours, the Employee will stop accruing Flex Holiday hours. Flex Holiday hours are not eligible for annual cash out applicable to Paid Time Off (PTO) hours. The Chief Executive Officer (CEO) may assign a specific date for the Flex Holiday for business reasons and/or needs. Assignment of the Flex Holiday will be announced in advance. Otherwise, Employees may take the Flex Holiday on any day elected by the Employee, subject to approval by the Employee's manager. If an Employee separates from CalOptima Health and has unused Flex Holiday hours, the unused Flex Holiday hours will be paid out at the same time and in the same manner as unused PTO hours upon termination.

D. Regular full-time and regular part-time Employees shall be paid their regular rate of pay for the holidays specified in this Policy.

E. CalOptima Health may, in its discretion, amend the list of paid holidays and/or require an Employee to work on one or more of the observed holidays.

F. From time to time, at the discretion of the CEO, the CEO, or their Designee, may authorize managers, at their discretion, to release Employees early, up to a maximum of two (2) hours, with pay, on the workday immediately preceding a holiday, as long as departments ensure critical areas are covered for the entire business day. The release of Employees early as provided herein is intended to benefit only those Employees who are working on the workday immediately preceding a holiday. Employees who are on PTO on the day Employees are permitted to leave early are not entitled to any credit or future early release.

III. PROCEDURE

A. CalOptima Health will note holiday observances annually on its payroll schedule. In the event of a change to the published schedule, CalOptima Health will provide prompt notice to all Employees.

B. When a holiday falls on a regular nine (9) hour workday for a full-time non-exempt Employee on a 9/80 schedule pursuant to CalOptima Health Policy GA.8020: 9/80 Work Schedule, the Employee has the option of using one (1) hour of accrued PTO or making up the time if approved by their supervisor. For Employees on the 9/80 Work Schedule, should a holiday fall on an Employee's scheduled day off, the Employee will be permitted to take another day off in the same workweek.

C. All regular, non-exempt, full-time employees who are eligible for paid holidays but who may be required to work on a holiday observed by CalOptima Health will receive Holiday Premium Pay in accordance with CalOptima Health Policy GA.8042: Supplemental Compensation. If a regular, non-exempt part-time Employee is required to work a scheduled holiday, they will receive their regular rate of pay for the holiday, in addition to their regular compensation for the hours of actual work performed.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Policy GA.8020: 9/80 Work Schedule
B. CalOptima Health Policy GA.8042: Supplemental Compensation

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors
04/07/2016	Regular Meeting of the CalOptima Board of Directors
04/05/2018	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	04/01/2014	GA.8056	Paid Holidays	Administrative
Revised	04/07/2016	GA.8056	Paid Holidays	Administrative
Revised	04/05/2018	GA.8056	Paid Holidays	Administrative
Revised	02/01/2021	GA.8056	Paid Holidays	Administrative
Revised	TBD	GA.8056	Paid Holidays	Administrative

IX. GLOSSARY

Term	Definition
Employee	For the purposes of this policy, employees include regular full-time and regular part-time employees of CalOptima Health.

Policy:	GA.8059
Title:	**Attendance and Timekeeping**
Department:	CalOptima Health Administrative
Section:	Human Resources
CEO Approval:	*/s/*
Effective Date:	09/06/2018
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy provides employees and leaders with timekeeping guidelines to manage attendance requirements.

II. POLICY

A. ~~CalOptima~~CalOptima Health is a public agency and health plan that provides valuable services to eligible ~~members~~Members in Orange County. To accomplish this mission, it is imperative that every employee be present and ready to work when scheduled in order to maintain excellent service to our ~~members~~Members throughout the business day during ~~CalOptima~~CalOptima Health's core business hours. ~~CalOptima~~CalOptima Health provides eligible employees with paid time off (PTO), holidays, and one (1) flexible holiday throughout the year to enable them to take time off for rest and recreation and to recover from illness.

B. Regular, predictable, and reliable attendance is an essential function of all job positions at ~~CalOptima~~CalOptima Health, and the responsibility of each employee at ~~CalOptima~~CalOptima Health. ~~CalOptima~~CalOptima Health's policies and practices are established pursuant to principles of public accountability. Employees are expected to be punctual and report to work at the start of their scheduled shift, observe the time limits for scheduled break and meal ~~periods~~breaks, and not leave work earlier or later than scheduled without prior approval from their immediate supervisor. Efficient business operations depend on the reliability of all employees.

C. Directors, managers, and supervisors are accountable to ensure that attendance and timekeeping policies and procedures are adhered to and to monitor their employees' attendance on a daily basis and address unsatisfactory attendance issues in a timely and consistent manner.

D. Work Schedule

1. An employee's schedule is determined by the employee's immediate supervisor, or the department supervisor based on ~~CalOptima~~CalOptima Health's core business hours to ensure coverage, where applicable.

2. An employee is ~~given~~ assigned their work schedule by their immediate supervisor prior to or within their first week of employment.

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3. An employee's immediate supervisor shall notify an employee of a change to the employee's work schedule in a timely manner. At least one (1) weeks' notice is a recommended best practice, unless the change involves a 9/80 ~~schedule~~Work Schedule, which requires at least two (2) weeks' notice for non-exempt ~~(hourly)~~ employees. All changes must have an effective date on the first day of a future pay period.

4. Non-exempt ~~(hourly)~~ employees on a 9/80 ~~schedule~~Work Schedule must follow their exact scheduled hours on their eight (8)-hour day. If there is a need to switch the scheduled 9/80 day off to another day for a non-exempt ~~(hourly)~~ employee, it must be done in the same work week.

5. As a public agency, ~~CalOptima~~CalOptima Health is not subject to California labor laws regarding meal and rest period requirements. The federal Fair Labor Standards Act (FLSA), which ~~CalOptima~~CalOptima Health is subject to, does not mandate meal and rest periods. ~~However~~While not required to provide meal and rest periods under FLSA, ~~CalOptima~~CalOptima Health recognizes how important it is to have a break during the ~~day. Employees and~~ workday. Meal breaks are included in all default assigned work schedules and ~~CalOptima~~CalOptima Health requires that all employees work within their ~~immediate supervisors will work out~~scheduled times for shift start, meal break start, meal break end, and shift end. Supervisors can assign alternate individual meal and rest periods consistent with applicable ~~CalOptima~~CalOptima Health policies.

6. Non-exempt ~~(hourly)~~ employees are prohibited from off-the-clock work, including prior to clocking-in for the day, following clocking-out for the day, and during meal breaks. Non-exempt ~~(hourly)~~ employees who need to obtain remote access into ~~CalOptima~~CalOptima Health's system shall not perform any work prior to clocking-in for the day, and are encouraged to discuss computer system issues and access issues with their immediate supervisors to ensure any compensable work time is addressed, but should refrain from performing ~~CalOptima~~CalOptima Health-related work until they have clocked-in. Between logging into ~~CalOptima~~CalOptima Health's system and clocking-in, employees shall not perform ~~CalOptima~~CalOptima Health-related work and are free to attend to personal matters if waiting to clock-in. If an employee experiences a delay in logging into ~~CalOptima~~CalOptima Health's system of over ten (10) minutes, the employee should promptly contact Information Services to resolve such delays.

7. For non-exempt ~~(hourly)~~ employees who work from a Remote Work Location (other than the Central Worksite), commute time may be compensated and included as part of the ~~work day~~workday only if all of the following apply:

   a. The employee is required to be onsite at the Central Worksite for meetings, training or other events as determined by the employee's leadership in the middle of the ~~work day~~workday; and

   ~~b.~~ The commute to or from the employee's Remote Work Location and ~~CalOptima~~CalOptima Health occurs in the middle of the non-exempt employee's ~~work day~~workday; and

   b.

   c. The employee cannot work from the Central Worksite for the entire ~~work day.~~ workday.

E. Timekeeping Requirements

1. Non-exempt ~~(hourly)~~ employees shall accurately record their time in and time away from work, including unpaid meal breaks, in ~~CalOptima~~CalOptima Health's timekeeping system on a daily basis. Daily time entry is required to ensure employees are paid based on the actual time worked. ~~CalOptima~~CalOptima Health's timekeeping system will not round up or down an employee's time and will capture the time worked based on clock-in/clock-out timestamps.

2. The immediate supervisor shall approve and/or correct the non-exempt ~~(hourly)~~ employee's time record on a daily basis.

3. The time record for the non-exempt ~~(hourly)~~ employee will include the total hours worked each day, including all regular and overtime hours worked, any Absence(s), Tardiness, or time Leaving Early, and unpaid time taken for meal breaks.

4. Exempt ~~(salaried)~~ employees' agreed upon work schedule and requested time off ~~is~~are recorded and tracked in the timekeeping system. Exempt employees are responsible for timely notifying their immediate supervisors of any deviations from their scheduled shift consistent with applicable ~~CalOptima~~CalOptima Health policies and department requirements.

F. Overtime

1. When business requirements or other needs cannot be met during regular working hours, employees may be scheduled to work overtime hours. A non-exempt employee will be expected to work overtime when necessary to meet business needs, and non-exempt employees will be paid time-and-a-half overtime accordingly for any overtime worked~~.~~ in the FLSA workweek. Exempt employees are not eligible for overtime payment, but exempt employees are expected to work beyond the forty (40)-hour workweek when business needs require. ~~CalOptima~~CalOptima Health does not provide "comp time" to non-exempt or exempt employees for hours worked beyond the forty (40)-hour workweek.

2. When possible, an employee's immediate supervisor will provide advance notice of mandatory overtime.

3. A non-exempt employee may ~~NOT~~not work overtime without prior ~~written~~ authorization from their immediate supervisor.

~~4. A non-exempt employee may receive corrective action for incurring overtime by working before their scheduled work time or working after their scheduled work time without prior authorization from his/her immediate supervisor.~~

~~5.~~4. ~~A non-exempt employee is~~Non-exempt employees are not permitted to start work early, finish work late, work during scheduled meal ~~periods~~break, take work home, work on weekends, or perform any other unauthorized ~~extra~~schedule deviations and/or overtime work without prior authorization from their immediate supervisors. A non-exempt employee may receive corrective action for working outside of their normal schedule without prior authorization.

III. PROCEDURE

A. Scheduled Absence

1. A Scheduled Absence occurs when an employee's time-off is arranged and approved in advance with notice to the employee's immediate or department supervisor consistent with applicable ~~CalOptima~~CalOptima Health Policies or within the specific time frame defined by the department.

2. Employees may use PTO for Scheduled Absences as described in ~~CalOptima~~CalOptima Health Policy GA.8018: Paid Time Off (PTO).

3. Employees may also take time off for Scheduled Absences consistent with other applicable ~~CalOptima~~CalOptima Health Policies, including, but not limited to ~~CalOptima~~CalOptima Health Policies: GA.8037: Leave of Absence; GA.8038: Personal Leave of Absence; GA.8039: Pregnancy Disability Leave of Absence; GA.8040: FMLA and CFRA Leave of Absence; and GA.8041: Workers' Compensation Leave of Absence.

B. Unscheduled Absence

1. Employees may occasionally incur an Unscheduled Absence. Regardless of the reason for the Unscheduled Absence:

   a. The employee must personally notify ~~his/her~~their immediate supervisor as far in advance as possible, but no later than one (1) hour prior to the start of the employee's scheduled shift or within the specific time frame defined by the department.

      i. If the supervisor cannot be reached, the employee is expected to notify the department head or other designated department contact.

      ii. If the employee is unable to call, ~~he/she~~ they must have someone make the call on ~~his/her~~their behalf as soon as possible or no later than end of scheduled shift, unless the situation makes this impossible, then as soon as reasonably practical under the circumstances.

   b. ~~The~~Without disclosing specific health, medical, or genetic information, the employee must provide a reason for the Unscheduled Absence and the expected date of return or time of arrival.

   c. The employee who is late for work may not stay on duty beyond ~~his/her~~their regular scheduled shift to make up for the lost time unless specifically authorized to do so by ~~his/her~~their immediate supervisor.

   d. Employees must call in each day they will be absent or tardy unless they are on an approved Leave of Absence (LOA).

2. An immediate supervisor may grant an Authorized Absence for an Unscheduled Absence if the employee meets the ~~four (4)~~three (3) criteria for an Authorized Absence as described in Section III.C.1.

3. Failure of the employee to contact ~~the Employee's~~ their immediate supervisor or designated department contact in a timely manner may be counted as an Occurrence as described in Section III.J.

C. Authorized Absence

1. An Authorized Absence or excused absence occurs when all ~~four (4)~~ of the following conditions are met:

a. The employee provides sufficient notice (a minimum of one (1) hour prior to the start of the scheduled work time or within the specific time frame defined by the department) to ~~his/her~~their immediate supervisor prior to the commencement of ~~his/her~~their shift;

~~The employee provides a valid reason acceptable to his/her immediate supervisor;~~

b. Such Absence request is approved by ~~his/her~~their immediate supervisor; and

c. The employee has:

i. Sufficient accrued PTO to cover such absence unless otherwise allowed by company policy (i.e., LOA, bereavement, jury duty); or

ii. The immediate supervisor or manager waives this requirement and allows the absence to be an unpaid absence because the employee has not accrued sufficient PTO; or

iii. Exceptions as defined by the department.

2. The employee's immediate supervisor may waive the notice requirement when it is warranted by the circumstance involved (example, when an employee has an emergent situation and cannot call).

3. An employee's immediate supervisor may approve up to five (5) consecutive scheduled ~~work days~~workdays of Authorized Absences.

4. Absences of more than five (5) consecutive scheduled ~~work days~~workdays for an illness or pre-planned surgery must be submitted to and approved by HR for Leave of Absence consideration in accordance with ~~CalOptima~~CalOptima Health Policy GA.8037: Leave of Absence.

5. Use of PTO for pre-planned scheduled time off (non-LOA) with ~~permission~~supervisor approval (e.g., vacation) does not require HR approval.

6. An approved LOA that is covered by ~~CalOptima~~CalOptima Health policies, State or Federal laws, including, but not limited to, Family and Medical Leave Act (FMLA), California Family Rights Act (CFRA), Pregnancy Disability Leave (PDL), Paid Sick Leave, and Kin Care is considered to be an Authorized Absence.

7. Exempt employees are expected to work a minimum of eighty (80) hours per pay period, excluding holiday weeks, and as a result, are eligible to work a flexible schedule, where appropriate, based on ~~CalOptima~~CalOptima Health's core business hours as determined by their immediate supervisor. Exempt employees requesting an occasional, short-term Scheduled Absence for a partial day may elect to make up time away from work within the same pay period or use accrued PTO if the employee does not otherwise make up the time off within the same pay period. An exempt employee who has exhausted all of ~~his/her~~their accrued PTO must enter in unpaid time off for full day ~~and partial day~~ absences if the employee does not otherwise make up the time off within the same pay period. Based on principles of public accountability, ~~CalOptima~~CalOptima Health will reduce the pay of an exempt employee for absences for personal reasons or because of illness or injury of one (1) full ~~work day~~workday ~~or less than one (1) work day~~ when accrued PTO is not used by an employee because:

a. Permission for its use has not been sought or has been sought and denied; or

b. Accrued PTO has been exhausted; or

c. The employee chooses to use leave without pay.

8. Failure to meet the above requirements may result in corrective action, up to and including termination, depending on the circumstances.

D. Unauthorized Absence

1. An Unauthorized Absence occurs when an employee misses one (1) hour or more of ~~his/her~~their scheduled shift without prior approval and when one (1), or more, of the four (4) conditions listed under Authorized Absence are not met.

2. If an employee fails to provide a doctor's note on the first day back after four (4) consecutive days~~,~~ or more~~,~~ on personal and unprotected sick time, then the days are considered Unauthorized Absences and an Occurrence will be imposed.

3. If a non-exempt ~~(hourly)~~ employee is scheduled to work approved overtime and either fails to report or reports after the scheduled start time, it will be considered as an Unauthorized Absence and an Occurrence will be imposed.

4. Unauthorized Absences may result in corrective action, up to and including termination, depending on the surrounding circumstances.

E. Department Specific Attendance Guidelines

1. Departments may establish guidelines for scheduling and reporting Absences or time away from work that meets their specific business needs.

a. The guidelines must meet the basic requirements of ~~CalOptima~~CalOptima Health policies.

b. A department must submit their guidelines in writing to HR for approval.

c. If department specific guidelines have been established, employees are to follow the procedures of their respective department to the extent such procedures do not conflict with applicable laws.

2. In the absence of a department-specific guideline or directive on attendance, a department shall adhere to the guidelines included in this Policy.

F. Timekeeping Guidelines

1. Employees are required to follow established guidelines for recording their hours worked.

2. A non-exempt employee is required to record time in the Timekeeping system and to clock in at the start of the scheduled shift and clock out at the end of their scheduled shift, as well as clock out at the beginning of their scheduled meal break and clock in at the end of their scheduled meal break.

3. If there is a problem recording a clock in/out, a non-exempt employee must notify ~~his/her~~their immediate supervisor in writing, no later than the conclusion of the shift.

4. Non-exempt employees who consistently fail to accurately and timely clock in/out may receive corrective action, up to and including termination of employment.

5. Excessive missed clock in/out will constitute an Occurrence as prescribed below in Section III.J.2 of this Policy.

   a. Failure to clock in/out at the beginning and/or end of their scheduled shift;

   b. Failure to clock in/out for their meal break period;

   c. Failure to accurately and timely report time worked; and/or

   d. Clocking in/out and/or early/late for a scheduled shift without prior approval from the non-exempt employee's immediate supervisor.

6. Clocking in/out for another employee or having another employee clock in/out for the employee constitutes falsification of timekeeping records and is grounds for immediate termination for one (1) or both employees, depending on the circumstances.

7. Misrepresentations of work hours violate this Policy and the ~~CalOptima~~CalOptima Health Code of Conduct. Any employee who knowingly misrepresents or falsifies documentation about their time worked will be subject to corrective action, up to and including termination from employment.

8. Warnings received under this Policy will affect an employee's ability to internally apply and be considered for open positions.

9. Exempt employees are not required to complete timecards; however, exempt employees are expected to work a regular work schedule based on ~~CalOptima~~CalOptima Health's core business hours and should notify their supervisors in advance of any deviations from their normal work schedule and accurately record any exceptions to their regular work schedule, including, but not limited to:

   a. Use of PTO when an employee does not otherwise make up time away from work during the same pay period; and

   b. Unpaid time off when an exempt employee has exhausted ~~his/her~~their PTO, does not work a full day or works less than a full day, and does not otherwise make up the full day or partial day away from work during the same pay period.

G. Supervisor Guidelines:

1. Supervisors or managers of non-exempt employees shall:

   a. Review and approve time records submitted by employees in the timekeeping system on a daily basis.

   b. Review and approve all time records submitted by these employees no later than 12 p.m. PST/PDT on the Monday following the week in which the time was worked, unless otherwise notified by payroll or HR.

   c. Monitor and address attendance issues timely and consistently.

   d. Schedule required on-site meetings, trainings or other events in a manner that effectively minimizes commute time in the middle of a ~~work day~~workday for non-exempt employees.

2. Supervisors or managers of exempt employees shall:

   a. Review and approve time worked in the Timekeeping system on a weekly basis;

   b. Review and approve time away from work requests; and

   c. Review and approve all worked time by these employees no later than 12 p.m. PST/PDT on the Monday following the week in which the time was worked~~.~~, unless otherwise notified by payroll or HR.

3. There may be situations where it is not possible for a supervisor or manager to review time on a timely basis. These circumstances include, but are not limited to:

   a. When the employee failed to record or submit ~~his/her~~their time in a timely manner;

   b. When the supervisor or manager is out of the office ~~due to an unforeseen event~~ and does not have access to the Timekeeping system; and/or

   c. When further investigation is needed regarding the time recorded and/or submitted to determine whether it is appropriate for approval.

4. When the immediate supervisor is not available to review their employees' time worked, the immediate supervisor's manager/director shall review and approve the employees' time worked in the Timekeeping system.

5. Supervisors or managers who fail to review and approve submitted time before the applicable deadline or fail to review/approve time at all may be subject to corrective action.

6. ~~CalOptima~~CalOptima Health retains the right to apply the appropriate level of corrective action, as circumstances require.

7. Warnings received under this Policy will affect a supervisor's or manager's ability to internally apply and be considered for open positions and from bonus consideration as per the guidelines and eligibility of those programs.

8. An employee is not permitted to approve ~~his/her~~their own time under any circumstance.

H. Noncompliance

1. Unscheduled Absences and Unauthorized Absences are to be handled expeditiously and fairly by leaders, including consistent policy application within each department.

2. Noncompliance includes:

   a. Failure to give timely notice of an Unscheduled Absence (no call, no show).

   b. Excessive Absenteeism, including, but not limited to:

      i. Multiple occurrences of Unscheduled/Unauthorized Absences, full day or partial day, is to be noted and documented by the immediate supervisor in a timely and consistent manner.

ii. An Absence may be counted as an Occurrence as described in Section III.J.

iii. Unscheduled/Unauthorized Absence is considered excessive when the employee has three (3) or more Unauthorized/Unscheduled Occurrences within a rolling twelve (12)-month period.

c. Excessive Tardiness

i. A late arrival of fifteen (15) minutes or more, or the specific timeframe as defined by the department, past the scheduled shift start time is considered tardy.

ii. A pattern of unexcused late arrivals and/or returning late from break/meal breaks is also considered tardy and is to be noted and documented by the immediate supervisor in a timely and consistent manner.

iii. Tardiness may be counted as an Occurrence as described in Section III.J.

iv. Tardiness is considered excessive when the employee has eight (8) Occurrences in a rolling twelve (12)-month period. When consecutive multiple occurrences ~~(~~[i.e., five (5) occurrences in one (1) week~~)~~] take place, these may also be considered excessive.

d. Excessive Leave Early

i. Leaving fifteen (15) minutes or more, or the specific time frame as defined by the department, before the end of scheduled work shift is considered to be Leave Early.

ii. A pattern of Leaving Early before the end of the scheduled work shift, or prior to a scheduled break/meal break is to be noted and documented by the immediate supervisor in a timely and consistent manner.

iii. A Leave Early may be counted as an Occurrence as described in Section III.J.

iv. Leaving Early is considered excessive when the employee has three (3) or more Occurrences of Leaving Early from their scheduled shift and/or scheduled break/meal break without prior approval within a rolling twelve (12)-month period.

e. Excessive Missed Clocking In or Out

i. Three (3) incidents of failing to clock-in or clock-out of a scheduled shift and/or scheduled meal break within a thirty (30) business day period is considered excessive.

3. Frequent or excessive incidents of not following ~~CalOptima~~CalOptima Health's and/or the departmental attendance and punctuality requirements, notification procedures and/or the guidelines in this policy, including no-call/no-show, will be addressed by HR in accordance with the ~~CalOptima~~CalOptima Health Policy GA.8022: Performance and Behavior Standards.

I. Patterns of Absence, Leave Early, or Tardiness

1. The following may be considered patterns of excessive or unacceptable attendance issues:

a. Pattern of Unscheduled Absences, Leave Early, or Tardiness on Fridays, Mondays or other specific days.

b. Pattern of Unscheduled Absences, Leave Early, or Tardiness on days previously requested off but could not approved due to business needs.

c. Pattern of Unscheduled Absences, Leave Early, or Tardiness around the holidays, i.e., preceding or following a holiday or scheduled day off.

2. If a pattern of unscheduled usage of accrued PTO and/or unpaid time off is noticed, the immediate supervisor should work with HR on managing the corrective action process and addressing the issues with the employee.

a. When an employee has been previously counseled under ~~CalOptima~~CalOptima Health Policy GA.8022: Performance and Behavior Standards, the totality of the circumstances will be assessed when determining further action.

b. For situations involving corrective actions or termination of employment, the immediate supervisor or manager should consult with HR prior to taking action.

3. As timely and regular attendance is a performance expectation and condition of employment at ~~CalOptima~~CalOptima Health, employees who have exhibited unsatisfactory attendance during the year will have the behavior documented in their annual performance evaluation.

4. When the employee fails to report to work without giving notice to and/or receiving authorization from ~~his/her~~their immediate supervisor for three (3) consecutive scheduled ~~work days~~workdays, the employee is considered to have resigned, unless the situation makes this impossible.

J. Occurrence

1. Incidents of an employee's Unscheduled or Unauthorized Absence, Tardiness, or Leaving Early should be documented by the immediate supervisor.

2. In the case of frequent or excessive incidents, each Occurrence may be calculated as follows:

OCCURRENCE	**POINTS**
Unauthorized Absence - one (1) or more consecutive day(s) of Absence(s) for the same reason	1 point for each Absence
Unscheduled Absence - one (1) or more day(s) of Absence for different reasons	1 point for each day
Unscheduled Absence (partial day) - over one (1) hour of Absence.	0.5 point for each incident
Tardiness or Leaving Early (15 or more minutes*)	0.5 point for each incident
Excessive Missed Clocking In or Out three (3) incidents within a thirty (30) business day period	0.5 point for each incident

* Or the specific time frame as defined by the department

3. Absences due to injuries or illness that qualify under applicable laws and ~~CalOptima~~CalOptima Health Policies will not be counted against an employee.

a. Documentation within the guidelines of the applicable laws may be required in these instances.

b. ~~CalOptima~~CalOptima Health will comply with the requirements of applicable federal, state or local laws that are relevant to this Policy.

4. ~~Unscheduled/Unauthorized Absence, Tardiness, or Leaving Early occurring because of the~~The following will not be included when considering the employee's attendance record:

   a. An approved LOA;

   b. ~~"~~"Kin Care" or "Protected Sick Leave" time using PTO in accordance with ~~CalOptima~~CalOptima Health Policy GA.8018 Paid Time Off (PTO);

   c. Child-Related activities defined under Labor Code Section 230.8;

   d. Work related injuries; or

   e. As a reasonable accommodation under the Americans with Disabilities Act.

5. The immediate supervisor should properly document each occurrence of Unauthorized Absence, Tardiness, and/or Leave Early.

6. Patterns or issues with attendance should first be discussed with the employee. The immediate supervisor may partner with HR to discuss the attendance issue(s).

K. Performance Management Guidelines

1. When notified of an attendance issue by the employee's immediate supervisor, manager, or director, HR shall review an employee's attendance record and may institute corrective action for excessive Unscheduled Absences, Tardiness, or Leaving Early dating from the most recent occurrence to the prior twelve (12) months. All corrective actions and job performance issues will be taken into consideration when determining level of corrective action, up to and including termination.

2. ~~CalOptima~~CalOptima Health may apply the following guidelines, with management discretion, based on circumstances. These guidelines do not account for other job performance or behavioral issues and shall not be the exclusive guide if management is addressing multiple issues in addition to attendance and timekeeping. The guidelines are based on attendance and timekeeping issues on a rolling twelve (12)-month calendar:

~~Verbal~~ Coaching Memo	Documented Counseling Memo	Written Warning	Final Warning	Possible Termination
Three (3) or more ~~Occurrences~~points	Four (4) or more ~~Occurrences~~points	Six (6) or more ~~Occurrences~~points	Eight (8) or more ~~Occurrences~~points	Nine (9) or more ~~Occurrences~~points

3. Employees are not guaranteed a right to corrective action prior to termination and can be terminated at any time. ~~CalOptima~~CalOptima Health may, at its sole and complete discretion, apply corrective action guidelines on a case by case basis; however, no formal order or system is necessary. ~~CalOptima~~CalOptima Health may terminate an employee at any time without following any particular series of steps.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. California Labor Code, §§230.8, 233, and 246 et seq.
B. ~~CalOptima~~CalOptima Health Code of Conduct
~~C. CalOptima Employee Handbook – Attendance, Tardiness and Reporting Absences~~
~~D.~~C. ~~CalOptima~~CalOptima Health Policy GA.8018: Paid Time Off (PTO)
~~E.~~D. ~~CalOptima~~CalOptima Health Policy GA.8022: Performance and Behavior Standards
~~F.~~E. ~~CalOptima~~CalOptima Health Policy GA.8037: Leave of Absence
~~G.~~F. ~~CalOptima~~CalOptima Health Policy GA.8038: Personal Leave of Absence
~~H.~~G. ~~CalOptima~~CalOptima Health Policy GA.8040: FMLA and CFRA Leaves of Absence
~~I.~~H. ~~CalOptima~~CalOptima Health Policy GA.8041: ~~Worker's~~Workers' Compensation Leave of Absence
I. Fair Labor Standards Act (FLSA) §§785.18 and 785.19
J. Healthy Workplaces, Healthy Families Act of 2014 (Labor Code §245 *et seq.*)
K. Title 29, Code of Federal Regulations (C.F.R.), §541.710
L. Title 29, Code of Federal Regulations (C.F.R.), §1630.9

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
09/06/2018	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	09/06/2018	GA.8059	Attendance and Timekeeping	Administrative
Revised	TBD	GA.8059	Attendance and Timekeeping	Administrative

IX. GLOSSARY

Term	Definition
Absence	The state of being away or not being present for a portion of or the entire scheduled shift.
Authorized Absence	An absence or deviation from a scheduled shift is authorized when all of the following are met: 1) The employee provides sufficient notice (a minimum of one (1) hour prior to the start of the scheduled work time or within the specific time frame defined by the department) to ~~his/her~~their immediate supervisor prior the commencement of ~~his/her~~their shift; ~~2) The employee provides a valid reason acceptable to his/her immediate supervisor;~~ ~~3)~~2) Such absence request is approved by ~~his/her~~their immediate supervisor; and ~~4)~~3) The employee has: a) Sufficient accrued PTO to cover such absence unless otherwise allowed by ~~CalOptima~~CalOptima Health policy (i.e., leave of absence, bereavement, jury duty); or b) The immediate supervisor or manager waives this requirement and allows the absence based on the circumstances; or c) Exceptions as defined by the department.
Central Worksite	~~CalOptima~~CalOptima Health's primary physical location of business applicable to the employee, which is either ~~CalOptima~~CalOptima Health's administration building at 505 City Parkway West or the PACE building.
Child Related Activities	Participation in activities at child's school or day care facility as permitted under Labor Code section 230.8, which includes: finding, enrolling, or reenrolling a child in a school or with a licensed child care provider; child care provider or school, emergency; request for child to be picked up from school/child care or an attendance policy that prohibits the child from attending or requires the child to be picked up from the school or child care provider; behavioral/discipline problems; closure or unexpected unavailability of school (excluding planned holidays); a natural disaster; or to participate in activities of the school or licensed child care provider of ~~his or her~~their child, if the employee, prior to taking the time off, gives reasonable notice to ~~CalOptima~~CalOptima Health.
Home Office	A designated workspace within the ~~Teleworker's~~Teleworker's residence.
Leave/Leaving Early	An early departure from the scheduled end time of a work shift and/or the scheduled meal break.
Leave of Absence (LOA)	A term used to describe a scheduled period of time off longer than five (5) days that an employee is to be away from ~~his or her~~their primary job, while maintaining the status of employee.
Member	A beneficiary of a ~~CalOptima~~CalOptima Health Program.
Occurrence	An incident of (1) a period of Unauthorized Absence; (2) Tardiness or late arrival; (3) Leaving Early without prior approval; or (4) Excessive Missed Clocking In or Out.
Scheduled Absence	Any absence planned and approved in advance with notice consistent with applicable ~~CalOptima~~CalOptima Health policies.
Remote Work Location	The employee's Home Office or designated pre-approved work location.
Tardiness	The failure of an employee to report on time at the scheduled time of a work shift or return on time from breaks or meal breaks.

Term	Definition
Teleworker	An employee who meets ~~CalOptima~~CalOptima Health's Teleworker eligibility criteria and is approved to routinely work their regularly scheduled work hours from a Remote Work Location~~,~~ unless business needs require otherwise.
Timekeeping	Process of recording and reporting work arrival, meal breaks, and leave time.
Unauthorized Absence	Any absence when an employee misses one (1) hour or more of ~~his/her~~their scheduled shift without prior approval and when one (1), or more, of the four (4) conditions listed under Authorized Absence are not met.
Unscheduled Absence	An unplanned Absence, Tardiness or Leaving Early without sufficient notice or approval.
Normal Work Schedule	The normal work schedule is a 5/40 schedule which is five (5) eight (8)- hour days per work week excluding un-paid meal breaks.
9/80 Work Schedule	The 9/80 alternate work schedule consists of eight (8) workdays of nine (9) hours per day and one (1) workday of eight (8) hours, for a total of eighty (80) hours during two (2) consecutive workweeks. The eight (8) hour workday must be on the same day of the week as the employee's regularly scheduled day off. Therefore, under the 9/80 work schedule, one (1) calendar week will consist of forty-four (44) hours (four (4) nine (9)-hour days and one (1) eight (8)-hour day) and the alternating calendar week will consist of thirty-six (36) hours (four (4) nine (9)-hour days and one (1) day off). However, each workweek will only consist of forty (40) hours, in accordance with the 9/80 Fair Labor Standards Act (FLSA) Workweek.

Policy:	GA.8059
Title:	**Attendance and Timekeeping**
Department:	CalOptima Health Administrative
Section:	Human Resources
CEO Approval:	*/s/*
Effective Date:	09/06/2018
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy provides employees and leaders with timekeeping guidelines to manage attendance requirements.

II. POLICY

A. CalOptima Health is a public agency and health plan that provides valuable services to eligible Members in Orange County. To accomplish this mission, it is imperative that every employee be present and ready to work when scheduled in order to maintain excellent service to our Members throughout the business day during CalOptima Health's core business hours. CalOptima Health provides eligible employees with paid time off (PTO), holidays, and one (1) flexible holiday throughout the year to enable them to take time off for rest and recreation and to recover from illness.

B. Regular, predictable, and reliable attendance is an essential function of all job positions at CalOptima Health, and the responsibility of each employee at CalOptima Health. CalOptima Health's policies and practices are established pursuant to principles of public accountability. Employees are expected to be punctual and report to work at the start of their scheduled shift, observe the time limits for scheduled break and meal breaks, and not leave work earlier or later than scheduled without prior approval from their immediate supervisor. Efficient business operations depend on the reliability of all employees.

C. Directors, managers, and supervisors are accountable to ensure that attendance and timekeeping policies and procedures are adhered to and to monitor their employees' attendance on a daily basis and address unsatisfactory attendance issues in a timely and consistent manner.

D. Work Schedule

1. An employee's schedule is determined by the employee's immediate supervisor, or the department supervisor based on CalOptima Health's core business hours to ensure coverage, where applicable.

2. An employee is assigned their work schedule by their immediate supervisor prior to or within their first week of employment.

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3. An employee's immediate supervisor shall notify an employee of a change to the employee's work schedule in a timely manner. At least one (1) weeks' notice is a recommended best practice, unless the change involves a 9/80 Work Schedule, which requires at least two (2) weeks' notice for non-exempt employees. All changes must have an effective date on the first day of a future pay period.

4. Non-exempt employees on a 9/80 Work Schedule must follow their exact scheduled hours on their eight (8)-hour day. If there is a need to switch the scheduled 9/80 day off to another day for a non-exempt employee, it must be done in the same work week.

5. As a public agency, CalOptima Health is not subject to California labor laws regarding meal and rest period requirements. The federal Fair Labor Standards Act (FLSA), which CalOptima Health is subject to, does not mandate meal and rest periods. While not required to provide meal and rest periods under FLSA, CalOptima Health recognizes how important it is to have a break during the workday. Meal breaks are included in all default assigned work schedules and CalOptima Health requires that all employees work within their scheduled times for shift start, meal break start, meal break end, and shift end. Supervisors can assign alternate individual meal and rest periods consistent with applicable CalOptima Health policies.

6. Non-exempt employees are prohibited from off-the-clock work, including prior to clocking-in for the day, following clocking-out for the day, and during meal breaks. Non-exempt employees who need to obtain remote access into CalOptima Health's system shall not perform any work prior to clocking-in for the day, and are encouraged to discuss computer system issues and access issues with their immediate supervisors to ensure any compensable work time is addressed, but should refrain from performing CalOptima Health-related work until they have clocked-in. Between logging into CalOptima Health's system and clocking-in, employees shall not perform CalOptima Health-related work and are free to attend to personal matters if waiting to clock-in. If an employee experiences a delay in logging into CalOptima Health's system of over ten (10) minutes, the employee should promptly contact Information Services to resolve such delays.

7. For non-exempt employees who work from a Remote Work Location (other than the Central Worksite), commute time may be compensated and included as part of the workday only if all of the following apply:

   a. The employee is required to be onsite at the Central Worksite for meetings, training or other events as determined by the employee's leadership in the middle of the workday; and

   b. The commute to or from the employee's Remote Work Location and CalOptima Health occurs in the middle of the non-exempt employee's workday; and

   c. The employee cannot work from the Central Worksite for the entire workday.

E. Timekeeping Requirements

1. Non-exempt employees shall accurately record their time in and time away from work, including unpaid meal breaks, in CalOptima Health's timekeeping system on a daily basis. Daily time entry is required to ensure employees are paid based on the actual time worked. CalOptima Health's timekeeping system will not round up or down an employee's time and will capture the time worked based on clock-in/clock-out timestamps.

2. The immediate supervisor shall approve and/or correct the non-exempt employee's time record on a daily basis.

3. The time record for the non-exempt employee will include the total hours worked each day, including all regular and overtime hours worked, any Absence(s), Tardiness, or time Leaving Early, and unpaid time taken for meal breaks.

4. Exempt employees' agreed upon work schedule and requested time off are recorded and tracked in the timekeeping system. Exempt employees are responsible for timely notifying their immediate supervisors of any deviations from their scheduled shift consistent with applicable CalOptima Health policies and department requirements.

F. Overtime

1. When business requirements or other needs cannot be met during regular working hours, employees may be scheduled to work overtime hours. A non-exempt employee will be expected to work overtime when necessary to meet business needs, and non-exempt employees will be paid time-and-a-half overtime accordingly for any overtime worked in the FLSA workweek. Exempt employees are not eligible for overtime payment, but exempt employees are expected to work beyond the forty (40)-hour workweek when business needs require. CalOptima Health does not provide "comp time" to non-exempt or exempt employees for hours worked beyond the forty (40)-hour workweek.

2. When possible, an employee's immediate supervisor will provide advance notice of mandatory overtime.

3. A non-exempt employee may not work overtime without prior authorization from their immediate supervisor.

4. Non-exempt employees are not permitted to start work early, finish work late, work during scheduled meal break, take work home, work on weekends, or perform any other unauthorized schedule deviations and/or overtime work without prior authorization from their immediate supervisors. A non-exempt employee may receive corrective action for working outside of their normal schedule without prior authorization.

III. PROCEDURE

A. Scheduled Absence

1. A Scheduled Absence occurs when an employee's time-off is arranged and approved in advance with notice to the employee's immediate or department supervisor consistent with applicable CalOptima Health Policies or within the specific time frame defined by the department.

2. Employees may use PTO for Scheduled Absences as described in CalOptima Health Policy GA.8018: Paid Time Off (PTO).

3. Employees may also take time off for Scheduled Absences consistent with other applicable CalOptima Health Policies, including, but not limited to CalOptima Health Policies: GA.8037: Leave of Absence; GA.8038: Personal Leave of Absence; GA.8039: Pregnancy Disability Leave of Absence; GA.8040: FMLA and CFRA Leave of Absence; and GA.8041: Workers' Compensation Leave of Absence.

B. Unscheduled Absence

1. Employees may occasionally incur an Unscheduled Absence. Regardless of the reason for the Unscheduled Absence:

    a. The employee must personally notify their immediate supervisor as far in advance as possible, but no later than one (1) hour prior to the start of the employee's scheduled shift or within the specific time frame defined by the department.

        i. If the supervisor cannot be reached, the employee is expected to notify the department head or other designated department contact.

        ii. If the employee is unable to call, they must have someone make the call on their behalf as soon as possible or no later than end of scheduled shift, unless the situation makes this impossible, then as soon as reasonably practical under the circumstances.

    b. Without disclosing specific health, medical, or genetic information, the employee must provide a reason for the Unscheduled Absence and the expected date of return or time of arrival.

    c. The employee who is late for work may not stay on duty beyond their regular scheduled shift to make up for the lost time unless specifically authorized to do so by their immediate supervisor.

    d. Employees must call in each day they will be absent or tardy unless they are on an approved Leave of Absence (LOA).

2. An immediate supervisor may grant an Authorized Absence for an Unscheduled Absence if the employee meets the three (3) criteria for an Authorized Absence as described in Section III.C.1.

3. Failure of the employee to contact their immediate supervisor or designated department contact in a timely manner may be counted as an Occurrence as described in Section III.J.

C. Authorized Absence

1. An Authorized Absence or excused absence occurs when all of the following conditions are met:

    a. The employee provides sufficient notice (a minimum of one (1) hour prior to the start of the scheduled work time or within the specific time frame defined by the department) to their immediate supervisor prior to the commencement of their shift;

    b. Such Absence request is approved by their immediate supervisor; and

    c. The employee has:

        i. Sufficient accrued PTO to cover such absence unless otherwise allowed by company policy (i.e., LOA, bereavement, jury duty); or

        ii. The immediate supervisor or manager waives this requirement and allows the absence to be an unpaid absence because the employee has not accrued sufficient PTO; or

        iii. Exceptions as defined by the department.

2. The employee's immediate supervisor may waive the notice requirement when it is warranted by the circumstance involved (example, when an employee has an emergent situation and cannot call).

3. An employee's immediate supervisor may approve up to five (5) consecutive scheduled workdays of Authorized Absences.

4. Absences of more than five (5) consecutive scheduled workdays for an illness or pre-planned surgery must be submitted to and approved by HR for Leave of Absence consideration in accordance with CalOptima Health Policy GA.8037: Leave of Absence.

5. Use of PTO for pre-planned scheduled time off (non-LOA) with supervisor approval (e.g., vacation) does not require HR approval.

6. An approved LOA that is covered by CalOptima Health policies, State or Federal laws, including, but not limited to, Family and Medical Leave Act (FMLA), California Family Rights Act (CFRA), Pregnancy Disability Leave (PDL), Paid Sick Leave, and Kin Care is considered to be an Authorized Absence.

7. Exempt employees are expected to work a minimum of eighty (80) hours per pay period, excluding holiday weeks, and as a result, are eligible to work a flexible schedule, where appropriate, based on CalOptima Health's core business hours as determined by their immediate supervisor. Exempt employees requesting an occasional, short-term Scheduled Absence for a partial day may elect to make up time away from work within the same pay period or use accrued PTO if the employee does not otherwise make up the time off within the same pay period. An exempt employee who has exhausted all of their accrued PTO must enter in unpaid time off for full day absences if the employee does not otherwise make up the time off within the same pay period. Based on principles of public accountability, CalOptima Health will reduce the pay of an exempt employee for absences for personal reasons or because of illness or injury of one (1) full workday when accrued PTO is not used by an employee because:

   a. Permission for its use has not been sought or has been sought and denied; or

   b. Accrued PTO has been exhausted; or

   c. The employee chooses to use leave without pay.

8. Failure to meet the above requirements may result in corrective action, up to and including termination, depending on the circumstances.

D. Unauthorized Absence

1. An Unauthorized Absence occurs when an employee misses one (1) hour or more of their scheduled shift without prior approval and when one (1), or more, of the four (4) conditions listed under Authorized Absence are not met.

2. If an employee fails to provide a doctor's note on the first day back after four (4) consecutive days or more on personal and unprotected sick time, then the days are considered Unauthorized Absences and an Occurrence will be imposed.

3. If a non-exempt employee is scheduled to work approved overtime and either fails to report or reports after the scheduled start time, it will be considered as an Unauthorized Absence and an Occurrence will be imposed.

4. Unauthorized Absences may result in corrective action, up to and including termination, depending on the surrounding circumstances.

E. Department Specific Attendance Guidelines

1. Departments may establish guidelines for scheduling and reporting Absences or time away from work that meets their specific business needs.

   a. The guidelines must meet the basic requirements of CalOptima Health policies.

   b. A department must submit their guidelines in writing to HR for approval.

   c. If department specific guidelines have been established, employees are to follow the procedures of their respective department to the extent such procedures do not conflict with applicable laws.

2. In the absence of a department-specific guideline or directive on attendance, a department shall adhere to the guidelines included in this Policy.

F. Timekeeping Guidelines

1. Employees are required to follow established guidelines for recording their hours worked.

2. A non-exempt employee is required to record time in the Timekeeping system and to clock in at the start of the scheduled shift and clock out at the end of their scheduled shift, as well as clock out at the beginning of their scheduled meal break and clock in at the end of their scheduled meal break.

3. If there is a problem recording a clock in/out, a non-exempt employee must notify their immediate supervisor in writing, no later than the conclusion of the shift.

4. Non-exempt employees who consistently fail to accurately and timely clock in/out may receive corrective action, up to and including termination of employment.

5. Excessive missed clock in/out will constitute an Occurrence as prescribed below in Section III.J.2 of this Policy.

   a. Failure to clock in/out at the beginning and/or end of their scheduled shift;

   b. Failure to clock in/out for their meal break period;

   c. Failure to accurately and timely report time worked; and/or

   d. Clocking in/out and/or early/late for a scheduled shift without prior approval from the non-exempt employee's immediate supervisor.

6. Clocking in/out for another employee or having another employee clock in/out for the employee constitutes falsification of timekeeping records and is grounds for immediate termination for one (1) or both employees, depending on the circumstances.

7. Misrepresentations of work hours violate this Policy and the CalOptima Health Code of Conduct. Any employee who knowingly misrepresents or falsifies documentation about their

time worked will be subject to corrective action, up to and including termination from employment.

8. Warnings received under this Policy will affect an employee's ability to internally apply and be considered for open positions.

9. Exempt employees are not required to complete timecards; however, exempt employees are expected to work a regular work schedule based on CalOptima Health's core business hours and should notify their supervisors in advance of any deviations from their normal work schedule and accurately record any exceptions to their regular work schedule, including, but not limited to:

    a. Use of PTO when an employee does not otherwise make up time away from work during the same pay period; and

    b. Unpaid time off when an exempt employee has exhausted their PTO, does not work a full day or works less than a full day, and does not otherwise make up the full day or partial day away from work during the same pay period.

G. Supervisor Guidelines:

1. Supervisors or managers of non-exempt employees shall:

    a. Review and approve time records submitted by employees in the timekeeping system on a daily basis.

    b. Review and approve all time records submitted by these employees no later than 12 p.m. PST/PDT on the Monday following the week in which the time was worked, unless otherwise notified by payroll or HR.

    c. Monitor and address attendance issues timely and consistently.

    d. Schedule required on-site meetings, trainings or other events in a manner that effectively minimizes commute time in the middle of a workday for non-exempt employees.

2. Supervisors or managers of exempt employees shall:

    a. Review and approve time worked in the Timekeeping system on a weekly basis;

    b. Review and approve time away from work requests; and

    c. Review and approve all worked time by these employees no later than 12 p.m. PST/PDT on the Monday following the week in which the time was worked, unless otherwise notified by payroll or HR.

3. There may be situations where it is not possible for a supervisor or manager to review time on a timely basis. These circumstances include, but are not limited to:

    a. When the employee failed to record or submit their time in a timely manner;

    b. When the supervisor or manager is out of the office and does not have access to the Timekeeping system; and/or

c. When further investigation is needed regarding the time recorded and/or submitted to determine whether it is appropriate for approval.

4. When the immediate supervisor is not available to review their employees' time worked, the immediate supervisor's manager/director shall review and approve the employees' time worked in the Timekeeping system.

5. Supervisors or managers who fail to review and approve submitted time before the applicable deadline or fail to review/approve time at all may be subject to corrective action.

6. CalOptima Health retains the right to apply the appropriate level of corrective action, as circumstances require.

7. Warnings received under this Policy will affect a supervisor's or manager's ability to internally apply and be considered for open positions and from bonus consideration as per the guidelines and eligibility of those programs.

8. An employee is not permitted to approve their own time under any circumstance.

H. Noncompliance

1. Unscheduled Absences and Unauthorized Absences are to be handled expeditiously and fairly by leaders, including consistent policy application within each department.

2. Noncompliance includes:

a. Failure to give timely notice of an Unscheduled Absence (no call, no show).

b. Excessive Absenteeism, including, but not limited to:

i. Multiple occurrences of Unscheduled/Unauthorized Absences, full day or partial day, is to be noted and documented by the immediate supervisor in a timely and consistent manner.

ii. An Absence may be counted as an Occurrence as described in Section III.J.

iii. Unscheduled/Unauthorized Absence is considered excessive when the employee has three (3) or more Unauthorized/Unscheduled Occurrences within a rolling twelve (12)-month period.

c. Excessive Tardiness

i. A late arrival of fifteen (15) minutes or more, or the specific timeframe as defined by the department, past the scheduled shift start time is considered tardy.

ii. A pattern of unexcused late arrivals and/or returning late from break/meal breaks is also considered tardy and is to be noted and documented by the immediate supervisor in a timely and consistent manner.

iii. Tardiness may be counted as an Occurrence as described in Section III.J.

iv. Tardiness is considered excessive when the employee has eight (8) Occurrences in a rolling twelve (12)-month period. When consecutive multiple occurrences [i.e., five (5) occurrences in one (1) week] take place, these may also be considered excessive.

d. Excessive Leave Early

i. Leaving fifteen (15) minutes or more, or the specific time frame as defined by the department, before the end of scheduled work shift is considered to be Leave Early.

ii. A pattern of Leaving Early before the end of the scheduled work shift, or prior to a scheduled break/meal break is to be noted and documented by the immediate supervisor in a timely and consistent manner.

iii. A Leave Early may be counted as an Occurrence as described in Section III.J.

iv. Leaving Early is considered excessive when the employee has three (3) or more Occurrences of Leaving Early from their scheduled shift and/or scheduled break/meal break without prior approval within a rolling twelve (12)-month period.

e. Excessive Missed Clocking In or Out

i. Three (3) incidents of failing to clock-in or clock-out of a scheduled shift and/or scheduled meal break within a thirty (30) business day period is considered excessive.

3. Frequent or excessive incidents of not following CalOptima Health's and/or the departmental attendance and punctuality requirements, notification procedures and/or the guidelines in this policy, including no-call/no-show, will be addressed by HR in accordance with the CalOptima Health Policy GA.8022: Performance and Behavior Standards.

I. Patterns of Absence, Leave Early, or Tardiness

1. The following may be considered patterns of excessive or unacceptable attendance issues:

a. Pattern of Unscheduled Absences, Leave Early, or Tardiness on Fridays, Mondays or other specific days.

b. Pattern of Unscheduled Absences, Leave Early, or Tardiness on days previously requested off but could not approved due to business needs.

c. Pattern of Unscheduled Absences, Leave Early, or Tardiness around the holidays, i.e., preceding or following a holiday or scheduled day off.

2. If a pattern of unscheduled usage of accrued PTO and/or unpaid time off is noticed, the immediate supervisor should work with HR on managing the corrective action process and addressing the issues with the employee.

a. When an employee has been previously counseled under CalOptima Health Policy GA.8022: Performance and Behavior Standards, the totality of the circumstances will be assessed when determining further action.

b. For situations involving corrective actions or termination of employment, the immediate supervisor or manager should consult with HR prior to taking action.

3. As timely and regular attendance is a performance expectation and condition of employment at CalOptima Health, employees who have exhibited unsatisfactory attendance during the year will have the behavior documented in their annual performance evaluation.

4. When the employee fails to report to work without giving notice to and/or receiving authorization from their immediate supervisor for three (3) consecutive scheduled workdays, the employee is considered to have resigned, unless the situation makes this impossible.

J. Occurrence

1. Incidents of an employee's Unscheduled or Unauthorized Absence, Tardiness, or Leaving Early should be documented by the immediate supervisor.

2. In the case of frequent or excessive incidents, each Occurrence may be calculated as follows:

OCCURRENCE	**POINTS**
Unauthorized Absence - one (1) or more consecutive day(s) of Absence(s) for the same reason	1 point for each Absence
Unscheduled Absence - one (1) or more day(s) of Absence for different reasons	1 point for each day
Unscheduled Absence (partial day) - over one (1) hour of Absence.	0.5 point for each incident
Tardiness or Leaving Early (15 or more minutes*)	0.5 point for each incident
Excessive Missed Clocking In or Out three (3) incidents within a thirty (30) business day period	0.5 point for each incident

* Or the specific time frame as defined by the department

3. Absences due to injuries or illness that qualify under applicable laws and CalOptima Health Policies will not be counted against an employee.

   a. Documentation within the guidelines of the applicable laws may be required in these instances.

   b. CalOptima Health will comply with the requirements of applicable federal, state or local laws that are relevant to this Policy.

4. The following will not be included when considering the employee's attendance record:

   a. An approved LOA;

   b. "Kin Care" or "Protected Sick Leave" time using PTO in accordance with CalOptima Health Policy GA.8018 Paid Time Off (PTO);

   c. Child-Related activities defined under Labor Code Section 230.8;

   d. Work related injuries; or

   e. As a reasonable accommodation under the Americans with Disabilities Act.

5. The immediate supervisor should properly document each occurrence of Unauthorized Absence, Tardiness, and/or Leave Early.

6. Patterns or issues with attendance should first be discussed with the employee. The immediate supervisor may partner with HR to discuss the attendance issue(s).

K. Performance Management Guidelines

1. When notified of an attendance issue by the employee's immediate supervisor, manager, or director, HR shall review an employee's attendance record and may institute corrective action for excessive Unscheduled Absences, Tardiness, or Leaving Early dating from the most recent occurrence to the prior twelve (12) months. All corrective actions and job performance issues will be taken into consideration when determining level of corrective action, up to and including termination.

2. CalOptima Health may apply the following guidelines, with management discretion, based on circumstances. These guidelines do not account for other job performance or behavioral issues and shall not be the exclusive guide if management is addressing multiple issues in addition to attendance and timekeeping. The guidelines are based on attendance and timekeeping issues on a rolling twelve (12)-month calendar:

Coaching Memo	Documented Counseling Memo	Written Warning	Final Warning	Possible Termination
Three (3) or more points	Four (4) or more points	Six (6) or more points	Eight (8) or more points	Nine (9) or more points

3. Employees are not guaranteed a right to corrective action prior to termination and can be terminated at any time. CalOptima Health may, at its sole and complete discretion, apply corrective action guidelines on a case by case basis; however, no formal order or system is necessary. CalOptima Health may terminate an employee at any time without following any particular series of steps.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. California Labor Code, §§230.8, 233, and 246 et seq.
B. CalOptima Health Code of Conduct
C. CalOptima Health Policy GA.8018: Paid Time Off (PTO)
D. CalOptima Health Policy GA.8022: Performance and Behavior Standards
E. CalOptima Health Policy GA.8037: Leave of Absence
F. CalOptima Health Policy GA.8038: Personal Leave of Absence
G. CalOptima Health Policy GA.8040: FMLA and CFRA Leaves of Absence
H. CalOptima Health Policy GA.8041: Workers' Compensation Leave of Absence
I. Fair Labor Standards Act (FLSA) §§785.18 and 785.19
J. Healthy Workplaces, Healthy Families Act of 2014 (Labor Code §245 *et seq*.)
K. Title 29, Code of Federal Regulations (C.F.R.), §541.710
L. Title 29, Code of Federal Regulations (C.F.R.), §1630.9

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
09/06/2018	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	09/06/2018	GA.8059	Attendance and Timekeeping	Administrative
Revised	TBD	GA.8059	Attendance and Timekeeping	Administrative

IX. GLOSSARY

Term	Definition
Absence	The state of being away or not being present for a portion of or the entire scheduled shift.
Authorized Absence	An absence or deviation from a scheduled shift is authorized when all of the following are met: 1) The employee provides sufficient notice (a minimum of one (1) hour prior to the start of the scheduled work time or within the specific time frame defined by the department) to their immediate supervisor prior the commencement of their shift; 2) Such absence request is approved by their immediate supervisor; and 3) The employee has: a) Sufficient accrued PTO to cover such absence unless otherwise allowed by CalOptima Health policy (i.e., leave of absence, bereavement, jury duty); or b) The immediate supervisor or manager waives this requirement and allows the absence based on the circumstances; or c) Exceptions as defined by the department.
Central Worksite	CalOptima Health's primary physical location of business applicable to the employee, which is either CalOptima Health's administration building at 505 City Parkway West or the PACE building.
Child Related Activities	Participation in activities at child's school or day care facility as permitted under Labor Code section 230.8, which includes: finding, enrolling, or reenrolling a child in a school or with a licensed child care provider; child care provider or school, emergency; request for child to be picked up from school/child care or an attendance policy that prohibits the child from attending or requires the child to be picked up from the school or child care provider; behavioral/discipline problems; closure or unexpected unavailability of school (excluding planned holidays); a natural disaster; or to participate in activities of the school or licensed child care provider of their child, if the employee, prior to taking the time off, gives reasonable notice to CalOptima Health.
Home Office	A designated workspace within the Teleworker's residence.
Leave/Leaving Early	An early departure from the scheduled end time of a work shift and/or the scheduled meal break.
Leave of Absence (LOA)	A term used to describe a scheduled period of time off longer than five (5) days that an employee is to be away from their primary job, while maintaining the status of employee.
Member	A beneficiary of a CalOptima Health Program.
Occurrence	An incident of (1) a period of Unauthorized Absence; (2) Tardiness or late arrival; (3) Leaving Early without prior approval; or (4) Excessive Missed Clocking In or Out.
Scheduled Absence	Any absence planned and approved in advance with notice consistent with applicable CalOptima Health policies.
Remote Work Location	The employee's Home Office or designated pre-approved work location.
Tardiness	The failure of an employee to report on time at the scheduled time of a work shift or return on time from breaks or meal breaks.
Teleworker	An employee who meets CalOptima Health's Teleworker eligibility criteria and is approved to routinely work their regularly scheduled work hours from a Remote Work Location unless business needs require otherwise.

Term	Definition
Timekeeping	Process of recording and reporting work arrival, meal breaks, and leave time.
Unauthorized Absence	Any absence when an employee misses one (1) hour or more of their scheduled shift without prior approval and when one (1), or more, of the four (4) conditions listed under Authorized Absence are not met.
Unscheduled Absence	An unplanned Absence, Tardiness or Leaving Early without sufficient notice or approval.
Normal Work Schedule	The normal work schedule is a 5/40 schedule which is five (5) eight (8)- hour days per work week excluding un-paid meal breaks.
9/80 Work Schedule	The 9/80 alternate work schedule consists of eight (8) workdays of nine (9) hours per day and one (1) workday of eight (8) hours, for a total of eighty (80) hours during two (2) consecutive workweeks. The eight (8) hour workday must be on the same day of the week as the employee's regularly scheduled day off. Therefore, under the 9/80 work schedule, one (1) calendar week will consist of forty-four (44) hours (four (4) nine (9)-hour days and one (1) eight (8)-hour day) and the alternating calendar week will consist of thirty-six (36) hours (four (4) nine (9)-hour days and one (1) day off). However, each workweek will only consist of forty (40) hours, in accordance with the 9/80 Fair Labor Standards Act (FLSA) Workweek.

1

Policy:	GA.8062
Title:	**Social Media Conduct**
Department:	CalOptima Health Administrative
Section:	Human Resources
CEO Approval:	*/s/*
Effective Date:	TBD
Revised Date:	Not Applicable
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ PACE ☒ Administrative

I. PURPOSE

This policy outlines requirements for CalOptima Health Employee communication in Online Communities and compliance with legal and regulatory requirements, including laws concerning privacy and confidentiality.

II. POLICY

A. The emergence of digital communication technologies has led to various activities that integrate technology, social interaction, and the construction of words, pictures, videos, and audio, commonly referred to as Social Media.

B. CalOptima Health recognizes that Online Communities can promote better communication with CalOptima Health Members, business partners, the public, traditional and non-traditional media, and other community stakeholders.

C. CalOptima Health's Communications department controls the content on official sites and approves the links on the CalOptima Health website.

D. The California Public Records Act, the Federal Electronic Communications Privacy Act, Federal Communications Commission guidelines, court-directed action, or other legal requirements may obligate CalOptima Health to disclose information produced by CalOptima Health Employees electronically. If so, CalOptima Health shall not, in any way, be liable for the disclosure.

E. The personal opinions of CalOptima Health Employees who use Social Media or communicate through Online Communities do not represent CalOptima Health.

1. Online Communities include, but are not limited to, postings in online forums, blogs, micro-blogs, wikis or vlogs, such as Facebook, Instagram, Twitter, LinkedIn, MySpace, YouTube, Flickr, RSS feeds, media sites, or similar types of online forums.

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III. PROCEDURE

A. CalOptima Health-Hosted Social Media Sites

1. CalOptima Health's Communications department shall maintain CalOptima Health's official presence in Online Communities in accordance with policies and operational procedures. Communications in Online Communities shall be consistent with CalOptima Health values and applicable law and shall not be detrimental to CalOptima Health's best interests. Policies include the following:

    a. Disclosure of CalOptima Health Member names or Protected Health Information (PHI) is prohibited without express written permission. Images of unidentified people taken at CalOptima Health public events where no names are used are permitted.

    b. Disclosure of CalOptima Health Employee names and images is limited to pictures taken during CalOptima Health work or events that reflect positively on the organization, such as Employees posing in a professional manner at a community event.

    c. Postings that contain any product or service endorsement unrelated to CalOptima Health's programs or partnerships are prohibited.

    d. Postings that contain content that may be construed as political lobbying or solicitations for contributions are prohibited.

B. CalOptima Health Employees' Personal Social Media Sites

1. When a nexus exists between an Employee's Social Media communication and CalOptima Health the following apply:

    a. With regards to conduct on Social Media sites, all CalOptima Health Employees are expected and required to adhere to the Employee Handbook and all CalOptima Health policies such as, but not limited to:

        i. CalOptima Health Policy GA.8012: Conflicts of Interest

        ii. CalOptima Health Policy GA.8022: Performance and Behavior Standards

        iii. CalOptima Health Policy GA.8025: Equal Employment Opportunity

        iv. CalOptima Health Policy GA.8027: Anti-Harassment

        v. CalOptima Health Policy GA.8050: Confidentiality

    b. CalOptima Health Employees who use Social Media should be aware of and familiar with this policy regarding CalOptima Health's official use of Online Communities and their own personal Social Media use. Failure to abide by the policy may lead to corrective action, up to and including, termination.

    c. CalOptima Health Employees are prohibited from establishing a personal Social Media site representing CalOptima Health.

d. Unless a CalOptima Health Employee is serving as an approved, official spokesperson for CalOptima Health in online communications, it should be made clear to readers that the communications are the individual's personal opinions and do not reflect the opinion of CalOptima Health. CalOptima Health Employees are personally responsible for their posts, whether written, audio, video, photographs, or in any other format.

e. If Employees acknowledge their relationship with CalOptima Health in an Online Community, disclaimers shall be included in their online communications advising that they are not speaking officially on behalf of the CalOptima Health. In such situations, it is recommended that a disclaimer be used such as, "the views expressed on this blog are my own and do not reflect the views of my employer."

f. CalOptima Health Employees shall not post any material that may be reasonably understood to be defamatory, profane, obscene, threatening, harassing, abusive, discriminatory based on a protected class, embarrassing, or humiliating to another person or entity. Employees may be held personally liable for the improper use of CalOptima Health's proprietary information and defamatory or libelous commentary about CalOptima Health.

g. CalOptima Health employees and contractors shall not disclose information in connection with an information security or criminal investigation without authorization from CalOptima Health's Communication department or Legal counsel.

2. Disclosure of Member names or the posting of PHI including Member images or other identifiable information constitutes a violation of the Health Insurance Portability and Accountability Act (HIPAA) and CalOptima Health policy and confidentiality requirements. Employees will ensure that PII/PHI either on computer or in paper form are not visible in any photos or videos taken, as a measure to ensure protection of our member data. Any questions about the appropriateness of a picture to be posted shall be directed to the Communications department.

3. Disclosure of CalOptima Health Employee names and images may subject the posting Employee to corrective or legal action if rules or laws regarding confidentiality or privacy are violated. Any questions about the appropriateness of a picture of a CalOptima Health Employee shall be directed to the Communications department.

4. CalOptima Health equipment may not be utilized for personal Social Media sites. Personal Social Media use is prohibited while employee is on duty.

5. Employees are prohibited from unauthorized or unlawful use of CalOptima Health logos, trademarks or other intellectual property.

6. Invitations to link-in to participate in non-CalOptima Health hosted sites shall be declined by Employees unless Employees are utilizing a personal computer on personal time.

7. This policy is not intended to interfere with any rights Employees may have under applicable laws.

8. Any inappropriate communications that violate this Policy should be reported to Human Resources immediately. Failure to follow this policy may result in corrective action, up to and including termination.

IV. ATTACHMENT(S)

Not applicable

V. REFERENCE(S)

A. CalOptima Health Policy GA.8012: Conflicts of Interest
B. CalOptima Health Policy GA.8022: Performance and Behavior Standards
C. CalOptima Health Policy GA.8025: Equal Employment Opportunity
D. CalOptima Health Policy GA.8027: Anti-Harassment
E. CalOptima Health Policy GA.8050: Confidentiality
F. CalOptima Health Employee Handbook
G. CalOptima Health Policy GA.5005a: Use of Technology Resources

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
TBD		

VII. BOARD ACTION(S)

Date	Meeting
TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	TBD	GA.8062	Social Media Conduct	Administrative

IX. GLOSSARY

Term	Definition
Employee	Any and all employees of CalOptima, including all permanent and temporary employees, volunteers, and other employed personnel.
Online Communities	Online Communities include, but are not limited to, postings in online forums, blogs, micro-blogs, wikis or vlogs such as Facebook, Instagram, Twitter, LinkedIn, MySpace, YouTube, Flickr, RSS feeds, media sites or similar types of online forums.
Member	A beneficiary enrolled in a CalOptima program.
Protected Health Information (PHI)	Has the meaning in Title 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.
Social Media	Forms of electronic communication (such as websites for social networking and microblogging) through which users create Online Communities to share information, ideas, personal messages, and other content (such as videos).

CalOptima Health Board Action Agenda Referral

Action To Be Taken December 1, 2022
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar
14. Adopt Resolution No. 22-1201-04 Approving Updated CalOptima Health Policy GA.8012

Contacts
Michael Hunn, Chief Executive Officer, (657) 900-1481
Brigette Hoey, Chief Human Resources Officer, (714) 246-8405

Recommended Action
Adopt Resolution No. 22-1201-04 approving updated CalOptima Health policy GA. 8012: Conflicts of Interest and Attachments A-C.

Background
Near CalOptima Health's inception, the Board of Directors delegated authority to the Chief Executive Officer to develop and implement employee policies and procedures, and to amend them as appropriate from time to time, subject to bi-annual updates to the Board, with emphasis on changes. 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
GA. 8012: Conflicts of Interest: This policy establishes guidelines and standards for CalOptima Health employees to avoid conflicts of interest and incompatible outside activities. The changes are also intended align the policy with the active job classifications in GA.8058 Salary Schedule.

Policy Section	Proposed Change	Rationale	Impact
Attachment A	Additions, revisions and removal of positions on the Conflict of Interest Code Exhibit A.	Consistency with GA.8058 for Statement of Economic Interest Form 700 reporting.	Aligns with related policy.

Fiscal Impact
There is no fiscal impact.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

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Attachments

1. Resolution No. 22-1201-04, Approve Updated Human Resources Policy
2. Revised CalOptima Health Policy GA. 8012: Conflicts of Interest and Attachments A-C

/s/ Michael Hunn *11/23/2022*
Authorized Signature **Date**

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RESOLUTION NO. 22-1201-04

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 Bylaws of the Orange County Health Authority, dba CalOptima, provide that the Board of Directors shall adopt by resolution, and may from time to time amend, procedures, practices and policies for, inter alia, hiring employees, and managing personnel; and

WHEREAS, in 1994, the Board of Directors designated the Chief Executive Officer as the Appointing Authority with full power to hire and terminate CalOptima 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, California Code of Regulations, Title 2, Section 570.5, requires CalOptima Health to adopt a publicly available pay schedule that identifies the position title and pay rate for every employee position, and CalOptima Health regularly reviews CalOptima Health's salary schedule accordingly.

NOW, THEREFORE, BE IT RESOLVED:

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

- GA. 8012: Conflict of Interest

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima Health this 1st day of December 2022.

AYES:
NOES:
ABSENT:
ABSTAIN:

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

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

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Policy:	GA.8012
Title:	**Conflicts of Interest**
Department:	CalOptima Health Administrative
Section:	Human Resources
CEO Approval:	*/s/*
Effective Date:	02/01/2000
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☐ OneCare ~~☐ OneCare Connect~~ ☐ PACE ☒ Administrative

I. PURPOSE

This policy establishes guidelines and standards for CalOptima Health Employees to avoid conflicts of interest and incompatible outside activities.

II. POLICY

A. CalOptima Health Employees shall avoid anything that constitutes a real or apparent conflict between their personal interests and the interests of CalOptima Health.

B. CalOptima Health Employees shall avoid conflicts of interest and shall adhere to applicable state and federal laws and regulations, including, but not limited to:

1. California Government Code Section 81000 et seq., requiring all designated employees to comply with the reporting requirements in CalOptima Health's Conflict of Interest Code;

2. California Government Code Section 87100, prohibiting each CalOptima Health Employee from making, participating in making or in any way attempting to use his or her official position to influence a governmental decision in which he or she knows or has reason to know that he or she has a financial interest;

3. California Government Code section 1090, prohibiting each CalOptima Health Employee from being financially interested in any contract made by the employee in his or her official capacity, and prohibiting each employee from being a purchaser at any sale or vendor at any purchase made by him or her in his or her official capacity.

4. California Government Code section 1126, which prohibits each CalOptima Health Employee from engaging in any employment, activity, or enterprise for compensation which is inconsistent, incompatible, in conflict with, or inimical to his or her duties as a local agency officer or employee or with the duties, functions, or responsibilities of CalOptima Health.

5. Title 42 of the United States Code section 1320-7b(b), prohibiting the knowing and willful offer, payment, solicitation or receipt of incentives or remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind, to induce the

referral of business reimbursable under the Medi-Cal or Medicare programs or to induce an enrollee to use a particular practitioner, provider or supplier.

6. Title 42 of the Code of Federal Regulations section 460.68 regarding the disclosure and recusal requirement of the governing board for direct or indirect interest in any contract that supplies any administrative or care-related service or materials to PACE.

C. A conflict of interest exists in any situation in which an employee uses his or her position or association with CalOptima Health for personal or financial gain. The following guidelines are used to determine whether a real or apparent conflict of interest would exist.

1. *Avoidance of Unfair Competitive Advantage*. An employee's outside employment, consulting, or other business activity outside CalOptima Health may not influence decisions made by CalOptima Health in such a way as to give unfair competitive advantage to the employee's outside business activity.

2. *Use of Privileged or Official Information*. The use of privileged or official information for personal financial gain while employed with or after separating from employment is a type of conflict of interest and is prohibited. Privileged or official information is information that is known to an employee because of his or her employment with CalOptima Health but is not available to the public. The information covered under this provision includes, but is not limited to, personal health information (PHI), provider rates, personnel records, or proprietary information.

3. *Protection of Information Not Yet in Public Domain*. A CalOptima Health Employee acting as an independent consultant or as an employee of another organization may not use information, skills or knowledge obtained as a result of CalOptima Health employment, that is material or necessary to a current, in-progress, or proposed CalOptima Health project, that is proprietary to CalOptima Health and that is not yet in the public domain.

4. *Noncompetition with CalOptima Health*. An employee's outside employment or consulting activity must not compete with current or proposed CalOptima Health projects, programs or initiatives.

D. CalOptima 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.

E. CalOptima Health Employees shall comply with the Code of Conduct and CalOptima Health Policies AA.1204: Gifts, Honoraria, and Travel Payments and AA.1216: Solicitation and Receipt of Gifts to CalOptima Health. Other than as permitted in CalOptima Health Policies, employees shall not receive gratuity, rebates, kickbacks, accommodation, or other unlawful consideration from any one provider, supplier, vendor, firm, or organization with whom CalOptima Health is currently doing or could potentially do business with. It is the responsibility of the employee to return any gift delivered to them and to notify the Clerk of the Board of such action.

F. CalOptima Health Employees shall be aware of what outside activities, investments, and/or positions may conflict with or detract from their effectiveness in employment with CalOptima Health and shall avoid such conflicts.

G. CalOptima Health Employees shall promptly disclose all potential, suspected, or actual conflicts of interest to CalOptima Health's Human Resources Department (HR)and shall personally withdraw

from discussion, voting, or other decision-making process where an employee knows or has reason to know the employee has a real or apparent conflict of interest.

H. Designated CalOptima Health Employees in those positions listed in the CalOptima Health Conflict of Interest Code shall complete Statements of Economic Interests (FPPC Form 700) and a CalOptima Health Supplement to Form 700 upon hire, annually, and upon termination of employment. 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.

1. CalOptima Health Employees are required to promptly report any non-CalOptima Health job positions, positions held on non-profit/charitable organizations and/or their affiliations or interests in job-related businesses or organizations on an Employee Report of Outside Interest and/or Other Employment form provided by HR. CalOptima Health employees shall not participate in any of the following activities 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):

   a. Perform work or render services for any Contractor/Vendor/Provider, association of Contractors/Vendors/Providers or other organizations with which CalOptima Health does business or which seek to do business with CalOptima Health;

   b. Be a director, officer, or consultant of any Contractor/Vendor/Provider or association of Contractors/Vendors/Providers or other organizations with which CalOptima Health does business or which seek to do business with CalOptima Health; or

   c. Permit his or her name to be used in any fashion that would tend to indicate a business connection with any Contractor/Vendor/Provider or association of Contractors/Vendors/Providers or other organizations with which CalOptima Health does business or which seek to do business with CalOptima Health.

I. Employees 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.

J. As required in CalOptima Health's contract with the Department of Health Care Services (DHCS) and applicable state and federal laws and regulations, CalOptima Health shall avoid conflicts of interest in the employment of current and former state officers and employees.

K. Employees in Executive Staff positions shall not, for a period of twelve (12) months after leaving that position or employment with CalOptima Health, act as an agent for, or otherwise represent, for compensation, any other person, contractor, or organization, directly or indirectly, by negotiating, servicing, or soliciting contracts with CalOptima Health.

L. Failure to adhere to this Policy, including failure to promptly disclose any potential or actual conflicts or seek an exception may result in corrective action, up to and including termination of employment and/or legal action. Conflicts that violate state or federal laws may result in regulatory or legal action, including possible fines and criminal prosecution.

III. PROCEDURE

A. HR shall:

1. Provide all new CalOptima Health Employees with a copy of this Policy and CalOptima Health's Code of Conduct.

2. Provide each designated CalOptima Health employee with a copy of the Conflict of Interest Code and a link to the County of Orange's eDisclosure System to the Form 700 Statement of Economic Interests, to complete when assuming office, annually, and upon termination of employment. HR will also provide the Supplement to Form 700 upon hire and annually.

3. Make the Employee Report of Outside Interest and/or Other Employment form available to all CalOptima Health employees.

4. Collect and review the completed Supplement to Form 700 forms and/or Employee Report of Outside Interest and/or Other Employment Forms and obtain necessary approvals where required.

5. Not employ an individual holding a permanent or intermittent position in the State civil service or other appointed State official or an individual who was employed within the previous one (1) year as an appointee or civil service employee with DHCS, subject to certain exceptions which employment determination shall be made in conjunction with the Compliance Department.

B. All CalOptima Health Employees shall:

1. Review and comply with this Policy, CalOptima's Code of Conduct, and the CalOptima Health Employee Handbook;

2. Avoid any actual or potential conflict between their personal interests and the interest of CalOptima Health;

3. Promptly report any job-related outside or personal positions or interests on the Employee Report of Outside Interest and/or Other Employment form and submit such forms to HR.

4. Not make, or participate in making, or in any way attempt to use his or her official position to influence a governmental decision in which he or she knows or has reason to know he or she has a financial interest.

5. Not offer, pay, solicit or receive an incentive or remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind, to induce the referral of business reimbursable under the Medi-Cal or Medicare programs or to induce an enrollee to use a particular practitioner, provider or supplier.

6. Promptly report any suspected or apparent violation of this Policy to CalOptima Health's HR Department with detailed information sufficient for HR to investigate the issue and cooperate with any subsequent investigation.

7. CalOptima Health Employees unsure as to whether a certain transaction, activity, or relationship constitutes a conflict of interest should discuss it with their supervisor or HR for clarification.

8. Upon being notified that an actual or apparent conflict exists, and an exception is not granted, the employee must promptly resolve the conflict by:

   a. Terminating the outside activity;

   b. Cooperating in reassignment, when appropriate or reasonable or;

   c. Resigning from CalOptima Health.

C. Designated CalOptima Health Employees in those positions listed in the CalOptima Health Conflict of Interest Code shall:

1. Upon assuming office, annually, and upon termination of employment, complete and submit a Statement of Economic Interests (FPPC Form 700) on the County of Orange eDisclosure system (https://cobcoi.ocgov.com/edisclosure/); and

2. Complete a Supplement to Form 700 upon hire and annually.

IV. ATTACHMENT(S)

A. Conflict of Interest Code Exhibits A and B
B. Supplement to Form 700
C. Employee Report of Outside Interest and/or Other Employment Form

V. REFERENCE(S)

A. CalOptima Health Code of Conduct
B. CalOptima Health Conflict of Interest Code
C. CalOptima Health Employee Handbook
D. CalOptima Health Contract with the Department of Health Care Services (DHCS)
E. CalOptima Health Policy AA.1204: Gifts, Honoraria and Travel Payments ~~(20200604 BOD)~~
F. CalOptima Health Policy AA.1216: Solicitation and Receipt of Gifts to CalOptima Health ~~(20200604 BOD)~~
G. Political Reform Act, Government Code §§81000-91014
H. Title 2, California Code of Regulations (C.C.R.), §§18730 *et seq.*
I. California Government Code, §§1090 *et. seq.*
J. California Government Code, §1126
K. California Government Code §§ 87206.3 and 87206.3(c)
L. Title 22, California Code of Regulations, §53600
M. Title 42, United States Code, §§1320a-7b(b)
N. Title 42, Code of Federal Regulations, §460.68

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
01/08/2009	Regular Meeting of the CalOptima Board of Directors
05/04/2017	Regular Meeting of the CalOptima Board of Directors

Date	Meeting
02/07/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
09/01/2022	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	02/01/2000	GA.8012	Conflicts of Interest	Administrative
Revised	07/01/2007	GA.8012	Conflicts of Interest	Administrative
Revised	05/04/2017	GA.8012	Conflicts of Interest	Administrative
Revised	02/07/2019	GA.8012	Conflicts of Interest	Administrative
Revised	12/03/2020	GA.8012	Conflicts of Interest	Administrative
Revised	09/01/2022	GA.8012	Conflicts of Interest	Administrative
Revised	TBD	GA.8012	Conflicts of Interest	Administrative

IX. GLOSSARY

Term	Definition
CalOptima Health Employee(s)	For purposes of this policy, include, but are not limited to, all full-time and part-time regular CalOptima Health employees, all temporary employees, interns, CalOptima Health Board members, and applicable contractors and consultants.

Policy:	GA.8012
Title:	**Conflicts of Interest**
Department:	CalOptima Health Administrative
Section:	Human Resources
CEO Approval:	*/s/*
Effective Date:	02/01/2000
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ PACE ☒ Administrative

I. PURPOSE

This policy establishes guidelines and standards for CalOptima Health Employees to avoid conflicts of interest and incompatible outside activities.

II. POLICY

A. CalOptima Health Employees shall avoid anything that constitutes a real or apparent conflict between their personal interests and the interests of CalOptima Health.

B. CalOptima Health Employees shall avoid conflicts of interest and shall adhere to applicable state and federal laws and regulations, including, but not limited to:

1. California Government Code Section 81000 et seq., requiring all designated employees to comply with the reporting requirements in CalOptima Health's Conflict of Interest Code;

2. California Government Code Section 87100, prohibiting each CalOptima Health Employee from making, participating in making or in any way attempting to use his or her official position to influence a governmental decision in which he or she knows or has reason to know that he or she has a financial interest;

3. California Government Code section 1090, prohibiting each CalOptima Health Employee from being financially interested in any contract made by the employee in his or her official capacity, and prohibiting each employee from being a purchaser at any sale or vendor at any purchase made by him or her in his or her official capacity.

4. California Government Code section 1126, which prohibits each CalOptima Health Employee from engaging in any employment, activity, or enterprise for compensation which is inconsistent, incompatible, in conflict with, or inimical to his or her duties as a local agency officer or employee or with the duties, functions, or responsibilities of CalOptima Health.

5. Title 42 of the United States Code section 1320-7b(b), prohibiting the knowing and willful offer, payment, solicitation or receipt of incentives or remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind, to induce the referral of business reimbursable under the Medi-Cal or Medicare programs or to induce an enrollee to use a particular practitioner, provider or supplier.

6. Title 42 of the Code of Federal Regulations section 460.68 regarding the disclosure and recusal requirement of the governing board for direct or indirect interest in any contract that supplies any administrative or care-related service or materials to PACE.

C. A conflict of interest exists in any situation in which an employee uses his or her position or association with CalOptima Health for personal or financial gain. The following guidelines are used to determine whether a real or apparent conflict of interest would exist.

1. *Avoidance of Unfair Competitive Advantage*. An employee's outside employment, consulting, or other business activity outside CalOptima Health may not influence decisions made by CalOptima Health in such a way as to give unfair competitive advantage to the employee's outside business activity.

2. *Use of Privileged or Official Information*. The use of privileged or official information for personal financial gain while employed with or after separating from employment is a type of conflict of interest and is prohibited. Privileged or official information is information that is known to an employee because of his or her employment with CalOptima Health but is not available to the public. The information covered under this provision includes, but is not limited to, personal health information (PHI), provider rates, personnel records, or proprietary information.

3. *Protection of Information Not Yet in Public Domain*. A CalOptima Health Employee acting as an independent consultant or as an employee of another organization may not use information, skills or knowledge obtained as a result of CalOptima Health employment, that is material or necessary to a current, in-progress, or proposed CalOptima Health project, that is proprietary to CalOptima Health and that is not yet in the public domain.

4. *Noncompetition with CalOptima Health*. An employee's outside employment or consulting activity must not compete with current or proposed CalOptima Health projects, programs or initiatives.

D. CalOptima 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.

E. CalOptima Health Employees shall comply with the Code of Conduct and CalOptima Health Policies AA.1204: Gifts, Honoraria, and Travel Payments and AA.1216: Solicitation and Receipt of Gifts to CalOptima Health. Other than as permitted in CalOptima Health Policies, employees shall not receive gratuity, rebates, kickbacks, accommodation, or other unlawful consideration from any one provider, supplier, vendor, firm, or organization with whom CalOptima Health is currently doing or could potentially do business with. It is the responsibility of the employee to return any gift delivered to them and to notify the Clerk of the Board of such action.

F. CalOptima Health Employees shall be aware of what outside activities, investments, and/or positions may conflict with or detract from their effectiveness in employment with CalOptima Health and shall avoid such conflicts.

G. CalOptima Health Employees shall promptly disclose all potential, suspected, or actual conflicts of interest to CalOptima Health's Human Resources Department (HR)and shall personally withdraw from discussion, voting, or other decision-making process where an employee knows or has reason to know the employee has a real or apparent conflict of interest.

H. Designated CalOptima Health Employees in those positions listed in the CalOptima Health Conflict of Interest Code shall complete Statements of Economic Interests (FPPC Form 700) and a CalOptima Health Supplement to Form 700 upon hire, annually, and upon termination of employment. 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.

1. CalOptima Health Employees are required to promptly report any non-CalOptima Health job positions, positions held on non-profit/charitable organizations and/or their affiliations or interests in job-related businesses or organizations on an Employee Report of Outside Interest and/or Other Employment form provided by HR. CalOptima Health employees shall not participate in any of the following activities 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):

   a. Perform work or render services for any Contractor/Vendor/Provider, association of Contractors/Vendors/Providers or other organizations with which CalOptima Health does business or which seek to do business with CalOptima Health;

   b. Be a director, officer, or consultant of any Contractor/Vendor/Provider or association of Contractors/Vendors/Providers or other organizations with which CalOptima Health does business or which seek to do business with CalOptima Health; or

   c. Permit his or her name to be used in any fashion that would tend to indicate a business connection with any Contractor/Vendor/Provider or association of Contractors/Vendors/Providers or other organizations with which CalOptima Health does business or which seek to do business with CalOptima Health.

I. Employees 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.

J. As required in CalOptima Health's contract with the Department of Health Care Services (DHCS) and applicable state and federal laws and regulations, CalOptima Health shall avoid conflicts of interest in the employment of current and former state officers and employees.

K. Employees in Executive Staff positions shall not, for a period of twelve (12) months after leaving that position or employment with CalOptima Health, act as an agent for, or otherwise represent, for compensation, any other person, contractor, or organization, directly or indirectly, by negotiating, servicing, or soliciting contracts with CalOptima Health.

L. Failure to adhere to this Policy, including failure to promptly disclose any potential or actual conflicts or seek an exception may result in corrective action, up to and including termination of employment and/or legal action. Conflicts that violate state or federal laws may result in regulatory or legal action, including possible fines and criminal prosecution.

III. PROCEDURE

A. HR shall:

1. Provide all new CalOptima Health Employees with a copy of this Policy and CalOptima Health's Code of Conduct.

2. Provide each designated CalOptima Health employee with a copy of the Conflict of Interest Code and a link to the County of Orange's eDisclosure System to the Form 700 Statement of Economic Interests, to complete when assuming office, annually, and upon termination of employment. HR will also provide the Supplement to Form 700 upon hire and annually.

3. Make the Employee Report of Outside Interest and/or Other Employment form available to all CalOptima Health employees.

4. Collect and review the completed Supplement to Form 700 forms and/or Employee Report of Outside Interest and/or Other Employment Forms and obtain necessary approvals where required.

5. Not employ an individual holding a permanent or intermittent position in the State civil service or other appointed State official or an individual who was employed within the previous one (1) year as an appointee or civil service employee with DHCS, subject to certain exceptions which employment determination shall be made in conjunction with the Compliance Department.

B. All CalOptima Health Employees shall:

1. Review and comply with this Policy, CalOptima's Code of Conduct, and the CalOptima Health Employee Handbook;

2. Avoid any actual or potential conflict between their personal interests and the interest of CalOptima Health;

3. Promptly report any job-related outside or personal positions or interests on the Employee Report of Outside Interest and/or Other Employment form and submit such forms to HR.

4. Not make, or participate in making, or in any way attempt to use his or her official position to influence a governmental decision in which he or she knows or has reason to know he or she has a financial interest.

5. Not offer, pay, solicit or receive an incentive or remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind, to induce the referral of business reimbursable under the Medi-Cal or Medicare programs or to induce an enrollee to use a particular practitioner, provider or supplier.

6. Promptly report any suspected or apparent violation of this Policy to CalOptima Health's HR Department with detailed information sufficient for HR to investigate the issue and cooperate with any subsequent investigation.

7. CalOptima Health Employees unsure as to whether a certain transaction, activity, or relationship constitutes a conflict of interest should discuss it with their supervisor or HR for clarification.

8. Upon being notified that an actual or apparent conflict exists, and an exception is not granted, the employee must promptly resolve the conflict by:

   a. Terminating the outside activity;

b. Cooperating in reassignment, when appropriate or reasonable or;

c. Resigning from CalOptima Health.

C. Designated CalOptima Health Employees in those positions listed in the CalOptima Health Conflict of Interest Code shall:

1. Upon assuming office, annually, and upon termination of employment, complete and submit a Statement of Economic Interests (FPPC Form 700) on the County of Orange eDisclosure system (https://cobcoi.ocgov.com/edisclosure/); and

2. Complete a Supplement to Form 700 upon hire and annually.

IV. ATTACHMENT(S)

A. Conflict of Interest Code Exhibits A and B
B. Supplement to Form 700
C. Employee Report of Outside Interest and/or Other Employment Form

V. REFERENCE(S)

A. CalOptima Health Code of Conduct
B. CalOptima Health Conflict of Interest Code
C. CalOptima Health Employee Handbook
D. CalOptima Health Contract with the Department of Health Care Services (DHCS)
E. CalOptima Health Policy AA.1204: Gifts, Honoraria and Travel Payments
F. CalOptima Health Policy AA.1216: Solicitation and Receipt of Gifts to CalOptima Health
G. Political Reform Act, Government Code §§81000-91014
H. Title 2, California Code of Regulations (C.C.R.), §§18730 *et seq.*
I. California Government Code, §§1090 *et. seq.*
J. California Government Code, §1126
K. California Government Code §§ 87206.3 and 87206.3(c)
L. Title 22, California Code of Regulations, §53600
M. Title 42, United States Code, §§1320a-7b(b)
N. Title 42, Code of Federal Regulations, §460.68

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
01/08/2009	Regular Meeting of the CalOptima Board of Directors
05/04/2017	Regular Meeting of the CalOptima Board of Directors
02/07/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
09/01/2022	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	02/01/2000	GA.8012	Conflicts of Interest	Administrative
Revised	07/01/2007	GA.8012	Conflicts of Interest	Administrative
Revised	05/04/2017	GA.8012	Conflicts of Interest	Administrative
Revised	02/07/2019	GA.8012	Conflicts of Interest	Administrative
Revised	12/03/2020	GA.8012	Conflicts of Interest	Administrative
Revised	09/01/2022	GA.8012	Conflicts of Interest	Administrative
Revised	TBD	GA.8012	Conflicts of Interest	Administrative

IX. GLOSSARY

Term	Definition
CalOptima Health Employee(s)	For purposes of this policy, include, but are not limited to, all full-time and part-time regular CalOptima Health employees, all temporary employees, interns, CalOptima Health Board members, and applicable contractors and consultants.

Conflict of Interest Code
EXHIBIT A

Approved December 01, 2022, by
CalOptima Health Board of Directors

Entity: Other Misc. Authorities, Districts and Commissions
Agency: CalOptima Health

Position	Disclosure Category	Files With	Status
Associate Director I	OC-41	COB	Unchanged
Associate Director II	OC-41	COB	Unchanged
Associate Director III	OC-41	COB	Unchanged
Associate Director IV	OC-41	COB	Unchanged
Buyer	OC-01	COB	Unchanged
Buyer, Int.	OC-01	COB	Unchanged
Buyer, Sr.	OC-01	COB	Unchanged
Chief Compliance Officer	OC-01	COB	Unchanged
Chief Executive Officer	OC-01	COB	Unchanged
Chief Financial Officer	OC-01	COB	Unchanged
Chief Health Equity Officer	OC-01	COB	Unchanged
Chief Human Resources Officer	OC-01	COB	Unchanged
Chief Information Officer	OC-01	COB	Unchanged
Chief Medical Officer	OC-01	COB	Unchanged
Chief of Staff	OC-01	COB	Unchanged
Chief Operating Officer	OC-01	COB	Unchanged
Chief Strategy Officer	OC-01	COB	New Position
Clerk of the Board	OC-06	COB	Unchanged
Clinical Pharmacist	OC-20	COB	Unchanged
Consultant	OC-01	Agency	Unchanged
Contract Administrator	OC-06	COB	Unchanged
Contracts Manager	OC-06	COB	Unchanged
Contracts Manager, Sr.	OC-06	COB	Unchanged
Contracts Specialist	OC-06	COB	Unchanged
Contracts Specialist, Int.	OC-06	COB	Unchanged
Contracts Specialist, Sr.	OC-06	COB	Unchanged
Controller	OC-01	COB	Unchanged
Deputy Chief Medical Officer	OC-01	COB	Unchanged

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Conflict of Interest Code
EXHIBIT A

Approved December 01, 2022, by
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Position	Disclosure Category	Files With	Status
~~Deputy Clerk of the Board~~	~~OC-06~~	~~COB~~	Remove Job Title
Director I	OC-01	COB	Unchanged
Director II	OC-01	COB	Unchanged
Director III	OC-01	COB	Unchanged
Director IV	OC-01	COB	Unchanged
Enterprise Analytics Manager	OC-06	COB	Unchanged
Executive Director	OC-01	COB	Unchanged
Financial Analyst I	OC-01	COB	Unchanged
Financial Analyst II	OC-01	COB	Unchanged
Financial Analyst III	OC-01	COB	Unchanged
Financial Analyst IV	OC-01	COB	Unchanged
Financial Reporting Analyst	OC-01	COB	Unchanged
Litigation Support Specialist	OC-41	COB	Unchanged
Manager, Accounting	OC-01	COB	Unchanged
Manager, Actuary	OC-01	COB	Unchanged
Manager, Audit and Oversight	OC-01	COB	Unchanged
Manager, Behavioral Health	OC-41	COB	Unchanged
Manager, Business Integration	OC-06	COB	Unchanged
Manager, Case Management	OC-41	COB	Unchanged
Manager, Claims	OC-41	COB	Unchanged
Manager, Clinic Operations	OC-06	COB	Unchanged
Manager, Clinical Pharmacists	OC-20	COB	Unchanged
Manager, Coding Quality	OC-06	COB	Unchanged
Manager, Communications	OC-13	COB	Unchanged
Manager, Community Relations	OC-06	COB	Unchanged
Manager, Contracting	OC-41	COB	Unchanged
Manager, Creative Branding	OC-13	COB	Unchanged
Manager, Cultural & Linguistics	OC-06	COB	Unchanged
Manager, Customer Service	OC-41	COB	Unchanged
Manager, Electronic Business	OC-06	COB	Unchanged

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Position	Disclosure Category	Files With	Status
Manager, Encounters	OC-06	COB	Unchanged
Manager, Environmental Health & Safety	OC-06	COB	Unchanged
Manager, Finance	OC-01	COB	Unchanged
Manager, Financial Analysis	OC-01	COB	Unchanged
Manager, Government Affairs	OC-41	COB	Unchanged
Manager, Grievance and Appeals	OC-41	COB	Unchanged
Manager, Human Resources	OC-11	COB	Unchanged
Manager, Information Technology Services	OC-08	COB	Unchanged
Manager, Long Term Support Services	OC-41	COB	Unchanged
Manager, Marketing & Outreach	OC-06	COB	Unchanged
Manager, Marketing and Enrollment (PACE)	OC-06	COB	Unchanged
Manager, Member Liaison Program	OC-41	COB	Unchanged
Manager, Member Outreach & Education	OC-41	COB	Unchanged
Manager, MSSP	OC-41	COB	Unchanged
Manager, OneCare Clinical	OC-41	COB	Unchanged
Manager, OneCare Customer Service	OC-41	COB	Unchanged
Manager, Outreach & Enrollment	OC-41	COB	Unchanged
Manager, PACE Center	OC-41	COB	Unchanged
Manager, Population Health Management	OC-41	COB	Unchanged
Manager, Process Excellence	OC-41	COB	Unchanged
Manager, Program Implementation	OC-06	COB	Unchanged
Manager, Provider Data Management Services	OC-41	COB	Unchanged
Manager, Provider Network	OC-41	COB	Unchanged
Manager, Provider Relations	OC-41	COB	Unchanged
Manager, Purchasing	OC-01	COB	Unchanged
Manager, QI Initiatives	OC-41	COB	Unchanged
Manager, Quality Analytics	OC-06	COB	Unchanged
Manager, Quality Improvement	OC-41	COB	Unchanged
Manager, Regulatory Affairs and Compliance	OC-41	COB	Unchanged
Manager, Reporting & Financial Compliance	OC-01	COB	Unchanged

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EXHIBIT A

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CalOptima Health Board of Directors

Position	Disclosure Category	Files With	Status
Manager, Strategic Development	OC-41	COB	Unchanged
Manager, Utilization Management	OC-06	COB	Unchanged
Medical Case Manager	OC-41	COB	Unchanged
Medical Case Manager (LVN)	OC-41	COB	Unchanged
Medical Director	OC-01	COB	Unchanged
Medical Services Case Manager	OC-41	COB	Unchanged
Nurse Practitioner (PACE)	OC-41	COB	Unchanged
OneCare Operations Manager	OC-41	COB	Unchanged
Pharmacy Resident	OC-20	COB	Unchanged
Pharmacy Services Specialist	OC-20	COB	Unchanged
Pharmacy Services Specialist, Int.	OC-20	COB	Unchanged
Pharmacy Services Specialist, Sr.	OC-20	COB	Unchanged
Policy Advisor, Sr.	OC-41	COB	Unchanged
Principal Financial Analyst	OC-01	COB	Unchanged
Privacy Manager	OC-41	COB	Unchanged
Privacy Officer	OC-41	COB	Unchanged
~~Process Excellence Manager~~	~~OC-41~~	~~COB~~	Remove Job Title
Process Excellence Manager II	OC-41	COB	New Position
Process Excellence Manager III	OC-41	COB	New Position
Process Excellence Manager IV	OC-41	COB	New Position
Program Manager	OC-06	COB	Unchanged
Program Manager, Sr.	OC-06	COB	Unchanged
~~Project Manager~~	~~OC-06~~	~~COB~~	Remove Job Title
~~Project Manager, Lead~~	~~OC-06~~	~~COB~~	Remove Job Title
~~Project Manager, Sr.~~	~~OC-06~~	~~COB~~	Remove Job Title
Project Manager II	OC-O6	COB	New Position
Project Manager III	OC-O6	COB	New Position
Project Manager IV	OC-O6	COB	New Position
QI Nurse Specialist (RN or LVN)	OC-06	COB	Unchanged

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Position	Disclosure Category	Files With	Status
Records Manager	OC-06	COB	Unchanged
Regulatory Affairs and Compliance Analyst	OC-41	COB	Unchanged
Regulatory Affairs and Compliance Analyst, Sr.	OC-41	COB	Unchanged
Regulatory Affairs and Compliance, Lead	OC-41	COB	Unchanged
RN (PACE)	OC-41	COB	Unchanged
Sr Director	OC-01	COB	Unchanged
Sr Manager I	OC-01	COB	Unchanged
Sr Manager II	OC-01	COB	Unchanged
Sr Manager III	OC-01	COB	Unchanged
Sr Manager IV	OC-01	COB	Unchanged
Supervisor, Accounting	OC-01	COB	Unchanged
Supervisor, Audit and Oversight	OC-01	COB	Unchanged
Supervisor, Behavioral Health	OC-41	COB	Unchanged
Supervisor, Budgeting	OC-01	COB	Unchanged
Supervisor, Case Management	OC-41	COB	Unchanged
Supervisor, Claims	OC-06	COB	Unchanged
Supervisor, Coding Initiatives	OC-06	COB	Unchanged
Supervisor, Credentialing	OC-41	COB	Unchanged
Supervisor, Customer Service	OC-06	COB	Unchanged
Supervisor, Data Entry	OC-06	COB	Unchanged
Supervisor, Day Center (PACE)	OC-06	COB	Unchanged
Supervisor, Dietary Services (PACE)	OC-41	COB	Unchanged
Supervisor, Encounters	OC-06	COB	Unchanged
Supervisor, Facilities	OC-41	COB	Unchanged
Supervisor, Finance	OC-01	COB	Unchanged
Supervisor, Grievance and Appeals	OC-41	COB	Unchanged
Supervisor, Information Technology Services	OC-08	COB	Unchanged
Supervisor, Long Term Support Services	OC-41	COB	Unchanged
Supervisor, Member Outreach and Education	OC-06	COB	Unchanged
Supervisor, MSSP	OC-06	COB	Unchanged

Conflict of Interest Code
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Position	Disclosure Category	Files With	Status
Supervisor, Nursing Services (PACE)	OC-41	COB	Unchanged
Supervisor, OneCare Customer Service	OC-06	COB	Unchanged
Supervisor, Payroll	OC-06	COB	Unchanged
Supervisor, Pharmacist	OC-20	COB	Unchanged
Supervisor, Population Health Management	OC-41	COB	Unchanged
Supervisor, Provider Data Management Services	OC-06	COB	Unchanged
Supervisor, Provider Relations	OC-41	COB	Unchanged
Supervisor, Quality Analytics	OC-06	COB	Unchanged
Supervisor, Quality Improvement	OC-41	COB	Unchanged
Supervisor, Regulatory Affairs and Compliance	OC-41	COB	Unchanged
Supervisor, Social Work (PACE)	OC-41	COB	Unchanged
Supervisor, Therapy Services (PACE)	OC-41	COB	Unchanged
Supervisor, Utilization Management	OC-06	COB	Unchanged

Total: 1553

OFFICIALS WHO ARE SPECIFIED IN GOVERNMENT CODE SECTION 87200

Officials who are specified in Government Code section 87200 (including officials who manage public investments, as defined by 2 Cal. Code of Regs. § 18700.3 (b)), are NOT subject to the Agency's Conflict of Interest Code but are subject to the disclosure requirements of the Political Reform Act, Government Code section 87100, et seq. Gov't Code § 87203. These positions are listed here for informational purposes only.

The positions listed below are officials who are specified in Government Code section 87200:

Alternate Member of the Board of Directors	Files with	COB
Chief Executive Officer	Files with	COB
Chief Financial Officer	Files with	COB
Member of the Board of Directors	Files with	COB

The disclosure requirements for these positions are set forth in Government Code section 87200, et. seq. They require the disclosure of interests in real property in the agency's jurisdiction, as well as investments, business positions and sources of income (including gifts, loans and travel payments).

Disclosure Descriptions
EXHIBIT B

Entity: **Other Misc. Authorities, Districts and Commissions Agency:** **CalOptima Health**

Disclosure Category	Disclosure Description
87200 Filer	Form 87200 filers shall complete all schedules for Form 700 and disclose all reportable sources of income, interests in real property, investments and business positions in business entities, if applicable, pursuant to Government Code Section 87200 *et seq*...
OC-01	All interests in real property in Orange County, the authority or the District as applicable, as well as investments, business positions and sources of income (including gifts, loans and travel payments).
OC-06	All investments in, business positions with and income (including gifts, loans and travel payments) from sources that provide leased facilities and goods, supplies, equipment, vehicles, machinery or services (including training and consulting services) of the types used by the County Department, Authority or District, as applicable.
OC-08	All investments in, business positions with and income (including gifts, loans and travel payments) from sources that develop or provide computer hardware/software, voice data communications, or data processing goods, supplies, equipment, or services (including training and consulting services) used by the County Department, Authority or District, as applicable.
OC-11	All interests in real property in Orange County or located entirely or partly within the Authority or District boundaries as applicable, as well as investments in, business positions with and income (including gifts, loans and travel payments) from sources that are engaged in the supply of equipment related to recruitment, employment search & marketing, classification, training, or negotiation with personnel; employee benefits, and health and welfare benefits.
OC-13	All investments in, business positions with and income (including gifts, loans and travel payments) from sources that produce or provide promotional items for public outreach programs; present, facilitate, market or otherwise act as agent for media relations with regard to public relations; provide printing, copying, or mail services; or provide training for or development of customer service representatives.
OC-20	All investments in, business positions with and income (including gifts, loans and travel payments) from sources that provide pharmaceutical services, supplies, materials or equipment.

Disclosure Category	Disclosure Description
OC-30	Consultants shall be included in the list of designated employees and shall disclose pursuant to the broadest category in the code subject to the following limitation: The County Department Head/Director/General Manager/Superintendent/etc. may determine that a particular consultant, although a "designated position," is hired to perform a range of duties that is limited in scope and thus is not required to fully comply with the disclosure requirements in this section. Such written determination shall include a description of the consultant's duties and based upon that description, a statement of the extent of disclosure required. The determination of disclosure is a public record and shall be filed with the Form 700 and retained by the Filing Officer for public inspection.
OC-41	All interests in real property in Orange County, the District or Authority, as applicable, as well as investments in, business positions with and income (including gifts, loans and travel payments) from sources that provide services, supplies, materials, machinery, vehicles, or equipment (including training and consulting services) used by the County Department, Authority or District, as applicable.

Grand Total: 9

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Entity: Other Misc. Authorities, Districts and Commissions
Agency: CalOptima Health

Position	Disclosure Category	Files With
Associate Director I	OC-41	COB
Associate Director II	OC-41	COB
Associate Director III	OC-41	COB
Associate Director IV	OC-41	COB
Buyer	OC-01	COB
Buyer, Int.	OC-01	COB
Buyer, Sr.	OC-01	COB
Chief Compliance Officer	OC-01	COB
Chief Executive Officer	OC-01	COB
Chief Financial Officer	OC-01	COB
Chief Health Equity Officer	OC-01	COB
Chief Human Resources Officer	OC-01	COB
Chief Information Officer	OC-01	COB
Chief Medical Officer	OC-01	COB
Chief of Staff	OC-01	COB
Chief Operating Officer	OC-01	COB
Chief Strategy Officer	OC-01	COB
Clerk of the Board	OC-06	COB
Clinical Pharmacist	OC-20	COB
Consultant	OC-01	Agency
Contract Administrator	OC-06	COB
Contracts Manager	OC-06	COB
Contracts Manager, Sr.	OC-06	COB
Contracts Specialist	OC-06	COB
Contracts Specialist, Int.	OC-06	COB
Contracts Specialist, Sr.	OC-06	COB
Controller	OC-01	COB
Deputy Chief Medical Officer	OC-01	COB

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EXHIBIT A

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CalOptima Health Board of Directors

Position	Disclosure Category	Files With
Director I	OC-01	COB
Director II	OC-01	COB
Director III	OC-01	COB
Director IV	OC-01	COB
Enterprise Analytics Manager	OC-06	COB
Executive Director	OC-01	COB
Financial Analyst I	OC-01	COB
Financial Analyst II	OC-01	COB
Financial Analyst III	OC-01	COB
Financial Analyst IV	OC-01	COB
Financial Reporting Analyst	OC-01	COB
Litigation Support Specialist	OC-41	COB
Manager, Accounting	OC-01	COB
Manager, Actuary	OC-01	COB
Manager, Audit and Oversight	OC-01	COB
Manager, Behavioral Health	OC-41	COB
Manager, Business Integration	OC-06	COB
Manager, Case Management	OC-41	COB
Manager, Claims	OC-41	COB
Manager, Clinic Operations	OC-06	COB
Manager, Clinical Pharmacists	OC-20	COB
Manager, Coding Quality	OC-06	COB
Manager, Communications	OC-13	COB
Manager, Community Relations	OC-06	COB
Manager, Contracting	OC-41	COB
Manager, Creative Branding	OC-13	COB
Manager, Cultural & Linguistics	OC-06	COB
Manager, Customer Service	OC-41	COB
Manager, Electronic Business	OC-06	COB
Manager, Encounters	OC-06	COB

Conflict of Interest Code
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CalOptima Health Board of Directors

Position	Disclosure Category	Files With
Manager, Environmental Health & Safety	OC-06	COB
Manager, Finance	OC-01	COB
Manager, Financial Analysis	OC-01	COB
Manager, Government Affairs	OC-41	COB
Manager, Grievance and Appeals	OC-41	COB
Manager, Human Resources	OC-11	COB
Manager, Information Technology Services	OC-08	COB
Manager, Long Term Support Services	OC-41	COB
Manager, Marketing & Outreach	OC-06	COB
Manager, Marketing and Enrollment (PACE)	OC-06	COB
Manager, Member Liaison Program	OC-41	COB
Manager, Member Outreach & Education	OC-41	COB
Manager, MSSP	OC-41	COB
Manager, OneCare Clinical	OC-41	COB
Manager, OneCare Customer Service	OC-41	COB
Manager, Outreach & Enrollment	OC-41	COB
Manager, PACE Center	OC-41	COB
Manager, Population Health Management	OC-41	COB
Manager, Process Excellence	OC-41	COB
Manager, Program Implementation	OC-06	COB
Manager, Provider Data Management Services	OC-41	COB
Manager, Provider Network	OC-41	COB
Manager, Provider Relations	OC-41	COB
Manager, Purchasing	OC-01	COB
Manager, QI Initiatives	OC-41	COB
Manager, Quality Analytics	OC-06	COB
Manager, Quality Improvement	OC-41	COB
Manager, Regulatory Affairs and Compliance	OC-41	COB
Manager, Reporting & Financial Compliance	OC-01	COB
Manager, Strategic Development	OC-41	COB

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Approved December 01, 2022, by
CalOptima Health Board of Directors

Position	Disclosure Category	Files With
Manager, Utilization Management	OC-06	COB
Medical Case Manager	OC-41	COB
Medical Case Manager (LVN)	OC-41	COB
Medical Director	OC-01	COB
Medical Services Case Manager	OC-41	COB
Nurse Practitioner (PACE)	OC-41	COB
OneCare Operations Manager	OC-41	COB
Pharmacy Resident	OC-20	COB
Pharmacy Services Specialist	OC-20	COB
Pharmacy Services Specialist, Int.	OC-20	COB
Pharmacy Services Specialist, Sr.	OC-20	COB
Policy Advisor, Sr.	OC-41	COB
Principal Financial Analyst	OC-01	COB
Privacy Manager	OC-41	COB
Privacy Officer	OC-41	COB
Process Excellence Manager II	OC-41	COB
Process Excellence Manager III	OC-41	COB
Process Excellence Manager IV	OC-41	COB
Program Manager	OC-06	COB
Program Manager, Sr.	OC-06	COB
Project Manager II	OC-O6	COB
Project Manager III	OC-O6	COB
Project Manager IV	OC-O6	COB
QI Nurse Specialist (RN or LVN)	OC-06	COB
Records Manager	OC-06	COB
Regulatory Affairs and Compliance Analyst	OC-41	COB
Regulatory Affairs and Compliance Analyst, Sr.	OC-41	COB
Regulatory Affairs and Compliance, Lead	OC-41	COB
RN (PACE)	OC-41	COB
Sr Director	OC-01	COB

Conflict of Interest Code
EXHIBIT A

Approved December 01, 2022, by
CalOptima Health Board of Directors

Position	Disclosure Category	Files With
Sr Manager I	OC-01	COB
Sr Manager II	OC-01	COB
Sr Manager III	OC-01	COB
Sr Manager IV	OC-01	COB
Supervisor, Accounting	OC-01	COB
Supervisor, Audit and Oversight	OC-01	COB
Supervisor, Behavioral Health	OC-41	COB
Supervisor, Budgeting	OC-01	COB
Supervisor, Case Management	OC-41	COB
Supervisor, Claims	OC-06	COB
Supervisor, Coding Initiatives	OC-06	COB
Supervisor, Credentialing	OC-41	COB
Supervisor, Customer Service	OC-06	COB
Supervisor, Data Entry	OC-06	COB
Supervisor, Day Center (PACE)	OC-06	COB
Supervisor, Dietary Services (PACE)	OC-41	COB
Supervisor, Encounters	OC-06	COB
Supervisor, Facilities	OC-41	COB
Supervisor, Finance	OC-01	COB
Supervisor, Grievance and Appeals	OC-41	COB
Supervisor, Information Technology Services	OC-08	COB
Supervisor, Long Term Support Services	OC-41	COB
Supervisor, Member Outreach and Education	OC-06	COB
Supervisor, MSSP	OC-06	COB
Supervisor, Nursing Services (PACE)	OC-41	COB
Supervisor, OneCare Customer Service	OC-06	COB
Supervisor, Payroll	OC-06	COB
Supervisor, Pharmacist	OC-20	COB
Supervisor, Population Health Management	OC-41	COB
Supervisor, Provider Data Management Services	OC-06	COB

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Conflict of Interest Code
EXHIBIT A

Approved December 01, 2022, by
CalOptima Health Board of Directors

Position	Disclosure Category	Files With
Supervisor, Provider Relations	OC-41	COB
Supervisor, Quality Analytics	OC-06	COB
Supervisor, Quality Improvement	OC-41	COB
Supervisor, Regulatory Affairs and Compliance	OC-41	COB
Supervisor, Social Work (PACE)	OC-41	COB
Supervisor, Therapy Services (PACE)	OC-41	COB
Supervisor, Utilization Management	OC-06	COB

Total: 155

OFFICIALS WHO ARE SPECIFIED IN GOVERNMENT CODE SECTION 87200

Officials who are specified in Government Code section 87200 (including officials who manage public investments, as defined by 2 Cal. Code of Regs. § 18700.3 (b)), are NOT subject to the Agency's Conflict of Interest Code but are subject to the disclosure requirements of the Political Reform Act, Government Code section 87100, et seq. Gov't Code § 87203. These positions are listed here for informational purposes only.

The positions listed below are officials who are specified in Government Code section 87200:

Alternate Member of the Board of Directors	Files with	COB
Chief Executive Officer	Files with	COB
Chief Financial Officer	Files with	COB
Member of the Board of Directors	Files with	COB

The disclosure requirements for these positions are set forth in Government Code section 87200, et. seq. They require the disclosure of interests in real property in the agency's jurisdiction, as well as investments, business positions and sources of income (including gifts, loans and travel payments).

Disclosure Descriptions
EXHIBIT B

Entity: **Other Misc. Authorities, Districts and Commissions Agency:** **CalOptima Health**

Disclosure Category	Disclosure Description
87200 Filer	Form 87200 filers shall complete all schedules for Form 700 and disclose all reportable sources of income, interests in real property, investments and business positions in business entities, if applicable, pursuant to Government Code Section 87200 *et seq*...
OC-01	All interests in real property in Orange County, the authority or the District as applicable, as well as investments, business positions and sources of income (including gifts, loans and travel payments).
OC-06	All investments in, business positions with and income (including gifts, loans and travel payments) from sources that provide leased facilities and goods, supplies, equipment, vehicles, machinery or services (including training and consulting services) of the types used by the County Department, Authority or District, as applicable.
OC-08	All investments in, business positions with and income (including gifts, loans and travel payments) from sources that develop or provide computer hardware/software, voice data communications, or data processing goods, supplies, equipment, or services (including training and consulting services) used by the County Department, Authority or District, as applicable.
OC-11	All interests in real property in Orange County or located entirely or partly within the Authority or District boundaries as applicable, as well as investments in, business positions with and income (including gifts, loans and travel payments) from sources that are engaged in the supply of equipment related to recruitment, employment search & marketing, classification, training, or negotiation with personnel; employee benefits, and health and welfare benefits.
OC-13	All investments in, business positions with and income (including gifts, loans and travel payments) from sources that produce or provide promotional items for public outreach programs; present, facilitate, market or otherwise act as agent for media relations with regard to public relations; provide printing, copying, or mail services; or provide training for or development of customer service representatives.
OC-20	All investments in, business positions with and income (including gifts, loans and travel payments) from sources that provide pharmaceutical services, supplies, materials or equipment.

Disclosure Category	Disclosure Description
OC-30	Consultants shall be included in the list of designated employees and shall disclose pursuant to the broadest category in the code subject to the following limitation: The County Department Head/Director/General Manager/Superintendent/etc. may determine that a particular consultant, although a "designated position," is hired to perform a range of duties that is limited in scope and thus is not required to fully comply with the disclosure requirements in this section. Such written determination shall include a description of the consultant's duties and based upon that description, a statement of the extent of disclosure required. The determination of disclosure is a public record and shall be filed with the Form 700 and retained by the Filing Officer for public inspection.
OC-41	All interests in real property in Orange County, the District or Authority, as applicable, as well as investments in, business positions with and income (including gifts, loans and travel payments) from sources that provide services, supplies, materials, machinery, vehicles, or equipment (including training and consulting services) used by the County Department, Authority or District, as applicable.

Grand Total: 9

CalOptima Health Board Action Agenda Referral

Action To Be Taken December 1, 2022
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

15. Adopt Resolution No. 22-1201-05 Approving and Adopting Updated CalOptima Health Policy GA.8058: Salary Schedule and Authorize the Chief Executive Officer to Implement Changes to Executive Level Job Titles

Contacts

Michael Hunn, Chief Executive Officer, (657) 900-1481
Brigette Hoey, Chief Human Resources Officer, (714) 246-8405

Recommended Actions

1. Adopt Resolution No. 22-1201-05 approving updated CalOptima Health Policy GA.8058: Salary Schedule and Attachment A – CalOptima Health Annual Base Salary Schedule; and
2. Authorize the Chief Executive Officer to implement changes to chief positions with one (1) net increase to the total number of executive level positions.

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.

CalOptima Policy GA.8057 Compensation Program, sets forth the Compensation Administration Guidelines. Pursuant to this policy, additional positions at the level of the chief or executive director require approval by the Board. Currently, a total of nineteen (19) positions have been authorized by the Board at the level of chief (8 positions) and executive director (11 positions).

Discussion

CalOptima Health Policy GA.8058 Salary Schedule and Attachment A are presented with the proposed changes as follows, with pay grade minimums, midpoints, and maximums remaining unchanged:

Policy Section	Proposed Change	Rationale	Impact
Attachment A, throughout	Added 37 new job titles	Added job titles, including a Chief of Strategy Officer, to meet agency and program needs, including the support of the digital transformation effort and CalOptima Health's strategic plan	• Ability to better distinguish between job level and/or duties • Improved outlook for recruitment and retention • Implementing proposed changes on December 4, 2022 will coincide
	Revised 7 job titles	Revised to better reflect actual job responsibilities and distinguish between job levels/duties	

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Policy Section	Proposed Change	Rationale	Impact
	Revised 7 job title pay grades	Revised to maintain competitiveness in the labor market	with the start of a pay period for ease of administration.
	Removed 14 job titles	Removed job titles that are not being used or were combined with other job titles	

Fiscal Impact

The recommended action to revise GA.8058 to add and revise job titles and their associated pay grades has no additional fiscal impact in the current year. Staff will include updated administrative expenses in future operating budgets.

Staff projects current year budget savings within salaries and benefits under the CalOptima Health Fiscal Year (FY) 2022-23 Operating Budget are sufficient to cover projected expenses associated with the new chief position through June 30, 2023. Staff will include updated administrative expenses in future operating budgets.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. CalOptima Health Resolution No. 22-1201-05
2. Revised CalOptima Health Policy GA. 8058: Salary Schedule and Attachment A (redline and clean copies)
3. GA.8057: Compensation Program and Attachment A Compensation Administration Guidelines

/s/ Michael Hunn *11/23/2022*
Authorized Signature **Date**

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RESOLUTION NO. 22-1201-05

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 Bylaws of the Orange County Health Authority, dba CalOptima Health, provide that the Board of Directors shall adopt by resolution, and may from time to time amend, procedures, practices and policies for, inter alia, hiring employees, and managing personnel; and

WHEREAS, in 1994, the Board of Directors designated the Chief Executive Officer as the Appointing Authority with full power to hire and terminate CalOptima 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, California Code of Regulations, Title 2, Section 570.5, requires CalOptima Health to adopt a publicly available pay schedule that identifies the position title and pay rate for every employee position, and CalOptima Health regularly reviews CalOptima Health's salary schedule accordingly.

NOW, THEREFORE, BE IT RESOLVED:

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

- GA. 8058: Salary Schedule

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima Health this 1st day of December 2022.

AYES:
NOES:
ABSENT:
ABSTAIN:

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

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

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Policy:	GA.8058
Title:	**Salary Schedule**
Department:	CalOptima Health Administrative
Section:	Human Resources
CEO Approval:	*/s/*
Effective Date:	05/01/2014
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

A. This policy maintains a CalOptima Health Salary Schedule that lists all active job classifications including job title, salary grade, and salary ranges (minimum, midpoint, and maximum pay rate amounts).

B. This policy ensures the salary schedule is publicly available pursuant to the requirements of Title 2, California Code of Regulations (CCR) §570.5 so that employees who are members of the California Public Employees Retirement System (CalPERS) have their compensation considered qualified for pension calculation under CalPERS regulations.

II. POLICY

A. Pursuant to the requirements under Title 2, California Code of Regulations (CCR) §570.5, CalOptima Health has established the attached salary schedule for each CalOptima Health job position. In order for CalPERS member's pay rates to be credited by CalPERS, the Human Resources Department (HR) shall maintain a salary schedule that meets the following eight (8) separate criteria:

1. Approval and adoption by the governing body in accordance with requirements applicable to public meetings laws;

2. Identification of position titles for every employee position;

3. Listing of pay rate for each identified position, which may be stated as a single amount or as multiple amounts with a range;

4. Specifies the time base, including, but not limited to, whether the time base is hourly, daily, bi-weekly, monthly, bi-monthly, or annually;

5. Posted at the employer's office or immediately accessible and available for public review from the employer during normal business hours or posted on the employer's internet website;

6. Indicates the effective date and date of any revisions;

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7. Retained by the employer and available for public inspection for not less than five (5) years; and

8. Does not reference another document in lieu of disclosing the pay rate.

B. The Chief Executive Officer (CEO) is authorized and directed to take all steps necessary and proper to implement the salary schedule for all other employees not inconsistent therewith.

III. PROCEDURE

A. The Human Resources Department (HR) will ensure that the salary schedule meets the requirements above and is available at ~~CalOptima's~~CalOptima Health's offices, immediately accessible for public review during normal business hours and posted on ~~CalOptima's~~CalOptima Health's internal and external websites.

B. HR shall retain the salary schedule for not less than five (5) years.

C. HR shall review the salary schedule and provide recommendations to maintain the competitiveness of the salary schedule to market pay levels.

D. Any adjustments to the salary schedule will require the Executive Director of HR to make a recommendation to the CEO for approval, with the CEO taking the recommendation to the CalOptima Health Board of Directors for final approval. No changes to the salary schedule, or CEO compensation, shall be effective unless and until approved by the CalOptima Health Board of Directors.

IV. ATTACHMENT(S)

A. CalOptima Health- Annual Base Salary Schedule (Revised: ~~06/02~~12/01/2022)

V. REFERENCE(S)

A. Title 2, California Code of Regulations, §570.5

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors
08/07/2014	Regular Meeting of the CalOptima Board of Directors
11/06/2014	Regular Meeting of the CalOptima Board of Directors
12/04/2014	Regular Meeting of the CalOptima Board of Directors
03/05/2015	Regular Meeting of the CalOptima Board of Directors
06/04/2015	Regular Meeting of the CalOptima Board of Directors
10/01/2015	Regular Meeting of the CalOptima Board of Directors
12/03/2015	Regular Meeting of the CalOptima Board of Directors
03/03/2016	Regular Meeting of the CalOptima Board of Directors

Date	Meeting
06/02/2016	Regular Meeting of the CalOptima Board of Directors
08/04/2016	Regular Meeting of the CalOptima Board of Directors
09/01/2016	Regular Meeting of the CalOptima Board of Directors
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03/03/2022	Regular Meeting of the CalOptima Board of Directors
06/02/2022	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	05/01/2014	GA.8057	Compensation Program and Salary	Administrative
Revised	08/07/2014	GA.8057	Compensation Program and Salary	Administrative
Revised	11/06/2014	GA.8057	Compensation Program and Salary	Administrative
Revised	12/04/2014	GA.8057	Compensation Program and Salary	Administrative
Revised	03/05/2015	GA.8057	Compensation Program and Salary	Administrative
Revised	06/04/2015	GA.8058	Salary Schedule	Administrative
Revised	10/01/2015	GA.8058	Salary Schedule	Administrative
Revised	12/03/2015	GA.8058	Salary Schedule	Administrative
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Revised	11/03/2016	GA.8058	Salary Schedule	Administrative
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Revised	03/02/2017	GA.8058	Salary Schedule	Administrative

Action	Date	Policy	Policy Title	Program(s)
Revised	05/04/2017	GA.8058	Salary Schedule	Administrative
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Revised	08/03/2017	GA.8058	Salary Schedule	Administrative
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Revised	11/02/2017	GA.8058	Salary Schedule	Administrative
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Revised	08/05/2021	GA.8058	Salary Schedule	Administrative
Revised	09/02/2021	GA.8058	Salary Schedule	Administrative
Revised	03/03/2022	GA.8058	Salary Schedule	Administrative
Revised	06/02/2022	GA.8058	Salary Schedule	Administrative
Revised	TBD	GA.8058	Salary Schedule	Administrative

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IX. GLOSSARY

Not Applicable

Policy:	GA.8058
Title:	**Salary Schedule**
Department:	CalOptima Health Administrative
Section:	Human Resources
CEO Approval:	*/s/*
Effective Date:	05/01/2014
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

A. This policy maintains a CalOptima Health Salary Schedule that lists all active job classifications including job title, salary grade, and salary ranges (minimum, midpoint, and maximum pay rate amounts).

B. This policy ensures the salary schedule is publicly available pursuant to the requirements of Title 2, California Code of Regulations (CCR) §570.5 so that employees who are members of the California Public Employees Retirement System (CalPERS) have their compensation considered qualified for pension calculation under CalPERS regulations.

II. POLICY

A. Pursuant to the requirements under Title 2, California Code of Regulations (CCR) §570.5, CalOptima Health has established the attached salary schedule for each CalOptima Health job position. In order for CalPERS member's pay rates to be credited by CalPERS, the Human Resources Department (HR) shall maintain a salary schedule that meets the following eight (8) separate criteria:

1. Approval and adoption by the governing body in accordance with requirements applicable to public meetings laws;

2. Identification of position titles for every employee position;

3. Listing of pay rate for each identified position, which may be stated as a single amount or as multiple amounts with a range;

4. Specifies the time base, including, but not limited to, whether the time base is hourly, daily, bi-weekly, monthly, bi-monthly, or annually;

5. Posted at the employer's office or immediately accessible and available for public review from the employer during normal business hours or posted on the employer's internet website;

6. Indicates the effective date and date of any revisions;

7. Retained by the employer and available for public inspection for not less than five (5) years; and

8. Does not reference another document in lieu of disclosing the pay rate.

B. The Chief Executive Officer (CEO) is authorized and directed to take all steps necessary and proper to implement the salary schedule for all other employees not inconsistent therewith.

III. PROCEDURE

A. The Human Resources Department (HR) will ensure that the salary schedule meets the requirements above and is available at CalOptima Health's offices, immediately accessible for public review during normal business hours and posted on CalOptima Health's internal and external websites.

B. HR shall retain the salary schedule for not less than five (5) years.

C. HR shall review the salary schedule and provide recommendations to maintain the competitiveness of the salary schedule to market pay levels.

D. Any adjustments to the salary schedule will require the Executive Director of HR to make a recommendation to the CEO for approval, with the CEO taking the recommendation to the CalOptima Health Board of Directors for final approval. No changes to the salary schedule, or CEO compensation, shall be effective unless and until approved by the CalOptima Health Board of Directors.

IV. ATTACHMENT(S)

A. CalOptima Health- Annual Base Salary Schedule (Revised: 12/01/2022)

V. REFERENCE(S)

A. Title 2, California Code of Regulations, §570.5

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

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Action	Date	Policy	Policy Title	Program(s)
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Revised	09/02/2021	GA.8058	Salary Schedule	Administrative
Revised	03/03/2022	GA.8058	Salary Schedule	Administrative
Revised	06/02/2022	GA.8058	Salary Schedule	Administrative
Revised	TBD	GA.8058	Salary Schedule	Administrative

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IX. GLOSSARY

Not Applicable

CalOptima Health

Annual Base Salary Schedule - Revised: ~~June 02, 2022~~ December 1, 2022

To be implemented: ~~June 05, 2022~~ December 4, 2022

Job Title	Pay Grade	Job Code	Min	Proposed Min	Mid	Proposed Mid	Max	Proposed Max	For Approval
~~Accountant~~ Accountant I	H	39	$59,000		$71,850		$84,700		Change title
~~Accountant Int~~ Accountant II	~~I~~ J	634	~~$61,000~~	$65,000	~~$77,250~~	$82,550	~~$93,500~~	$100,100	Change title; Regrade job
Accountant IV	M	TBD		$85,000		$109,050		$133,100	Add title
~~Accountant Sr~~ Accountant III	K	68	$70,000		$88,900		$107,800		Change title
Accounting Clerk	D	334	$44,000		$53,900		$63,800		
Accounting Clerk Sr	E	680	$48,000		$58,100		$68,200		
Activity Coordinator (PACE)	E	681	$48,000		$58,100		$68,200		
Actuarial Analyst	K	558	$70,000		$88,900		$107,800		
Actuarial Analyst Sr	L	559	$77,000		$98,450		$119,900		
Actuary	O	357	$105,000		$134,450		$163,900		
Actuary Principal	Q	882	$130,000		$166,200		$202,400		
Actuary Sr	P	883	$117,000		$149,250		$181,500		
Administrative Assistant	D	19	$44,000		$53,900		$63,800		
Administrative Fellow	J	902	$65,000		$82,550		$100,100		
Analyst	H	562	$59,000		$71,850		$84,700		
Analyst Int	I	563	$61,000		$77,250		$93,500		
Analyst Sr	J	564	$65,000		$82,550		$100,100		
Applications Analyst	I	232	$61,000		$77,250		$93,500		
Applications Analyst Int	J	233	$65,000		$82,550		$100,100		
Applications Analyst Sr	L	298	$77,000		$98,450		$119,900		
Associate Director I	P	884	$117,000		$149,250		$181,500		
Associate Director II	Q	885	$130,000		$166,200		$202,400		
Associate Director III	R	886	$144,000		$184,200		$224,400		
Associate Director IV	S	887	$154,000		$204,600		$255,200		
Auditor	I	565	$61,000		$77,250		$93,500		
Auditor Sr	J	566	$65,000		$82,550		$100,100		
Batch Automation Analyst	J	TBD		$65,000		$82,550		$100,100	Add title
Batch Automation Analyst Sr	K	TBD		$70,000		$88,900		$107,800	Add title
Behavioral Health Manager	M	383	$85,000		$109,050		$133,100		
Biostatistics Manager	M	418	$85,000		$109,050		$133,100		
~~Board Services Specialist~~	~~E~~	~~435~~	~~$48,000~~		~~$58,100~~		~~$68,200~~		Remove title
Business Analyst	J	40	$65,000		$82,550		$100,100		
Business Analyst Sr	L	611	$77,000		$98,450		$119,900		
Business Systems Analyst Sr	K	69	$70,000		$88,900		$107,800		
Buyer	G	29	$55,000		$66,550		$78,100		
Buyer Int	~~H~~ I	49	~~$59,000~~	$61,000	~~$71,850~~	$77,250	~~$84,700~~	$93,500	Regrade job
Buyer Sr	~~I~~ L	67	~~$61,000~~	$77,000	~~$77,250~~	$98,450	~~$93,500~~	$119,900	Regrade job
Care Manager	K	657	$70,000		$88,900		$107,800		
Care Transition Intervention Coach (RN)	L	417	$77,000		$98,450		$119,900		
Certified Coder	H	399	$59,000		$71,850		$84,700		
Certified Coding Specialist	H	639	$59,000		$71,850		$84,700		
Certified Coding Specialist Sr	J	640	$65,000		$82,550		$100,100		
Change Control Administrator	I	499	$61,000		$77,250		$93,500		
Change Control Administrator Int	J	500	$65,000		$82,550		$100,100		
** Chief Compliance Officer	W	888	$313,000		$414,450		$515,900		
** Chief Executive Officer	Z	138	$560,000		$700,750		$841,500		
** Chief Financial Officer	X	134	$368,000		$487,600		$607,200		
** Chief Health Equity Officer	W	889	$313,000		$414,450		$515,900		
** Chief Human Resources Officer	W	890	$313,000		$414,450		$515,900		
** Chief Information Officer	W	131	$313,000		$414,450		$515,900		
** Chief Medical Officer	X	137	$368,000		$487,600		$607,200		
** Chief of Staff	U	692	$226,000		$298,900		$371,800		
** Chief Operating Officer	Y	136	$433,000		$573,450		$713,900		
** Chief Strategy Officer	W	TBD		$313,000		$414,450		$515,900	Add title
Claims - Lead	G	574	$55,000		$66,550		$78,100		
Claims Examiner	C	9	$43,281		$50,790		$58,300		
Claims Examiner - Lead	F	236	$51,000		$62,350		$73,700		
Claims Examiner Sr	E	20	$48,000		$58,100		$68,200		
Claims QA Analyst	F	28	$51,000		$62,350		$73,700		
Claims QA Analyst Sr	G	540	$55,000		$66,550		$78,100		
Claims Recovery Specialist	F	283	$51,000		$62,350		$73,700		
Claims Resolution Specialist	F	262	$51,000		$62,350		$73,700		
Clerk of the Board	O	59	$105,000		$134,450		$163,900		
Clinical Auditor	L	567	$77,000		$98,450		$119,900		
Clinical Auditor Sr	M	568	$85,000		$109,050		$133,100		
Clinical Documentation Specialist (RN)	M	641	$85,000		$109,050		$133,100		
Clinical Pharmacist	P	297	$117,000		$149,250		$181,500		
Clinical Systems Administrator	K	607	$70,000		$88,900		$107,800		
Clinical Trainer	M	903	$85,000		$109,050		$133,100		
Clinical Trainer (LVN)	L	904	$77,000		$98,450		$119,900		
Clinician (Behavioral Health)	K	513	$70,000		$88,900		$107,800		
Cloud Engineer	O	TBD		$105,000		$134,450		$163,900	Add title
Cloud Engineer Sr	P	TBD		$117,000		$149,250		$181,500	Add title
Communications Specialist	G	188	$55,000		$66,550		$78,100		
Communications Specialist - Lead	J	707	$65,000		$82,550		$100,100		
Communications Specialist Sr	H	708	$59,000		$71,850		$84,700		

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Annual Base Salary Schedule - Revised: ~~June 02, 2022~~ December 1, 2022

To be implemented: ~~June 05, 2022~~ December 4, 2022

	Job Title	Pay Grade	Job Code	Min	Proposed Min	Mid	Proposed Mid	Max	Proposed Max	For Approval
	Community Partner	G	575	$55,000		$66,550		$78,100		
	Community Partner Sr	H	612	$59,000		$71,850		$84,700		
	Community Relations Specialist	G	288	$55,000		$66,550		$78,100		
	Community Relations Specialist Sr	I	646	$61,000		$77,250		$93,500		
	Compliance Claims Auditor	G	222	$55,000		$66,550		$78,100		
	Compliance Claims Auditor Sr	H	279	$59,000		$71,850		$84,700		
	Contract Administrator	~~K~~ L	385	~~$70,000~~	$77,000	~~$88,900~~	$98,450	~~$107,800~~	$119,900	Regrade job
	Contracts Manager	M	207	$85,000		$109,050		$133,100		
	Contracts Manager Sr	N	683	$95,000		$120,650		$146,300		
	Contracts Specialist	I	257	$61,000		$77,250		$93,500		
	Contracts Specialist Int	J	469	$65,000		$82,550		$100,100		
	Contracts Specialist Sr	K	331	$70,000		$88,900		$107,800		
*	Controller	T	464	$182,000		$240,600		$299,200		
	Credentialing Coordinator	E	41	$48,000		$58,100		$68,200		
	Credentialing Coordinator - Lead	F	510	$51,000		$62,350		$73,700		
	Customer Service Coordinator	E	182	$48,000		$58,100		$68,200		
	Customer Service Rep	C	5	$43,281		$50,790		$58,300		
	Customer Service Rep - Lead	~~E~~ G	482	~~$48,000~~	$55,000	~~$58,100~~	$66,550	~~$68,200~~	$78,100	Regrade job
	Customer Service Rep Sr	D	481	$44,000		$53,900		$63,800		
	Cybersecurity Analyst	I	TBD		$61,000		$77,250		$93,500	Add title
	Cybersecurity Engineer	O	TBD		$105,000		$134,450		$163,900	Add title
	Cybersecurity Engineer Sr	Q	TBD		$130,000		$166,200		$202,400	Add title
	Cybersecurity Principal	S	TBD		$154,000		$204,600		$255,200	Add title
	Data Analyst	J	337	$65,000		$82,550		$100,100		
	Data Analyst Int	K	341	$70,000		$88,900		$107,800		
	Data Analyst Sr	L	342	$77,000		$98,450		$119,900		
	Data and Reporting Analyst - Lead	M	654	$85,000		$109,050		$133,100		
	Data Entry Tech	A	3	$41,600		$46,100		$50,600		
	Data Warehouse Architect	N	363	$95,000		$120,650		$146,300		
	Data Warehouse Programmer/Analyst	N	364	$95,000		$120,650		$146,300		
	Data Warehouse Reporting Analyst	M	412	$85,000		$109,050		$133,100		
	Data Warehouse Reporting Analyst Sr	N	522	$95,000		$120,650		$146,300		
	Database Administrator	L	90	$77,000		$98,450		$119,900		
	Database Administrator Sr	N	179	$95,000		$120,650		$146,300		
**	Deputy Chief Medical Officer	W	561	$313,000		$414,450		$515,900		
	~~Deputy Clerk of the Board~~	~~K~~	~~684~~	~~$70,000~~		~~$88,900~~		~~$107,800~~		Remove title
	Designer	K	387	$70,000		$88,900		$107,800		
	Designer Sr	L	901	$77,000		$98,450		$119,900		
*	Director I	Q	891	$130,000		$166,200		$202,400		
*	Director II	R	892	$144,000		$184,200		$224,400		
*	Director III	S	893	$154,000		$204,600		$255,200		
*	Director IV	T	894	$182,000		$240,600		$299,200		
	Enrollment Coordinator (PACE)	F	441	$51,000		$62,350		$73,700		
	Enterprise Analytics Manager	O	582	$105,000		$134,450		$163,900		
	Executive Administrative Services Manager	J	661	$65,000		$82,550		$100,100		
	Executive Assistant	G	339	$55,000		$66,550		$78,100		
	Executive Assistant to CEO	I	261	$61,000		$77,250		$93,500		
**	Executive Director	U	895	$226,000		$298,900		$371,800		
	Facilities & Support Services Coord - Lead	G	631	$55,000		$66,550		$78,100		
	Facilities & Support Services Coordinator	E	10	$48,000		$58,100		$68,200		
	Facilities & Support Services Coordinator Sr	F	511	$51,000		$62,350		$73,700		
	Facilities Coordinator	E	438	$48,000		$58,100		$68,200		
	Financial Analyst I	J	51	$65,000		$82,550		$100,100		
	Financial Analyst II	L	84	$77,000		$98,450		$119,900		
	Financial Analyst III	M	905	$85,000		$109,050		$133,100		
	Financial Analyst IV	N	906	$95,000		$120,650		$146,300		
	Financial Reporting Analyst	I	475	$61,000		$77,250		$93,500		
	Grievance & Appeals Nurse Specialist	M	226	$85,000		$109,050		$133,100		
	Grievance Resolution Specialist	F	42	$51,000		$62,350		$73,700		
	Grievance Resolution Specialist - Lead	I	590	$61,000		$77,250		$93,500		
	Grievance Resolution Specialist Sr	H	589	$59,000		$71,850		$84,700		
	Health Coach	K	556	$70,000		$88,900		$107,800		
	Health Educator	H	47	$59,000		$71,850		$84,700		
	Health Educator Sr	I	355	$61,000		$77,250		$93,500		
	Health Network Liaison Specialist (RN)	L	524	$77,000		$98,450		$119,900		
	Health Network Oversight Specialist	K	323	$70,000		$88,900		$107,800		
	HEDIS Case Manager	M	443	$85,000		$109,050		$133,100		
	~~Help Desk Technician~~ Service Desk Technician	E	571	$48,000		$58,100		$68,200		Change title
	~~Help Desk Technician Sr~~ Service Desk Technician Sr	F	573	$51,000		$62,350		$73,700		Change title
	Human Resources Assistant	D	181	$44,000		$53,900		$63,800		
	Human Resources Business Partner	M	584	$85,000		$109,050		$133,100		
	Human Resources Coordinator	F	316	$51,000		$62,350		$73,700		
	Human Resources Representative	J	278	$65,000		$82,550		$100,100		
	Human Resources Representative Sr	L	350	$77,000		$98,450		$119,900		
	Human Resources Specialist	G	505	$55,000		$66,550		$78,100		
	Human Resources Specialist Sr	H	608	$59,000		$71,850		$84,700		

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Annual Base Salary Schedule - Revised: ~~June 02, 2022~~ December 1, 2022

To be implemented: ~~June 05, 2022~~ December 4, 2022

Job Title	Pay Grade	Job Code	Min	Proposed Min	Mid	Proposed Mid	Max	Proposed Max	For Approval
Information Technology Services Coordinator	E	365	$48,000		$58,100		$68,200		
~~Information Technology Services Project Manager~~	~~N~~	~~424~~	~~$95,000~~		~~$120,650~~		~~$146,300~~		Remove title
~~Information Technology Services Project Manager Sr~~	~~O~~	~~509~~	~~$105,000~~		~~$134,450~~		~~$163,900~~		Remove title
~~Information Technology Services Project Specialist~~	~~K~~	~~549~~	~~$70,000~~		~~$88,900~~		~~$107,800~~		Remove title
~~Information Technology Services Project Specialist Sr~~	~~L~~	~~550~~	~~$77,000~~		~~$98,450~~		~~$119,900~~		Remove title
~~Infrastructure Systems Administrator~~	~~F~~	~~541~~	~~$51,000~~		~~$62,350~~		~~$73,700~~		Remove title
~~Infrastructure Systems Administrator Int~~	~~G~~	~~542~~	~~$55,000~~		~~$66,550~~		~~$78,100~~		Remove title
Inpatient Quality Coding Auditor	I	642	$61,000		$77,250		$93,500		
Intern	A	237	$41,600		$46,100		$50,600		
Investigator Sr	I	553	$61,000		$77,250		$93,500		
ITS Analyst	I	TBD		$61,000		$77,250		$93,500	Add title
ITS Analyst Int	L	TBD		$77,000		$98,450		$119,900	Add title
ITS Analyst Sr	N	TBD		$95,000		$120,650		$146,300	Add title
ITS Architect II	O	TBD		$105,000		$134,450		$163,900	Add title
ITS Architect III	P	TBD		$117,000		$149,250		$181,500	Add title
ITS Architect IV	Q	TBD		$130,000		$166,200		$202,400	Add title
ITS Developer Advisor	O	TBD		$105,000		$134,450		$163,900	Add title
ITS Product Manager	N	TBD		$95,000		$120,650		$146,300	Add title
ITS Product Manager Sr	O	TBD		$105,000		$134,450		$163,900	Add title
Kitchen Assistant	A	585	$41,600		$46,100		$50,600		
Licensed Clinical Social Worker	J	598	$65,000		$82,550		$100,100		
Litigation Support Specialist	K	588	$70,000		$88,900		$107,800		
LVN (PACE)	K	533	$70,000		$88,900		$107,800		
LVN Specialist	K	686	$70,000		$88,900		$107,800		
Mailroom Clerk	A	1	$41,600		$46,100		$50,600		
Manager Accounting	O	98	$105,000		$134,450		$163,900		
Manager Actuary	R	453	$144,000		$184,200		$224,400		
Manager Audit & Oversight	O	539	$105,000		$134,450		$163,900		
Manager Behavioral Health	O	633	$105,000		$134,450		$163,900		
Manager Business Integration	O	544	$105,000		$134,450		$163,900		
Manager Case Management	P	270	$117,000		$149,250		$181,500		
Manager Claims	O	92	$105,000		$134,450		$163,900		
Manager Clinic Operations	N	551	$95,000		$120,650		$146,300		
Manager Clinical Pharmacist	R	296	$144,000		$184,200		$224,400		
Manager Coding Quality	N	382	$95,000		$120,650		$146,300		
Manager Communications	N	398	$95,000		$120,650		$146,300		
Manager Community Relations	N	384	$95,000		$120,650		$146,300		
Manager Contracting	O	329	$105,000		$134,450		$163,900		
Manager Creative Branding	M	430	$85,000		$109,050		$133,100		
Manager Cultural & Linguistic	M	349	$85,000		$109,050		$133,100		
Manager Customer Service	M	94	$85,000		$109,050		$133,100		
Manager Electronic Business	N	422	$95,000		$120,650		$146,300		
Manager Encounters	N	516	$95,000		$120,650		$146,300		
Manager Environmental Health & Safety	N	495	$95,000		$120,650		$146,300		
Manager Finance	O	148	$105,000		$134,450		$163,900		
Manager Financial Analysis	P	356	$117,000		$149,250		$181,500		
Manager Government Affairs	N	437	$95,000		$120,650		$146,300		
Manager Grievance & Appeals	O	426	$105,000		$134,450		$163,900		
Manager Human Resources	O	526	$105,000		$134,450		$163,900		
Manager Information Technology Services	P	560	$117,000		$149,250		$181,500		
Manager Long Term Support Services	O	200	$105,000		$134,450		$163,900		
Manager Marketing & Enrollment (PACE)	N	414	$95,000		$120,650		$146,300		
Manager Marketing & Outreach	M	687	$85,000		$109,050		$133,100		
Manager Member Liaison Program	M	354	$85,000		$109,050		$133,100		
Manager Member Outreach & Education	M	616	$85,000		$109,050		$133,100		
Manager MSSP	O	393	$105,000		$134,450		$163,900		
Manager OneCare Clinical	P	359	$117,000		$149,250		$181,500		
Manager OneCare Customer Service	M	429	$85,000		$109,050		$133,100		
Manager Outreach & Enrollment	M	477	$85,000		$109,050		$133,100		
Manager PACE Center	N	432	$95,000		$120,650		$146,300		
Manager Population Health Management	N	674	$95,000		$120,650		$146,300		
Manager Process Excellence	O	622	$105,000		$134,450		$163,900		
Manager Program Implementation	N	488	$95,000		$120,650		$146,300		
Manager Provider Data Management Services	M	653	$85,000		$109,050		$133,100		
Manager Provider Network	O	191	$105,000		$134,450		$163,900		
Manager Provider Relations	M	171	$85,000		$109,050		$133,100		
Manager Purchasing	O	275	$105,000		$134,450		$163,900		
Manager QI Initiatives	M	433	$85,000		$109,050		$133,100		
Manager Quality Analytics	N	617	$95,000		$120,650		$146,300		
Manager Quality Improvement	N	104	$95,000		$120,650		$146,300		
Manager Regulatory Affairs and Compliance	O	626	$105,000		$134,450		$163,900		
Manager Reporting & Financial Compliance	O	572	$105,000		$134,450		$163,900		
Manager Strategic Development	O	603	$105,000		$134,450		$163,900		
Manager Utilization Management	P	250	$117,000		$149,250		$181,500		
Marketing and Outreach Specialist	F	496	$51,000		$62,350		$73,700		
Medical Assistant	C	535	$43,281		$50,790		$58,300		

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To be implemented: ~~June 05, 2022~~ December 4, 2022

	Job Title	Pay Grade	Job Code	Min	Proposed Min	Mid	Proposed Mid	Max	Proposed Max	For Approval
	Medical Authorization Asst	C	11	$43,281		$50,790		$58,300		
	Medical Case Manager	L	72	$77,000		$98,450		$119,900		
	Medical Case Manager (LVN)	K	444	$70,000		$88,900		$107,800		
*	Medical Director	V	306	$266,000		$351,900		$437,800		
	Medical Records & Health Plan Assistant	B	548	$42,432		$48,716		$55,000		
	Medical Records Clerk	B	523	$42,432		$48,716		$55,000		
	Medical Services Case Manager	G	54	$55,000		$66,550		$78,100		
	Member Liaison Specialist	D	353	$44,000		$53,900		$63,800		
	MMS Program Coordinator	G	360	$55,000		$66,550		$78,100		
	Network Engineer	N	TBD		$95,000		$120,650		$146,300	Add title
	Network Engineer Principal	Q	TBD		$130,000		$166,200		$202,400	Add title
	Network Engineer Sr	O	TBD		$105,000		$134,450		$163,900	Add title
	Nurse Practitioner (PACE)	O	635	$105,000		$134,450		$163,900		
	Occupational Therapist	L	531	$77,000		$98,450		$119,900		
	Occupational Therapist Assistant	H	623	$59,000		$71,850		$84,700		
	Office Clerk	A	335	$41,600		$46,100		$50,600		
	OneCare Operations Manager	N	461	$95,000		$120,650		$146,300		
	OneCare Partner - Sales	F	230	$51,000		$62,350		$73,700		
	OneCare Partner - Sales (Lead)	G	537	$55,000		$66,550		$78,100		
	OneCare Partner - Service	C	231	$43,281		$50,790		$58,300		
	OneCare Partner (Inside Sales)	E	371	$48,000		$58,100		$68,200		
	Outreach Specialist	C	218	$43,281		$50,790		$58,300		
	Paralegal/Legal Secretary	I	376	$61,000		$77,250		$93,500		
	Payroll Specialist	E	554	$48,000		$58,100		$68,200		
	Payroll Specialist Sr	G	688	$55,000		$66,550		$78,100		
	Performance Analyst	I	538	$61,000		$77,250		$93,500		
	Personal Care Attendant	A	485	$41,600		$46,100		$50,600		
	Personal Care Attendant - Lead	B	498	$42,432		$48,716		$55,000		
	Personal Care Coordinator	C	525	$43,281		$50,790		$58,300		
	Personal Care Coordinator Sr	D	689	$44,000		$53,900		$63,800		
	Pharmacy Resident	G	379	$55,000		$66,550		$78,100		
	Pharmacy Services Specialist	C	23	$43,281		$50,790		$58,300		
	Pharmacy Services Specialist Int	D	35	$44,000		$53,900		$63,800		
	Pharmacy Services Specialist Sr	E	507	$48,000		$58,100		$68,200		
	Physical Therapist	L	530	$77,000		$98,450		$119,900		
	Physical Therapist Assistant	H	624	$59,000		$71,850		$84,700		
	Policy Advisor Sr	M	580	$85,000		$109,050		$133,100		
	Principal Financial Analyst	O	907	$105,000		$134,450		$163,900		
	Privacy Manager	N	536	$95,000		$120,650		$146,300		
	Privacy Officer	O	648	$105,000		$134,450		$163,900		
	~~Process Excellence Manager~~	~~N~~	~~529~~	~~$95,000~~		~~$120,650~~		~~$146,300~~		Remove title
	Process Excellence Manager I	H	TBD		$59,000		$71,850		$84,700	Add title
	Process Excellence Manager II	J	TBD		$65,000		$82,550		$100,100	Add title
	Process Excellence Manager III	M	TBD		$85,000		$109,050		$133,100	Add title
	Process Excellence Manager IV	O	TBD		$105,000		$134,450		$163,900	Add title
	Program Assistant	C	24	$43,281		$50,790		$58,300		
	Program Coordinator	C	284	$43,281		$50,790		$58,300		
	Program Development Analyst Sr	K	492	$70,000		$88,900		$107,800		
	Program Manager	L	421	$77,000		$98,450		$119,900		
	Program Manager Sr	M	594	$85,000		$109,050		$133,100		
	Program Specialist	E	36	$48,000		$58,100		$68,200		
	Program Specialist Int	G	61	$55,000		$66,550		$78,100		
	Program Specialist Sr	I	508	$61,000		$77,250		$93,500		
	Program/Policy Analyst	I	56	$61,000		$77,250		$93,500		
	Program/Policy Analyst Sr	K	85	$70,000		$88,900		$107,800		
	Programmer	K	43	$70,000		$88,900		$107,800		
	Programmer Int	M	74	$85,000		$109,050		$133,100		
	Programmer Sr	N	80	$95,000		$120,650		$146,300		
	~~Project Manager~~	~~L~~	~~81~~	~~$77,000~~		~~$98,450~~		~~$119,900~~		Remove title
	~~Project Manager - Lead~~	~~M~~	~~467~~	~~$85,000~~		~~$109,050~~		~~$133,100~~		Remove title
	Project Manager I	I	TBD		$61,000		$77,250		$93,500	Add title
	Project Manager II	L	TBD		$77,000		$98,450		$119,900	Add title
	Project Manager III	O	TBD		$105,000		$134,450		$163,900	Add title
	Project Manager IV	P	TBD		$117,000		$149,250		$181,500	Add title
	~~Project Manager Sr~~	~~N~~	~~105~~	~~$95,000~~		~~$120,650~~		~~$146,300~~		Remove title
	Project Specialist	E	291	$48,000		$58,100		$68,200		
	~~Project Specialist Sr~~	~~I~~	~~503~~	~~$61,000~~		~~$77,250~~		~~$93,500~~		Remove title
	~~Projects Analyst~~	~~G~~	~~254~~	~~$55,000~~		~~$66,550~~		~~$78,100~~		Remove title
	Provider Data Management Services Coordinator	D	12	$44,000		$53,900		$63,800		
	Provider Data Management Services Coordinator Sr	F	586	$51,000		$62,350		$73,700		
	Provider Enrollment Manager	G	190	$55,000		$66,550		$78,100		
	Provider Network Rep Sr	I	391	$61,000		$77,250		$93,500		
	Provider Network Specialist	H	44	$59,000		$71,850		$84,700		
	Provider Network Specialist Sr	J	595	$65,000		$82,550		$100,100		
	Provider Office Education Manager	I	300	$61,000		$77,250		$93,500		
	Provider Relations Rep	G	205	$55,000		$66,550		$78,100		

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CalOptima Health

Annual Base Salary Schedule - Revised: ~~June 02, 2022~~ December 1, 2022

To be implemented: ~~June 05, 2022~~ December 4, 2022

	Job Title	Pay Grade	Job Code	Min	Proposed Min	Mid	Proposed Mid	Max	Proposed Max	For Approval
	Provider Relations Rep Sr	I	285	$61,000		$77,250		$93,500		
	Publications Coordinator	G	293	$55,000		$66,550		$78,100		
	QA Analyst	I	486	$61,000		$77,250		$93,500		
	QA Analyst Sr	L	380	$77,000		$98,450		$119,900		
	QA Test Automation Engineer	J	TBD		$65,000		$82,550		$100,100	Add title
	QA Test Automation Engineer Advisor	O	TBD		$105,000		$134,450		$163,900	Add title
	QA Test Automation Engineer Sr.	N	TBD		$95,000		$120,650		$146,300	Add title
	QI Nurse Specialist	M	82	$85,000		$109,050		$133,100		
	QI Nurse Specialist (LVN)	L	445	$77,000		$98,450		$119,900		
	Receptionist	B	140	$42,432		$48,716		$55,000		
	Records Manager	Q	778	$130,000		$166,200		$202,400		
	Recreational Therapist	H	487	$59,000		$71,850		$84,700		
	Registered Dietitian	I	57	$61,000		$77,250		$93,500		
	Regulatory Affairs and Compliance - Lead	L	630	$77,000		$98,450		$119,900		
	Regulatory Affairs and Compliance Analyst	I	628	$61,000		$77,250		$93,500		
	Regulatory Affairs and Compliance Analyst Sr	K	629	$70,000		$88,900		$107,800		
	RN (PACE)	M	480	$85,000		$109,050		$133,100		
	Security Analyst Int	M	534	$85,000		$109,050		$133,100		
	Security Analyst Sr	N	474	$95,000		$120,650		$146,300		
	Security Officer	B	311	$42,432		$48,716		$55,000		
	SharePoint Developer/Administrator Sr	N	397	$95,000		$120,650		$146,300		
	Social Worker	J	463	$65,000		$82,550		$100,100		
	Social Worker Sr	K	690	$70,000		$88,900		$107,800		
	Speech Therapist	L	TBD		$77,000		$98,450		$119,900	Add title
*	Sr Director	T	896	$182,000		$240,600		$299,200		
	Sr Manager I	P	897	$117,000		$149,250		$181,500		
	Sr Manager II	Q	898	$130,000		$166,200		$202,400		
	Sr Manager III	R	899	$144,000		$184,200		$224,400		
	Sr Manager IV	S	900	$154,000		$204,600		$255,200		
	Supervisor Accounting	~~M~~ N	434	~~$85,000~~	$95,000	~~$109,050~~	$120,650	~~$133,100~~	$146,300	Regrade job
	Supervisor Audit and Oversight	M	618	$85,000		$109,050		$133,100		
	Supervisor Behavioral Health	M	659	$85,000		$109,050		$133,100		
	Supervisor Budgeting	N	466	$95,000		$120,650		$146,300		
	Supervisor Case Management	M	86	$85,000		$109,050		$133,100		
	Supervisor Claims	J	219	$65,000		$82,550		$100,100		
	Supervisor Coding Initiatives	M	502	$85,000		$109,050		$133,100		
	Supervisor Credentialing	I	671	$61,000		$77,250		$93,500		
	Supervisor Customer Service	I	34	$61,000		$77,250		$93,500		
	Supervisor Data Entry	H	192	$59,000		$71,850		$84,700		
	Supervisor Day Center (PACE)	H	619	$59,000		$71,850		$84,700		
	Supervisor Dietary Services (PACE)	J	643	$65,000		$82,550		$100,100		
	Supervisor Encounters	I	253	$61,000		$77,250		$93,500		
	Supervisor Facilities	J	162	$65,000		$82,550		$100,100		
	Supervisor Finance	~~M~~ N	419	~~$85,000~~	$95,000	~~$109,050~~	$120,650	~~$133,100~~	$146,300	Regrade job
	Supervisor Grievance and Appeals	L	620	$77,000		$98,450		$119,900		
	Supervisor Information Technology Services	N	457	$95,000		$120,650		$146,300		
	Supervisor Long Term Support Services	M	587	$85,000		$109,050		$133,100		
	Supervisor Member Outreach and Education	K	592	$70,000		$88,900		$107,800		
	Supervisor MSSP	M	348	$85,000		$109,050		$133,100		
	Supervisor Nursing Services (PACE)	M	662	$85,000		$109,050		$133,100		
	Supervisor OneCare Customer Service	I	408	$61,000		$77,250		$93,500		
	Supervisor Payroll	M	517	$85,000		$109,050		$133,100		
	Supervisor Pharmacist	Q	610	$130,000		$166,200		$202,400		
	Supervisor Population Health Management	M	673	$85,000		$109,050		$133,100		
	Supervisor Provider Data Management Services	K	439	$70,000		$88,900		$107,800		
	Supervisor Provider Relations	L	652	$77,000		$98,450		$119,900		
	Supervisor Quality Analytics	M	609	$85,000		$109,050		$133,100		
	Supervisor Quality Improvement	M	600	$85,000		$109,050		$133,100		
	Supervisor Regulatory Affairs and Compliance	M	627	$85,000		$109,050		$133,100		
	Supervisor Social Work (PACE)	J	636	$65,000		$82,550		$100,100		
	Supervisor Therapy Services (PACE)	M	645	$85,000		$109,050		$133,100		
	Supervisor Utilization Management	M	637	$85,000		$109,050		$133,100		
	~~Systems Network Administrator Int~~ ITS Administrator	L	63	$77,000		$98,450		$119,900		Change title
	~~Systems Network Administrator Sr~~ ITS Administrator Sr	M	89	$85,000		$109,050		$133,100		Change title
	Systems Operations Analyst	F	32	$51,000		$62,350		$73,700		
	Systems Operations Analyst Int	G	45	$55,000		$66,550		$78,100		
	Technical Analyst Int	J	64	$65,000		$82,550		$100,100		
	Technical Analyst Sr	L	75	$77,000		$98,450		$119,900		
	Technical Support Specialist Sr	I	TBD		$61,000		$77,250		$93,500	Add title
	Telephony Engineer	N	TBD		$95,000		$120,650		$146,300	Add title
	Telephony Engineer Sr	O	TBD		$105,000		$134,450		$163,900	Add title
	Therapy Aide	E	521	$48,000		$58,100		$68,200		
	Training Administrator	I	621	$61,000		$77,250		$93,500		
	Training Program Coordinator	H	471	$59,000		$71,850		$84,700		
	Translation Specialist	B	241	$42,432		$48,716		$55,000		
	Web Architect	N	366	$95,000		$120,650		$146,300		

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Annual Base Salary Schedule - Revised: ~~June 02, 2022~~ December 1, 2022

To be implemented: ~~June 05, 2022~~ December 4, 2022

Job Title	Pay Grade	Job Code	Min	Proposed Min	Mid	Proposed Mid	Max	Proposed Max	For Approval

* These positions are identified for the purposes of CalOptima Health Policy GA. 8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution.

** These positions are identified for the purposes of CalOptima Health Policy GA. 8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution and are also Chief or Executive Director level positions.

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Annual Base Salary Schedule - Revised: December 1, 2022
To be implemented: December 4, 2022

	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Accountant I	H	39	$59,000	$71,850	$84,700
	Accountant II	J	634	$65,000	$82,550	$100,100
	Accountant III	K	68	$70,000	$88,900	$107,800
	Accountant IV	M	TBD	$85,000	$109,050	$133,100
	Accounting Clerk	D	334	$44,000	$53,900	$63,800
	Accounting Clerk Sr	E	680	$48,000	$58,100	$68,200
	Activity Coordinator (PACE)	E	681	$48,000	$58,100	$68,200
	Actuarial Analyst	K	558	$70,000	$88,900	$107,800
	Actuarial Analyst Sr	L	559	$77,000	$98,450	$119,900
	Actuary	O	357	$105,000	$134,450	$163,900
	Actuary Principal	Q	882	$130,000	$166,200	$202,400
	Actuary Sr	P	883	$117,000	$149,250	$181,500
	Administrative Assistant	D	19	$44,000	$53,900	$63,800
	Administrative Fellow	J	902	$65,000	$82,550	$100,100
	Analyst	H	562	$59,000	$71,850	$84,700
	Analyst Int	I	563	$61,000	$77,250	$93,500
	Analyst Sr	J	564	$65,000	$82,550	$100,100
	Applications Analyst	I	232	$61,000	$77,250	$93,500
	Applications Analyst Int	J	233	$65,000	$82,550	$100,100
	Applications Analyst Sr	L	298	$77,000	$98,450	$119,900
	Associate Director I	P	884	$117,000	$149,250	$181,500
	Associate Director II	Q	885	$130,000	$166,200	$202,400
	Associate Director III	R	886	$144,000	$184,200	$224,400
	Associate Director IV	S	887	$154,000	$204,600	$255,200
	Auditor	I	565	$61,000	$77,250	$93,500
	Auditor Sr	J	566	$65,000	$82,550	$100,100
	Batch Automation Analyst	J	TBD	$65,000	$82,550	$100,100
	Batch Automation Analyst Sr	K	TBD	$70,000	$88,900	$107,800
	Behavioral Health Manager	M	383	$85,000	$109,050	$133,100
	Biostatistics Manager	M	418	$85,000	$109,050	$133,100
	Business Analyst	J	40	$65,000	$82,550	$100,100
	Business Analyst Sr	L	611	$77,000	$98,450	$119,900
	Business Systems Analyst Sr	K	69	$70,000	$88,900	$107,800
	Buyer	G	29	$55,000	$66,550	$78,100
	Buyer Int	I	49	$61,000	$77,250	$93,500
	Buyer Sr	L	67	$77,000	$98,450	$119,900
	Care Manager	K	657	$70,000	$88,900	$107,800
	Care Transition Intervention Coach (RN)	L	417	$77,000	$98,450	$119,900
	Certified Coder	H	399	$59,000	$71,850	$84,700
	Certified Coding Specialist	H	639	$59,000	$71,850	$84,700
	Certified Coding Specialist Sr	J	640	$65,000	$82,550	$100,100
	Change Control Administrator	I	499	$61,000	$77,250	$93,500
	Change Control Administrator Int	J	500	$65,000	$82,550	$100,100
**	Chief Compliance Officer	W	888	$313,000	$414,450	$515,900
**	Chief Executive Officer	Z	138	$560,000	$700,750	$841,500
**	Chief Financial Officer	X	134	$368,000	$487,600	$607,200
**	Chief Health Equity Officer	W	889	$313,000	$414,450	$515,900

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Annual Base Salary Schedule - Revised: December 1, 2022
To be implemented: December 4, 2022

	Job Title	Pay Grade	Job Code	Min	Mid	Max
**	Chief Human Resources Officer	W	890	$313,000	$414,450	$515,900
**	Chief Information Officer	W	131	$313,000	$414,450	$515,900
**	Chief Medical Officer	X	137	$368,000	$487,600	$607,200
**	Chief of Staff	U	692	$226,000	$298,900	$371,800
**	Chief Operating Officer	Y	136	$433,000	$573,450	$713,900
**	Chief Strategy Officer	W	TBD	$313,000	$414,450	$515,900
	Claims - Lead	G	574	$55,000	$66,550	$78,100
	Claims Examiner	C	9	$43,281	$50,790	$58,300
	Claims Examiner - Lead	F	236	$51,000	$62,350	$73,700
	Claims Examiner Sr	E	20	$48,000	$58,100	$68,200
	Claims QA Analyst	F	28	$51,000	$62,350	$73,700
	Claims QA Analyst Sr	G	540	$55,000	$66,550	$78,100
	Claims Recovery Specialist	F	283	$51,000	$62,350	$73,700
	Claims Resolution Specialist	F	262	$51,000	$62,350	$73,700
	Clerk of the Board	O	59	$105,000	$134,450	$163,900
	Clinical Auditor	L	567	$77,000	$98,450	$119,900
	Clinical Auditor Sr	M	568	$85,000	$109,050	$133,100
	Clinical Documentation Specialist (RN)	M	641	$85,000	$109,050	$133,100
	Clinical Pharmacist	P	297	$117,000	$149,250	$181,500
	Clinical Systems Administrator	K	607	$70,000	$88,900	$107,800
	Clinical Trainer	M	903	$85,000	$109,050	$133,100
	Clinical Trainer (LVN)	L	904	$77,000	$98,450	$119,900
	Clinician (Behavioral Health)	K	513	$70,000	$88,900	$107,800
	Cloud Engineer	O	TBD	$105,000	$134,450	$163,900
	Cloud Engineer Sr	P	TBD	$117,000	$149,250	$181,500
	Communications Specialist	G	188	$55,000	$66,550	$78,100
	Communications Specialist - Lead	J	707	$65,000	$82,550	$100,100
	Communications Specialist Sr	H	708	$59,000	$71,850	$84,700
	Community Partner	G	575	$55,000	$66,550	$78,100
	Community Partner Sr	H	612	$59,000	$71,850	$84,700
	Community Relations Specialist	G	288	$55,000	$66,550	$78,100
	Community Relations Specialist Sr	I	646	$61,000	$77,250	$93,500
	Compliance Claims Auditor	G	222	$55,000	$66,550	$78,100
	Compliance Claims Auditor Sr	H	279	$59,000	$71,850	$84,700
	Contract Administrator	L	385	$77,000	$98,450	$119,900
	Contracts Manager	M	207	$85,000	$109,050	$133,100
	Contracts Manager Sr	N	683	$95,000	$120,650	$146,300
	Contracts Specialist	I	257	$61,000	$77,250	$93,500
	Contracts Specialist Int	J	469	$65,000	$82,550	$100,100
	Contracts Specialist Sr	K	331	$70,000	$88,900	$107,800
*	Controller	T	464	$182,000	$240,600	$299,200
	Credentialing Coordinator	E	41	$48,000	$58,100	$68,200
	Credentialing Coordinator - Lead	F	510	$51,000	$62,350	$73,700
	Customer Service Coordinator	E	182	$48,000	$58,100	$68,200
	Customer Service Rep	C	5	$43,281	$50,790	$58,300
	Customer Service Rep - Lead	G	482	$55,000	$66,550	$78,100
	Customer Service Rep Sr	D	481	$44,000	$53,900	$63,800

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Annual Base Salary Schedule - Revised: December 1, 2022
To be implemented: December 4, 2022

	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Cybersecurity Analyst	I	TBD	$61,000	$77,250	$93,500
	Cybersecurity Engineer	O	TBD	$105,000	$134,450	$163,900
	Cybersecurity Engineer Sr	Q	TBD	$130,000	$166,200	$202,400
	Cybersecurity Principal	S	TBD	$154,000	$204,600	$255,200
	Data Analyst	J	337	$65,000	$82,550	$100,100
	Data Analyst Int	K	341	$70,000	$88,900	$107,800
	Data Analyst Sr	L	342	$77,000	$98,450	$119,900
	Data and Reporting Analyst - Lead	M	654	$85,000	$109,050	$133,100
	Data Entry Tech	A	3	$41,600	$46,100	$50,600
	Data Warehouse Architect	N	363	$95,000	$120,650	$146,300
	Data Warehouse Programmer/Analyst	N	364	$95,000	$120,650	$146,300
	Data Warehouse Reporting Analyst	M	412	$85,000	$109,050	$133,100
	Data Warehouse Reporting Analyst Sr	N	522	$95,000	$120,650	$146,300
	Database Administrator	L	90	$77,000	$98,450	$119,900
	Database Administrator Sr	N	179	$95,000	$120,650	$146,300
**	Deputy Chief Medical Officer	W	561	$313,000	$414,450	$515,900
	Designer	K	387	$70,000	$88,900	$107,800
	Designer Sr	L	901	$77,000	$98,450	$119,900
*	Director I	Q	891	$130,000	$166,200	$202,400
*	Director II	R	892	$144,000	$184,200	$224,400
*	Director III	S	893	$154,000	$204,600	$255,200
*	Director IV	T	894	$182,000	$240,600	$299,200
	Enrollment Coordinator (PACE)	F	441	$51,000	$62,350	$73,700
	Enterprise Analytics Manager	O	582	$105,000	$134,450	$163,900
	Executive Administrative Services Manager	J	661	$65,000	$82,550	$100,100
	Executive Assistant	G	339	$55,000	$66,550	$78,100
	Executive Assistant to CEO	I	261	$61,000	$77,250	$93,500
**	Executive Director	U	895	$226,000	$298,900	$371,800
	Facilities & Support Services Coord - Lead	G	631	$55,000	$66,550	$78,100
	Facilities & Support Services Coordinator	E	10	$48,000	$58,100	$68,200
	Facilities & Support Services Coordinator Sr	F	511	$51,000	$62,350	$73,700
	Facilities Coordinator	E	438	$48,000	$58,100	$68,200
	Financial Analyst I	J	51	$65,000	$82,550	$100,100
	Financial Analyst II	L	84	$77,000	$98,450	$119,900
	Financial Analyst III	M	905	$85,000	$109,050	$133,100
	Financial Analyst IV	N	906	$95,000	$120,650	$146,300
	Financial Reporting Analyst	I	475	$61,000	$77,250	$93,500
	Grievance & Appeals Nurse Specialist	M	226	$85,000	$109,050	$133,100
	Grievance Resolution Specialist	F	42	$51,000	$62,350	$73,700
	Grievance Resolution Specialist - Lead	I	590	$61,000	$77,250	$93,500
	Grievance Resolution Specialist Sr	H	589	$59,000	$71,850	$84,700
	Health Coach	K	556	$70,000	$88,900	$107,800
	Health Educator	H	47	$59,000	$71,850	$84,700
	Health Educator Sr	I	355	$61,000	$77,250	$93,500
	Health Network Liaison Specialist (RN)	L	524	$77,000	$98,450	$119,900
	Health Network Oversight Specialist	K	323	$70,000	$88,900	$107,800
	HEDIS Case Manager	M	443	$85,000	$109,050	$133,100

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Annual Base Salary Schedule - Revised: December 1, 2022
To be implemented: December 4, 2022

Job Title	Pay Grade	Job Code	Min	Mid	Max
Human Resources Assistant	D	181	$44,000	$53,900	$63,800
Human Resources Business Partner	M	584	$85,000	$109,050	$133,100
Human Resources Coordinator	F	316	$51,000	$62,350	$73,700
Human Resources Representative	J	278	$65,000	$82,550	$100,100
Human Resources Representative Sr	L	350	$77,000	$98,450	$119,900
Human Resources Specialist	G	505	$55,000	$66,550	$78,100
Human Resources Specialist Sr	H	608	$59,000	$71,850	$84,700
Information Technology Services Coordinator	E	365	$48,000	$58,100	$68,200
Inpatient Quality Coding Auditor	I	642	$61,000	$77,250	$93,500
Intern	A	237	$41,600	$46,100	$50,600
Investigator Sr	I	553	$61,000	$77,250	$93,500
ITS Administrator	L	63	$77,000	$98,450	$119,900
ITS Administrator Sr	M	89	$85,000	$109,050	$133,100
ITS Analyst	I	TBD	$61,000	$77,250	$93,500
ITS Analyst Int	L	TBD	$77,000	$98,450	$119,900
ITS Analyst Sr	N	TBD	$95,000	$120,650	$146,300
ITS Architect II	O	TBD	$105,000	$134,450	$163,900
ITS Architect III	P	TBD	$117,000	$149,250	$181,500
ITS Architect IV	Q	TBD	$130,000	$166,200	$202,400
ITS Developer Advisor	O	TBD	$105,000	$134,450	$163,900
ITS Product Manager	N	TBD	$95,000	$120,650	$146,300
ITS Product Manager Sr	O	TBD	$105,000	$134,450	$163,900
Kitchen Assistant	A	585	$41,600	$46,100	$50,600
Licensed Clinical Social Worker	J	598	$65,000	$82,550	$100,100
Litigation Support Specialist	K	588	$70,000	$88,900	$107,800
LVN (PACE)	K	533	$70,000	$88,900	$107,800
LVN Specialist	K	686	$70,000	$88,900	$107,800
Mailroom Clerk	A	1	$41,600	$46,100	$50,600
Manager Accounting	O	98	$105,000	$134,450	$163,900
Manager Actuary	R	453	$144,000	$184,200	$224,400
Manager Audit & Oversight	O	539	$105,000	$134,450	$163,900
Manager Behavioral Health	O	633	$105,000	$134,450	$163,900
Manager Business Integration	O	544	$105,000	$134,450	$163,900
Manager Case Management	P	270	$117,000	$149,250	$181,500
Manager Claims	O	92	$105,000	$134,450	$163,900
Manager Clinic Operations	N	551	$95,000	$120,650	$146,300
Manager Clinical Pharmacist	R	296	$144,000	$184,200	$224,400
Manager Coding Quality	N	382	$95,000	$120,650	$146,300
Manager Communications	N	398	$95,000	$120,650	$146,300
Manager Community Relations	N	384	$95,000	$120,650	$146,300
Manager Contracting	O	329	$105,000	$134,450	$163,900
Manager Creative Branding	M	430	$85,000	$109,050	$133,100
Manager Cultural & Linguistic	M	349	$85,000	$109,050	$133,100
Manager Customer Service	M	94	$85,000	$109,050	$133,100
Manager Electronic Business	N	422	$95,000	$120,650	$146,300
Manager Encounters	N	516	$95,000	$120,650	$146,300
Manager Environmental Health & Safety	N	495	$95,000	$120,650	$146,300

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Annual Base Salary Schedule - Revised: December 1, 2022
To be implemented: December 4, 2022

	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Manager Finance	O	148	$105,000	$134,450	$163,900
	Manager Financial Analysis	P	356	$117,000	$149,250	$181,500
	Manager Government Affairs	N	437	$95,000	$120,650	$146,300
	Manager Grievance & Appeals	O	426	$105,000	$134,450	$163,900
	Manager Human Resources	O	526	$105,000	$134,450	$163,900
	Manager Information Technology Services	P	560	$117,000	$149,250	$181,500
	Manager Long Term Support Services	O	200	$105,000	$134,450	$163,900
	Manager Marketing & Enrollment (PACE)	N	414	$95,000	$120,650	$146,300
	Manager Marketing & Outreach	M	687	$85,000	$109,050	$133,100
	Manager Member Liaison Program	M	354	$85,000	$109,050	$133,100
	Manager Member Outreach & Education	M	616	$85,000	$109,050	$133,100
	Manager MSSP	O	393	$105,000	$134,450	$163,900
	Manager OneCare Clinical	P	359	$117,000	$149,250	$181,500
	Manager OneCare Customer Service	M	429	$85,000	$109,050	$133,100
	Manager Outreach & Enrollment	M	477	$85,000	$109,050	$133,100
	Manager PACE Center	N	432	$95,000	$120,650	$146,300
	Manager Population Health Management	N	674	$95,000	$120,650	$146,300
	Manager Process Excellence	O	622	$105,000	$134,450	$163,900
	Manager Program Implementation	N	488	$95,000	$120,650	$146,300
	Manager Provider Data Management Services	M	653	$85,000	$109,050	$133,100
	Manager Provider Network	O	191	$105,000	$134,450	$163,900
	Manager Provider Relations	M	171	$85,000	$109,050	$133,100
	Manager Purchasing	O	275	$105,000	$134,450	$163,900
	Manager QI Initiatives	M	433	$85,000	$109,050	$133,100
	Manager Quality Analytics	N	617	$95,000	$120,650	$146,300
	Manager Quality Improvement	N	104	$95,000	$120,650	$146,300
	Manager Regulatory Affairs and Compliance	O	626	$105,000	$134,450	$163,900
	Manager Reporting & Financial Compliance	O	572	$105,000	$134,450	$163,900
	Manager Strategic Development	O	603	$105,000	$134,450	$163,900
	Manager Utilization Management	P	250	$117,000	$149,250	$181,500
	Marketing and Outreach Specialist	F	496	$51,000	$62,350	$73,700
	Medical Assistant	C	535	$43,281	$50,790	$58,300
	Medical Authorization Asst	C	11	$43,281	$50,790	$58,300
	Medical Case Manager	L	72	$77,000	$98,450	$119,900
	Medical Case Manager (LVN)	K	444	$70,000	$88,900	$107,800
*	Medical Director	V	306	$266,000	$351,900	$437,800
	Medical Records & Health Plan Assistant	B	548	$42,432	$48,716	$55,000
	Medical Records Clerk	B	523	$42,432	$48,716	$55,000
	Medical Services Case Manager	G	54	$55,000	$66,550	$78,100
	Member Liaison Specialist	D	353	$44,000	$53,900	$63,800
	MMS Program Coordinator	G	360	$55,000	$66,550	$78,100
	Network Engineer	N	TBD	$95,000	$120,650	$146,300
	Network Engineer Principal	Q	TBD	$130,000	$166,200	$202,400
	Network Engineer Sr	O	TBD	$105,000	$134,450	$163,900
	Nurse Practitioner (PACE)	O	635	$105,000	$134,450	$163,900
	Occupational Therapist	L	531	$77,000	$98,450	$119,900
	Occupational Therapist Assistant	H	623	$59,000	$71,850	$84,700

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Job Title	Pay Grade	Job Code	Min	Mid	Max
Office Clerk	A	335	$41,600	$46,100	$50,600
OneCare Operations Manager	N	461	$95,000	$120,650	$146,300
OneCare Partner - Sales	F	230	$51,000	$62,350	$73,700
OneCare Partner - Sales (Lead)	G	537	$55,000	$66,550	$78,100
OneCare Partner - Service	C	231	$43,281	$50,790	$58,300
OneCare Partner (Inside Sales)	E	371	$48,000	$58,100	$68,200
Outreach Specialist	C	218	$43,281	$50,790	$58,300
Paralegal/Legal Secretary	I	376	$61,000	$77,250	$93,500
Payroll Specialist	E	554	$48,000	$58,100	$68,200
Payroll Specialist Sr	G	688	$55,000	$66,550	$78,100
Performance Analyst	I	538	$61,000	$77,250	$93,500
Personal Care Attendant	A	485	$41,600	$46,100	$50,600
Personal Care Attendant - Lead	B	498	$42,432	$48,716	$55,000
Personal Care Coordinator	C	525	$43,281	$50,790	$58,300
Personal Care Coordinator Sr	D	689	$44,000	$53,900	$63,800
Pharmacy Resident	G	379	$55,000	$66,550	$78,100
Pharmacy Services Specialist	C	23	$43,281	$50,790	$58,300
Pharmacy Services Specialist Int	D	35	$44,000	$53,900	$63,800
Pharmacy Services Specialist Sr	E	507	$48,000	$58,100	$68,200
Physical Therapist	L	530	$77,000	$98,450	$119,900
Physical Therapist Assistant	H	624	$59,000	$71,850	$84,700
Policy Advisor Sr	M	580	$85,000	$109,050	$133,100
Principal Financial Analyst	O	907	$105,000	$134,450	$163,900
Privacy Manager	N	536	$95,000	$120,650	$146,300
Privacy Officer	O	648	$105,000	$134,450	$163,900
Process Excellence Manager I	H	TBD	$59,000	$71,850	$84,700
Process Excellence Manager II	J	TBD	$65,000	$82,550	$100,100
Process Excellence Manager III	M	TBD	$85,000	$109,050	$133,100
Process Excellence Manager IV	O	TBD	$105,000	$134,450	$163,900
Program Assistant	C	24	$43,281	$50,790	$58,300
Program Coordinator	C	284	$43,281	$50,790	$58,300
Program Development Analyst Sr	K	492	$70,000	$88,900	$107,800
Program Manager	L	421	$77,000	$98,450	$119,900
Program Manager Sr	M	594	$85,000	$109,050	$133,100
Program Specialist	E	36	$48,000	$58,100	$68,200
Program Specialist Int	G	61	$55,000	$66,550	$78,100
Program Specialist Sr	I	508	$61,000	$77,250	$93,500
Program/Policy Analyst	I	56	$61,000	$77,250	$93,500
Program/Policy Analyst Sr	K	85	$70,000	$88,900	$107,800
Programmer	K	43	$70,000	$88,900	$107,800
Programmer Int	M	74	$85,000	$109,050	$133,100
Programmer Sr	N	80	$95,000	$120,650	$146,300
Project Manager I	I	TBD	$61,000	$77,250	$93,500
Project Manager II	L	TBD	$77,000	$98,450	$119,900
Project Manager III	O	TBD	$105,000	$134,450	$163,900
Project Manager IV	P	TBD	$117,000	$149,250	$181,500
Project Specialist	E	291	$48,000	$58,100	$68,200

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	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Provider Data Management Services Coordinator	D	12	$44,000	$53,900	$63,800
	Provider Data Management Services Coordinator Sr	F	586	$51,000	$62,350	$73,700
	Provider Enrollment Manager	G	190	$55,000	$66,550	$78,100
	Provider Network Rep Sr	I	391	$61,000	$77,250	$93,500
	Provider Network Specialist	H	44	$59,000	$71,850	$84,700
	Provider Network Specialist Sr	J	595	$65,000	$82,550	$100,100
	Provider Office Education Manager	I	300	$61,000	$77,250	$93,500
	Provider Relations Rep	G	205	$55,000	$66,550	$78,100
	Provider Relations Rep Sr	I	285	$61,000	$77,250	$93,500
	Publications Coordinator	G	293	$55,000	$66,550	$78,100
	QA Analyst	I	486	$61,000	$77,250	$93,500
	QA Analyst Sr	L	380	$77,000	$98,450	$119,900
	QA Test Automation Engineer	J	TBD	$65,000	$82,550	$100,100
	QA Test Automation Engineer Advisor	O	TBD	$105,000	$134,450	$163,900
	QA Test Automation Engineer Sr.	N	TBD	$95,000	$120,650	$146,300
	QI Nurse Specialist	M	82	$85,000	$109,050	$133,100
	QI Nurse Specialist (LVN)	L	445	$77,000	$98,450	$119,900
	Receptionist	B	140	$42,432	$48,716	$55,000
	Records Manager	Q	778	$130,000	$166,200	$202,400
	Recreational Therapist	H	487	$59,000	$71,850	$84,700
	Registered Dietitian	I	57	$61,000	$77,250	$93,500
	Regulatory Affairs and Compliance - Lead	L	630	$77,000	$98,450	$119,900
	Regulatory Affairs and Compliance Analyst	I	628	$61,000	$77,250	$93,500
	Regulatory Affairs and Compliance Analyst Sr	K	629	$70,000	$88,900	$107,800
	RN (PACE)	M	480	$85,000	$109,050	$133,100
	Security Analyst Int	M	534	$85,000	$109,050	$133,100
	Security Analyst Sr	N	474	$95,000	$120,650	$146,300
	Security Officer	B	311	$42,432	$48,716	$55,000
	Service Desk Technician	E	571	$48,000	$58,100	$68,200
	Service Desk Technician Sr	F	573	$51,000	$62,350	$73,700
	SharePoint Developer/Administrator Sr	N	397	$95,000	$120,650	$146,300
	Social Worker	J	463	$65,000	$82,550	$100,100
	Social Worker Sr	K	690	$70,000	$88,900	$107,800
	Speech Therapist	L	TBD	$77,000	$98,450	$119,900
*	Sr Director	T	896	$182,000	$240,600	$299,200
	Sr Manager I	P	897	$117,000	$149,250	$181,500
	Sr Manager II	Q	898	$130,000	$166,200	$202,400
	Sr Manager III	R	899	$144,000	$184,200	$224,400
	Sr Manager IV	S	900	$154,000	$204,600	$255,200
	Supervisor Accounting	N	434	$95,000	$120,650	$146,300
	Supervisor Audit and Oversight	M	618	$85,000	$109,050	$133,100
	Supervisor Behavioral Health	M	659	$85,000	$109,050	$133,100
	Supervisor Budgeting	N	466	$95,000	$120,650	$146,300
	Supervisor Case Management	M	86	$85,000	$109,050	$133,100
	Supervisor Claims	J	219	$65,000	$82,550	$100,100
	Supervisor Coding Initiatives	M	502	$85,000	$109,050	$133,100
	Supervisor Credentialing	I	671	$61,000	$77,250	$93,500

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Job Title	Pay Grade	Job Code	Min	Mid	Max
Supervisor Customer Service	I	34	$61,000	$77,250	$93,500
Supervisor Data Entry	H	192	$59,000	$71,850	$84,700
Supervisor Day Center (PACE)	H	619	$59,000	$71,850	$84,700
Supervisor Dietary Services (PACE)	J	643	$65,000	$82,550	$100,100
Supervisor Encounters	I	253	$61,000	$77,250	$93,500
Supervisor Facilities	J	162	$65,000	$82,550	$100,100
Supervisor Finance	N	419	$95,000	$120,650	$146,300
Supervisor Grievance and Appeals	L	620	$77,000	$98,450	$119,900
Supervisor Information Technology Services	N	457	$95,000	$120,650	$146,300
Supervisor Long Term Support Services	M	587	$85,000	$109,050	$133,100
Supervisor Member Outreach and Education	K	592	$70,000	$88,900	$107,800
Supervisor MSSP	M	348	$85,000	$109,050	$133,100
Supervisor Nursing Services (PACE)	M	662	$85,000	$109,050	$133,100
Supervisor OneCare Customer Service	I	408	$61,000	$77,250	$93,500
Supervisor Payroll	M	517	$85,000	$109,050	$133,100
Supervisor Pharmacist	Q	610	$130,000	$166,200	$202,400
Supervisor Population Health Management	M	673	$85,000	$109,050	$133,100
Supervisor Provider Data Management Services	K	439	$70,000	$88,900	$107,800
Supervisor Provider Relations	L	652	$77,000	$98,450	$119,900
Supervisor Quality Analytics	M	609	$85,000	$109,050	$133,100
Supervisor Quality Improvement	M	600	$85,000	$109,050	$133,100
Supervisor Regulatory Affairs and Compliance	M	627	$85,000	$109,050	$133,100
Supervisor Social Work (PACE)	J	636	$65,000	$82,550	$100,100
Supervisor Therapy Services (PACE)	M	645	$85,000	$109,050	$133,100
Supervisor Utilization Management	M	637	$85,000	$109,050	$133,100
Systems Operations Analyst	F	32	$51,000	$62,350	$73,700
Systems Operations Analyst Int	G	45	$55,000	$66,550	$78,100
Technical Analyst Int	J	64	$65,000	$82,550	$100,100
Technical Analyst Sr	L	75	$77,000	$98,450	$119,900
Technical Support Specialist Sr	I	TBD	$61,000	$77,250	$93,500
Telephony Engineer	N	TBD	$95,000	$120,650	$146,300
Telephony Engineer Sr	O	TBD	$105,000	$134,450	$163,900
Therapy Aide	E	521	$48,000	$58,100	$68,200
Training Administrator	I	621	$61,000	$77,250	$93,500
Training Program Coordinator	H	471	$59,000	$71,850	$84,700
Translation Specialist	B	241	$42,432	$48,716	$55,000
Web Architect	N	366	$95,000	$120,650	$146,300

* These positions are identified for the purposes of CalOptima Health Policy GA. 8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution.

** These positions are identified for the purposes of CalOptima Health Policy GA. 8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution and are also Chief or Executive Director level positions.

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Policy:	GA.8057
Title:	**Compensation Program**
Department:	CalOptima Administrative
Section:	Human Resources
Interim CEO Approval:	*/s/ Richard Sanchez 06/10/2020*
Effective Date:	05/01/2014
Revised Date:	06/04/2020
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy establishes a compensation program for CalOptima job classifications within clearly defined guidelines that promote consistent, competitive and equitable pay practices.

II. POLICY

A. CalOptima's compensation program is intended to:

1. Provide fair compensation based on organization and individual performance;
2. Attract, retain, and motivate employees;
3. Balance internal equity and market competitiveness to recruit and retain qualified employees; and
4. Be mindful of CalOptima's status as a public agency.

B. The Chief Executive Officer (CEO), in conjunction with the Executive Director of Human Resources, is directed to administer the compensation program consistent with the attached Compensation Administration Guidelines, which defines the principles upon which CalOptima's compensation practices will be managed, procedural aspects of how the compensation procedures will be administered, and how the overall compensation administration function will respond to changing market conditions and business demands. Some of these guidelines include, but are not limited to:

1. Establishing pay rates based on the market 50th percentile.
2. Determining appropriate pay rates within the pay range for a position by assessing an employee's or applicant's knowledge, skills, experience, and the pay rates currently being paid to similarly situated incumbents. Employees may be paid anywhere within the pay range based on proficiency levels. The following criteria shall be considered:

Minimum (Min)	The rate paid to an individual possessing the minimum job qualifications & meeting minimum job performance expectations

Midpoint (Mid) aka: 50th percentile	The rate paid to individuals that are fully proficient in all aspects of the job's requirements & performance expectations
Maximum (Max)	The maximum rate paid to individuals who possess qualifications significantly above market norms & consistently deliver superior performance

3. All new hires and employees should have a pay rate equal to or greater than the pay range minimum, unless the minimum job requirements are not met, then a training rate equal to ten percent (10%) below the salary grade minimum may be used for six (6) months.

4. Base pay for all employees shall be capped at the pay range maximum, and once an employee reaches the base pay maximum, the employee will not be eligible for future base pay increases. However, in lieu of future base pay increases, these employees may be eligible for merit pay delivered as a lump sum bonus provided that the employee's performance warrants this additional compensation.

C. The CEO is authorized and directed to take all steps necessary and proper to implement the CalOptima compensation program and the Compensation Administration Guidelines not inconsistent therewith.

III. PROCEDURE

Not Applicable

IV. ATTACHMENT(S)

A. Compensation Administration Guidelines

V. REFERENCE(S)

Not Applicable

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors
08/07/2014	Regular Meeting of the CalOptima Board of Directors
11/06/2014	Regular Meeting of the CalOptima Board of Directors
12/04/2014	Regular Meeting of the CalOptima Board of Directors
03/05/2015	Regular Meeting of the CalOptima Board of Directors
06/04/2015	Regular Meeting of the CalOptima Board of Directors
06/07/2018	Regular Meeting of the CalOptima Board of Directors
06/04/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	08/07/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	11/06/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	12/04/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	06/04/2015	GA.8057	Compensation Program	Administrative
Revised	06/07/2018	GA.8057	Compensation Program	Administrative
Revised	06/04/2020	GA.8057	Compensation Program	Administrative

IX. GLOSSARY

Not Applicable

Compensation Administration Guidelines

Revised June 04, 2020

Implemented March 29, 2020

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Contents

Pay Administration Guidelines

Common pay administration guidelines for CalOptima are detailed in this section. These Guidelines help maintain the integrity of the base pay program by introducing a common set of standards and assist managers in ongoing compensation program administration.

In addition, note the following administration of the Guidelines:

- Chief Executive Officer (CEO) compensation will be established by the Board of Directors.
- Chief and Executive Director compensation will be established by the CEO within the Guidelines.
- The Board will be informed of all Chief and Executive Director hires and compensation changes.

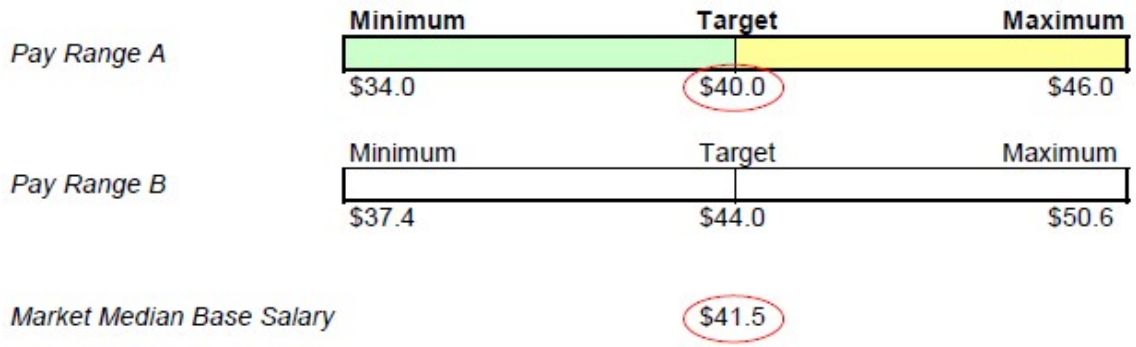
Proposed Pay Administration Guidelines

Pay ranges and pay levels	Pay range target Range minimums and maximums Pay above range maximums Pay range thirds Pay range halves Compa-ratio
Periodic pay adjustments/increases	New hire/Rehire Promotion Lateral Transfer Demotion Temporary Assignment Secondary job Job Re-evaluation Appeal Process Register/Certified Status Base pay program maintenance Salary structure adjustment Annual competitive assessment Market sensitive jobs
Annual pay adjustments/increases	Market Adjustment Merit pay Step increase
Special one-time pay considerations	Recruitment incentive

Pay Ranges and Pay Levels

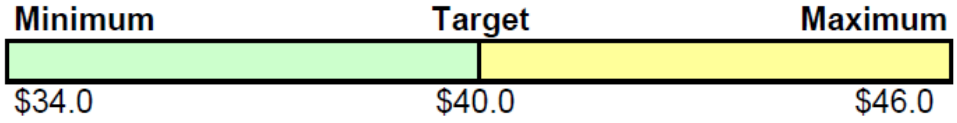
Range Target: internal "going market rate" for the job (50th percentile); represents the rate paid to individuals that are fully proficient in all aspects of the job's requirements and performance expectations.

- For benchmark jobs, the pay range (i.e. pay grade) is determined based on the comparability of values between market median base pay rates and the pay range targets.



Range Target $40.0 is Closest to Market Median of $41.5; job is assigned to Pay Range A

- For non-benchmark jobs, the pay range is determined based on comparability of the job to benchmark jobs within the same job family or other internal positions in terms of knowledge, skills, complexity and organizational impact.



Range Minimum: represents the rate paid to individuals possessing the minimum job qualifications and meeting minimum job performance expectations.

- All employees should have a pay rate equal to or greater than the pay range minimum.
- If the minimum job requirements are not met, a training rate equal to ten percent (10%) below the salary grade minimum may be used for six (6) months while a new incumbent is learning the skills to become proficient in the new role.

Range Maximum: represents the maximum rate paid to individuals who possess qualifications significantly above market norms and consistently deliver superior performance.

- Base pay growth is capped at the pay range maximum.

Pay Above Range Maximum: Employees are not paid above the range maximum.

- Employees whose current pay becomes above the pay range maximum will have their base pay frozen and will not be eligible for future base pay increases until such time as their base pay falls below the pay range maximum.

- In lieu of future base pay increases, these employees may be eligible for merit pay delivered as a lump sum bonus providing their performance warrants this additional compensation.

- As the pay structures and pay ranges move every twelve (12) – thirty-six (36) months or as necessary, the employees paid above the pay range maximum will eventually be paid below the pay range maximum and will then be eligible to receive base pay increases, as appropriate.

Pay Range: Employees may be paid anywhere within the open pay range; the pay range is divided into equal quartiles to assist in achieving competitive, equitable, and appropriate pay levels

- Developing Area – Below market pay; this area is used for employees possessing minimum job requirements and/or for those having significant learning curves to become fully proficient in the job's duties, responsibilities and performance expectations.

- Proficient/Fully Proficient Area – Market competitive pay; this area is used for employees possessing preferred job requirements and consistently demonstrate one hundred percent (100%) proficiency in all aspects of the job's duties, responsibilities and performance expectations.

- Expert Area – Above market pay; this area is used for employees possessing unique knowledge, skills, or abilities that far surpass the market's typical requirements and consistently demonstrate superior performance in all aspects of the job's duties, responsibilities, and performance expectations.

Compa-Ratio: In addition to pay range quartiles, this is a metric also used to communicate pay competitiveness.

- Compa-Ratio: A compa-ratio is calculated by taking the employee's base pay divided by his/her pay range target.

- Compa-Ratio of 100%: This ratio indicates the employee's base pay equals the pay range target, or the market rate.

  - Compa-Ratio <100%: This ratio indicates the employee's base pay is less than the pay range target.

  - Compa-Ratio >100%: This ratio indicates the employee's base pay is greater than the pay range target.

Illustrative Range Shown Below:

	Minimum	Target	Maximum
Compa-Ratio RNs	87.5%	100.0%	117.0%
Compa-Ratio Non-Exempt	88.0%	100.0%	117.0%
Compa-Ratio Exempt	83.0%	100.0%	118.0%

Note: *Range minimums and maximums will be based on the developed salary range spreads.*

Annual Pay Adjustments/Increases

Market Adjustment: A market adjustment is an increase or decrease to pay range grades based on market pay practices.

- A market adjustment may result in base pay increases for full-time, part-time, and some as-needed and limited term staff paid at or below the pay range target (there is no base pay increase between target and maximum for non-market sensitive jobs unless compression exists at the target).
    - For some market-sensitive jobs, a market adjustment may also be granted to full-time, part-time, and some as-needed and limited term staff paid above the pay range target but below the pay range maximum to maintain competitiveness and minimize pay compression.
- A market adjustment may result in a base pay increase to some staff to ensure employees are paid a base pay rate at least equal to the new pay range minimum.
    - If a market adjustment is made, employees paid below the new range minimum receive an increase to their base pay to ensure it is at least equal to the pay range minimum before any merit pay is awarded (cap at 10%).
- The appropriateness of a market adjustment is determined based on:
    1. A competitive assessment of the pay range target versus market base pay practices;
    2. Market trends and practices relative to average base pay and pay range increases; and
    3. Current recruiting and retention issues.
- Market adjustments are made prior to determining merit pay.
- Newly hired employees will be eligible for any market adjustments granted at the annual pay increase date if the employee is paid at or below the pay range target.

Base Pay Adjustment: All employees who achieve a satisfactory level of performance will be eligible for a merit pay adjustment.

- Merit Pay: Merit pay is variable pay that typically affects employees' base pay; it recognizes employees' job proficiency and performance of job duties.
    - Merit pay is applicable to full-time and part-time employees paid below, at, or above the pay range target; Per diem employees are not eligible for merit pay.
    - To be eligible for merit pay, the employee must have started work on or before March 31 to be eligible for a merit increase in July of the same year and have successfully completed the introductory period [three (3) months for transfers and new hires] prior to the annual pay adjustment date.
    - Merit pay will typically be an increase to base pay; however, it may also be delivered

as a one-time lump sum bonus for individuals paid above the pay range maximum.

- The budgeted amount for merit pay, if any, is based on 1) the organization's financial status; 2) market trends relative to average base pay increases; 3) competitiveness of current base pay practices; and, 4) recruiting and retention issues.

Merit Pay – Staff Paid At and Above Pay Range Target

- The combination of an individual's performance rating, the position of his/her pay within the pay range, the number of months he/she has been working, and the salary earned during those months determines the individual's merit pay opportunity.
  - Merit pay is typically calculated as a percent of base pay in effect on March 31, prorated to reflect the number of months an employee worked during the twelve (12)-month period starting from the first pay period in the fiscal year and ending with the last pay period of that same fiscal year.
  - Managers have the discretion to determine the actual increase amount within the published Guidelines; the appropriate merit pay amount will reflect the manager's internal equity, pay competitiveness, and performance recognition objectives.
  - Adjustments to employees' base pay are capped at the pay range maximums; therefore, some employees may receive a portion of their merit pay as a base pay increase up to the pay range maximum and also receive a lump sum amount for the remaining portion of the merit pay. Employees paid over the pay range maximum may be eligible to receive merit pay as a lump sum payment paid out in two (2) incremental amounts- the first half when merit pay is normally distributed; and the second half six (6) months later.
  - Merit pay may be held altogether or delayed for ninety (90) days if employees do not achieve a satisfactory level of performance or if a written warning or suspension/final written warning is active in their record.
  - Merit pay is typically awarded once a year at a specific time.
  - Full-time and part-time employees may receive both a market adjustment and a merit pay adjustment at the same time.
  - Executive Directors and Chief's must approve merit pay increases for all areas for which they are responsible before submitting to HR.
  - HR has final approval of all merit increases.

A Merit Pay Grid similar to the one shown below [assumes a three percent (3%) merit increase budget] is often used to provide managers with a guideline as to what merit pay increase may be appropriate based upon performance and to reflect:**

1. The organization's financial status;
2. Market trends relative to average base pay increases;
3. Competitiveness of current base practices; and

4. Recruiting and retention issues.

	Pay Range Position				
Performance Rating	**1st Quartile**	**2nd Quartile**	**3rd Quartile**	**4th Quartile**	**Above Max**
Highly Effective	6% - 5%	5% - 4%	4% - 3%	3% - 2%	3% - 2%
Effective	5% - 4%	4% - 3%	3% - 2%	3% - 2%	0%
Needs Improvement	0%	0%	0%	0%	0%

Above Max = Lump Sum Bonus

***The Merit Pay Grid is a sample only. Actual merit increase percentages will depend upon the salary distribution across the salary structure.*

- Employees who do not achieve a satisfactory level of performance at the time of their annual pay increase will not receive any type of pay increase – market adjustment, or merit pay.

- The increase may be withheld altogether or delayed ninety (90) days until the written performance improvement plan is complete and performance is judged to be acceptable by the manager; the pay increase will be effective at the time performance is judged to be acceptable (beginning of applicable pay period) and will not be retroactive; the manager is responsible for informing the employee in this situation and is responsible for notifying HR to initiate the increase.

- Employees on any type of leave of absence who are eligible for a market adjustment, and/or merit pay, may receive these adjustments upon their return to active status with a completed performance appraisal that is competent or above.

Special One-time Pay Considerations

Recruitment Incentive

- Recruitment incentives up to fifteen percent (15%) of an employee's base pay may be provided on an exception basis to entice an employee to join CalOptima.
    - Recruitment incentives require the approval of the CEO.
    - Board approval is required for recruitment incentives offered to Executive Director and above positions.

Incentives are provided with a "pay-back" provision if the employee terminates within twenty four (24) months of hire.

New Hires/Rehires

- A new hire's pay level corresponds to the appropriate pay range quartile and typically should not exceed the pay range target. Offers above the pay range target require the approval of the Executive Director of Human Resources and the CEO, when necessary.

- Factors to be considered in determining an appropriate pay level for a new hire include:

    - Job-related experience: What is the estimated learning curve given the individual's prior work experience? How many years of experience does the individual have in the same or equivalent classification?

    - Market conditions: What is the going rate of pay in the external market for the individual's skills and knowledge?

    - Internal equity: Is the proposed pay level lower, higher or in line with the pay levels of current employees having comparable skill and experience levels?

- At hire, external service is typically valued comparable to internal service.

    - For example, an RN having three (3) years of prior job experience is viewed comparably to an RN having three (3) years of job experience at CalOptima.

- Internal equity (how this position and compensation compares relative to existing employees) must be considered when making hiring decisions.

Process for Determining a New Hire Starting Pay Rate

HR determines applicable pay rate:

- Starting pay rate is at or near the minimum of the pay range for a candidate who only meets the job's minimum qualifications.

- Starting pay rate cannot be below the minimum of the pay range (unless it is viewed as a training rate).

- Determine appropriate pay rate by assessing candidate's knowledge, skills, and experience, as well as pay rates currently being paid to similarly situated incumbents.

- Candidates with superior knowledge, skills, and experience can be paid above the pay range midpoint. Starting pay rates above the pay range midpoint must have approval of the Executive Director of Human Resources and CEO, when necessary.

- There are certain positions that will usually be placed near the salary grade minimum (all entry level service and clerical).

- Pay rates for all positions are reviewed with the Compensation Unit before an offer is made. The Compensation Unit will review internal equity across the system to ensure that the appropriate offer is made.

- Rehires to the same classification should be paid at least the same amount they earned prior to termination, with adjustments and/or credit for recent additional career experience or education earned while away from CalOptima.

- The above policy applies to the current organization structure.
- Additional positions at the level of Chief or Executive Director require Board approval.

Promotion

An employee receives a promotion when the employee applies for and is selected for a job with a higher pay range target.

- An employee will receive a promotional increase to at least the pay range minimum of the new pay range.
- The amount of a promotional increase will be determined based on the incumbent's qualifications, performance, and internal pay practices. The typical promotional increase for a promotion without external competition is up to five percent (5%) of the employee's base pay per one (1) pay grade increase.
- Typically, the promotional increase should not exceed the pay range target.
- When an employee moves from non-exempt to exempt, the loss of overtime pay will be considered. However, the realization that overtime is not guaranteed must also be considered.
- The pay rate adjustment will be effective on the first day of the pay period in which the job change takes effect.
- Employees who are promoted after March 31, but prior to receiving their merit increase, will have their merit increase, if any, included in the base pay used to calculate their promotional pay. If the employee's performance evaluation rating and therefore merit increase amount is not known at the time the promotional pay is being calculated, a merit increase equivalent to "Fully Meets Expectations" will be included in the base pay used to calculate their promotional pay.
- The next merit pay adjustment after a promotion may be pro-rated based on the amount of time the employee has spent in the job.

Lateral Transfer

It is considered a lateral transfer if an employee moves to a job having the same pay range target.

- Lateral job changes will not typically result in a base pay increase or adjustment unless otherwise approved by the Executive Director of Human Resources.
- Employees who are laterally transferred after March 31, but prior to receiving their merit increase, will typically have their merit pay calculated as a percent of their base pay in effect on March 31.

Demotion

An employee is classified as having been demoted if the employee moves to a job with a lower pay range target.

- The pay of an employee demoted due to an organizational restructure, will not be decreased unless the employee is above the maximum on the new pay range; if so, the employee will be reduced to the maximum of the new pay range.

- For an involuntary demotion, due to performance, or for a voluntary demotion, the pay grade of the demoted employee will be assigned to the pay grade of the employee's new classification. The employee's base pay will typically be reduced up to five percent (5%) for each pay grade demoted.

- The pay rate adjustment will be effective on the first day of the pay period in which the job change takes effect.

- Future merit increases and market adjustments will not be affected by a demotion unless competent performance is not achieved.

- Employees who are demoted after March 31, but prior to receiving their merit increase, will typically have their merit pay calculated as a percent of their base pay in effect on March 31.

Temporary Assignment

An employee who is asked to assume a full-time temporary assignment in a job having a higher pay range target is eligible for a temporary base pay increase. The employee must assume some or all of the responsibilities of the new job to qualify for a temporary assignment increase.

- The employee's base pay rate prior to the assignment will be maintained and the higher temporary assignment rate will be added as a secondary job title and pay rate.

- This increased secondary pay rate is eliminated when the temporary assignment ends.

- The amount of the temporary assignment increase should be consistent with the promotion policy.

Training/Transition Overlap

In order to provide for a transition and/or training period, CalOptima may fill a regular position with a replacement in advance of the separation of a terminating employee. For the transition and/or training period, two employees may fill the same budgeted position for up to thirty (30) calendar days during the period of overlap. The immediate supervisor will determine which employee will be designated for decision-making and regulatory reporting purposes, if applicable.

Job Re-Evaluations

Job re-evaluations will be reviewed in the following priority order:

1. New Positions.
2. Change of thirty-five percent (35%) or more of duties [any change in responsibilities less than thirty-five percent (35%) will not be considered].
    - Enhancements must require a higher level of skills, abilities, scope of authority, autonomy, and/or education to qualify for a re-classification.
    - Additional duties that do not require the above will not be considered for reclassification.
    - All requests for job re-classification must be documented, signed by the department manager and submitted to the Compensation Unit.
    - In the case of management positions being re-classified, the appropriate Chief must sign the documentation.
    - The request must include the incumbent's current job description and revised job description with enhancements highlighted.
    - The request must also include justification that the re-classification supports a business need.

If the job is determined to be a priority, the Compensation Unit will analyze the job according to:

1. The job's scope against other jobs in the same discipline.
2. Available market data.
3. Appropriate title identification. The Compensation Unit will determine if the title fits within the hierarchy; if not, a benchmark title will be recommended.
4. Job family.
5. Fair Labor Standards Act (FLSA) status.
6. Appropriate pay grade – the job will be fit into one (1) of the pay grades that currently exists. No new pay grades created.

7. A pay rate will be determined.

8. A recommendation will be made to the Executive Director of Human Resources for approval, and the decision will be communicated to the appropriate manager.

If a job is reassigned to a higher grade, the change will be effective on the first day of the pay period following the evaluation. The pay increase is not retroactive to any earlier date. The manager will be informed of the decision to move the job to a higher pay grade by the Compensation Unit. The amount of the pay increase should follow the guidelines in the Promotion section. If the upgrade and a pay change occur less than six (6) months before the annual pay increase date, the employee's next merit pay adjustment may be pro-rated.

If the job is not reassigned to a higher pay grade, the manager will be notified. If dissatisfied with the decision, the manager may file an appeal with the Executive Director of Human Resources.

If a job is reassigned to a lower pay grade as a result of a job re-evaluation due to available market data, without a change in job responsibilities, the involuntary demotion due to organizational restructuring protocol will be followed.

If a job is reassigned to a lower pay grade due to a job evaluation and change in job responsibilities, the voluntary demotion protocol will be followed.

Job evaluations and re-evaluations will occur throughout the year; all priority jobs will be evaluated within one (1) month of the request.

If a job is not a priority or does not meet the guidelines, the manager will be notified.

Base Pay Program Maintenance

Salary Structure Adjustment

- The salary structure should be reviewed on a regular basis either annually or every other year to continue to reflect market competitiveness.
- The salary structure updates are designed to relieve any upward pressure on range minimums, midpoints and maximums that may impede the ability to attract, motivate, and retain the workforce.
- The salary structure is dynamic; it needs to be revised at regular intervals based upon market conditions to maintain market competitiveness. The goal is to keep the structure's market rates on track with market data.
- Market adjustments will be applied to the salary schedule as needed at least every two (2) years, using surveyed salary structure adjustment percentages.
- The salary structure adjustment approval process includes:
    - The Executive Director of Human Resources makes a recommendation to the CEO for approval.
    - CEO takes the recommendation to the Board for final approval.

Annual Competitive Assessment

- On a regular basis either annually or every other year, HR will identify the current competitiveness of CalOptima's pay practices by comparing: 1) current pay levels to market practices; 2) current pay levels to pay range targets; and, 3) current pay range targets to market practices.
    - CalOptima will on a regular basis either annually or every other year spot check benchmark jobs to determine market fluctuations in benchmark jobs' pay rates.
    - Based on market findings, the pay grade and ranges will be updated.
    - Any jobs in which reasonable benchmark data is not available can be slotted into the salary structure based on internal equity considerations.
- The results of these analyses, along with CalOptima's current financial performance and economic situation, will determine the appropriate market adjustments (i.e., pay range adjustments) and merit pay budgets.
- The following criteria is typically used to determine which jobs to market price each year:
    - Review job-level turnover statistics for jobs with above-average separation rates to identify jobs with potential retention issues.
    - Review the time-to-fill metrics for jobs requiring above-average recruiting efforts and

expenses to identify jobs with potential recruiting issues.

- Review the applicant tracking reports (if available) for jobs with a high level of initial/ subsequent offer rejections to identify additional potential recruiting issues.
- Review jobs with pay-to-pay range target compa-ratios in excess of 110% or below 90%.
- Review jobs with market-to-pay range target compa-ratios in excess of 110% or below 90%.
- Review all market-sensitive jobs and those on the "watch list."
- Review top ten (10) highest populated jobs on an annual basis.
- Jobs are ranked by degree of severity for each of the preceding criteria; the jobs that are most frequently identified across all criteria are typically market priced.
- It is recommended that at least two (2) jobs be selected from every pay range.

Market Adjustments (Structure and Pay Range Adjustments): Market adjustments to specific pay ranges or the entire pay structure may be made on an annual or as needed basis to reflect current competitiveness or market trends.

- On a regular basis either annually or every other year, the pay range targets are compared to the external market base pay practices and necessary adjustments are made to ensure alignment including job grade changes and range rate adjustments.
- Employees falling below the range minimum of the adjusted structures are typically brought to the pay range minimum, assuming the employee has a satisfactory level of performance; any pay compression resulting from structure adjustments should be addressed as part of the annual pay increase process.
    - Adjustments to pay range minimums occur prior to merit pay calculations.

Process for Making Market Adjustments

- HR performs, on a regular basis either annually or every other year, a review of compensation surveys to calculate the average market adjustment to pay structures; HR also analyzes the competitiveness of the current pay range targets to market practices for benchmarked jobs.
- HR reviews CalOptima's financial operating conditions and quantifies any recruiting/ retention issues.
- HR determines if an adjustment is appropriate (minor variations in the market may be recognized in the following year) and recommends the amount.
- HR multiplies the current pay range target of each grade by the necessary adjustment percentage; then HR recalculates the pay range minimum and maximum based on the existing structure design (i.e., pay range minimums = 80% of the new pay range target; pay range maximums = 120% of the new pay range target, etc.).

- HR identifies the cost implications for the market adjustment by identifying the difference between 1) current pay rates and new pay range minimums, and, 2) current pay rates.

- The market adjustment approval process will work as follows:

    - The Executive Director of Human Resources recommends an adjustment to the CEO for approval.

    - If the CEO agrees, the CEO will seek Board approval, unless the market adjustment is within the approved pay range for the classification as designated in the Board-approved salary schedule. In such case(s), the CEO may approve the market adjustment and inform the Board of such change(s).

Market-Sensitive Jobs: Market sensitive jobs are those for which market conditions make recruiting and retention challenging.

- Premium pay is built into the pay range targets for these jobs.

    - Prospectively, the pay range and grade selected for these jobs will reflect the desired market target rate (i.e., 60th or 75th percentile of base pay practices) based on business need.

    - The desired market target rate is established on a job-by-job basis to reflect specific market conditions.

- Criteria used to determine if a job is classified as market-sensitive typically includes two (2) or more of the following:

    - Time to fill the position – statistics will suggest the average amount of time required to fill a requisition for a market-sensitive position will be significantly higher than the historical norm for this position or similar positions.

    - Job offer rejections – statistics will illustrate an increase in the number of employment offers rejected due to low starting rates.

    - Turnover – statistics will suggest a higher than typical amount of turnover for the position within the last three (3) to six (6) months; turnover for the job will be compared to historical results for the same job and to other similarly-situated jobs.

    - Market Changes – market-sensitive jobs may experience an excessively large increase in competitive pay rates over the previous year's results; specifically, jobs considered to be market-sensitive may have:

        - a year-to-year increase significantly greater than the average year-to-year increase for other jobs analyzed,

        - a competitive market rate significantly higher [approximately ten percent (10%)] than its current pay range target, or

        - a competitive market rate with significantly higher pay practices [approximately ten percent (10%)] in the labor market than the average of current internal pay practices.

- When a job is classified as market-sensitive, typically some form of adjustment is made to employees' base pay rates and is typically referred to as a market adjustment and the pay increase policies noted under the market adjustment section apply.

- Jobs classified as market-sensitive are reviewed annually to determine if this status still applies.

    - Once a job is classified as market-sensitive, it typically remains as such until the recruiting and retention challenges subside and/or the market pay rates adjust themselves – typically not less than one (1) year.

    - When a job is no longer considered market-sensitive, the job's pay range and grade is reassigned to reflect a market median base pay rate target; no changes are typically made to the employees' base pay rates at this time.

- Throughout the year, jobs that are not yet considered market sensitive, but are showing signs of becoming so are placed on a "watch list" and monitored.

If necessary, these jobs will be moved to the market-sensitive category and handled accordingly.

CalOptima Health Board Action Agenda Referral

Action To Be Taken December 1, 2022
Regular Meeting of the CalOptima Health Board of Directors

Report Item

16. Adopt Resolution No. 22-1201-06 to Amend CalOptima Health's Conflict of Interest Code

Contacts

Michael Hunn, Chief Executive Officer, (657) 900-1481
Brigette Hoey, Chief Human Resources Officer, (714) 246-8405

Recommended Actions

1. Adopt Resolution No. 22-1201-06 adopting a Conflict of Interest Code which supersedes all prior Conflict of Interest Codes and amendments previously adopted; and
2. Upon adoption, direct the Clerk of the Board to submit the Conflict of Interest Code to the Orange County Board of Supervisors for review and approval.

Background

The Fair Political Practices Commission (FPPC) adopted Section 18730 of Title 2 of the California Code of Regulations (CCR) that contains terms for a standard Model Conflict of Interest Code (Model Code) that, together with amendments thereto, may be adopted by local public agencies and incorporated by reference. The CalOptima Health Board of Directors adopted the Model Code by reference on January 6, 2011, and amended Exhibit A to CalOptima Health's Code on December 3, 2020.

Changes have been proposed to the Conflict of Interest Code that update certain positions that have been added, deleted, or renamed. When designated positions or reporting categories are added or changed, local agencies are required under Government Code Section 87306 to make changes to their Conflict of Interest Code to reflect these changed circumstances. On June 2, 2022, the CalOptima Health Board of Directors adopted a new salary schedule with an updated list of CalOptima Health employee positions and job titles. The proposed amendment to the list of designated filer positions and disclosure categories (Exhibit A) reflects positions that make or participate in the making of governmental decisions which may foreseeably have a material financial effect on a financial interest. All individuals in designated positions will still be required to complete CalOptima Health's Supplement to FPPC Form 700.

Additional changes are also proposed to CalOptima Health's Conflict of Interest Code to ensure that disclosure requirements for each position are narrowly tailored to the type of economic interests that will foreseeably be materially affected by a designated employee's decision making. The General Counsel for the FPPC has issued memoranda opining that "conflict of interest code disclosure categories must be narrowly tailored to the type of economic interests that will foreseeably be affected by a designated employee's decision making." (See e.g., May 7, 2012, Memorandum from Zackery P. Morazzini, General Counsel of FPPC). Furthermore, in 2012, the FPPC adopted 2 CCR Section 18730.1 providing that designated positions are not required to report gifts outside an agency's jurisdiction if the purpose of disclosure of the source of the gift does not have some connection with or bearing upon the functions or duties of the position for which the

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reporting is required. The additional changes proposed narrowly tailor the disclosure requirements consistent with the FPPC regulation and the FPPC General Counsel memoranda.

Discussion
Adopting Resolution No. 22-1201-06 CalOptima Health's Conflict of Interest Code which supersedes all prior Conflict of Interest Codes and amendments previously adopted is necessary to reflect updates to certain positions that have been added, deleted, or renamed. Disclosure categories have been updated to conform with the County of Orange standard disclosure categories and to tailor the disclosure requirements to the type of economic interests that will foreseeably be affected by each position.

Fiscal Impact
There is no fiscal impact.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Resolution No. 22-1201-06, Adopting a Conflict of Interest Code Which Supersedes All Prior Conflict of Interest Codes and Amendments Previously Adopted.
2. Draft Conflict of Interest Code – Exhibits A and B

/s/ Michael Hunn *11/23/2022*
Authorized Signature **Date**

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RESOLUTION NO. 22-1201-06

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

ADOPTING A CONFLICT OF INTERST CODE WHICH SUPERSEDES ALL PRIOR CONFLICT OF INTEREST CODES AND AMENDMENTS PREVIOUSLY ADOPTED

WHEREAS, the Political Reform Act of 1974, Government Code Section 81000 et seq. ("the Act"), requires a local government agency to adopt a Conflict of Interest Code pursuant to the Act and conduct a biennial review of Designated Positions and Disclosure Categories; and,

WHEREAS, the Orange County Health Authority, dba CalOptima, has previously adopted a Conflict of Interest Code and that Conflict of Interest Code now requires updating; and,

WHEREAS, amendments to the Act have in the past and foreseeably will in the future require conforming amendments to be made to the Conflict of Interest Code; and,

WHEREAS, the Fair Political Practices Commission has adopted a regulation, Title 2, California Code of Regulations, Section 18730, which contains terms for a standard model Conflict of Interest Code, which, together with amendments thereto, may be adopted by public agencies and incorporated by reference to save public agencies time and money by minimizing the actions required of such agencies to keep their codes in conformity with the Political Reform Act.

NOW, THEREFORE, BE IT RESOLVED:

Section 1. The terms of Title 2, California Code of Regulations, Section 18730, and any amendments to it duly adopted by the Fair Political Practices Commission, and all additional guidance by the Fair Political Practices Commission, are hereby incorporated by reference, and together, with the attached Exhibits A and B in which members and employees are designated and disclosure categories are set forth, constitute the Conflict of Interest Code of the Orange County Health Authority, dba CalOptima Health.

Section 2. The provisions of all Conflict of Interest Codes and Amendments thereto previously adopted by the Orange County Health Authority, dba CalOptima Health are hereby superseded.

Section 3. The CalOptima Health Clerk of the Board is hereby authorized and directed to forward a copy of this Resolution to the Clerk of the Orange County Board of Supervisors for review and approval by the Orange County Board of Supervisors as required by California Government Code Section 87303.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima Health this 1st day of December 2022.

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AYES:
NOES:
ABSENT:
ABSTAIN:

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

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

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Conflict of Interest Code
EXHIBIT A (Working Draft)

Entity: **Other Misc Authorities, Districts and Commissions**

Agency: **CalOptima**

Position	Disclosure Category	Files With	Status
Assistant Director	OC-41	COB	Deleted
Reason: Revised Job Title			
Associate Director I	OC-41	COB	Added
Reason: New Position			
Associate Director II	OC-41	COB	Added
Reason: New Position			
Associate Director III	OC-41	COB	Added
Reason: New Position			
Associate Director IV	OC-41	COB	Added
Reason: New Position			
Associate Director, Customer Service	OC-41	COB	Deleted
Reason: Revised Job Title			
Associate Director, Information Services	OC-08	COB	Deleted
Reason: Revised Job Title			
Associate Director, Provider Network	OC-41	COB	Deleted
Reason: Revised Job Title			
Buyer	OC-01	COB	Unchanged
Buyer, Int.	OC-01	COB	Unchanged
Buyer, Sr.	OC-01	COB	Unchanged
Chief Compliance Officer	OC-01	COB	Added
Reason: New Position			
Chief Counsel	OC-01	COB	Deleted
Reason: Job Title Eliminated			
Chief Health Equity Officer	OC-01	COB	Added
Reason: New Position			
Chief Human Resoures Officer	OC-01	COB	Added
Reason: New Position			
Chief Information Officer	OC-01	COB	Unchanged
Chief Medical Officer	OC-01	COB	Unchanged
Chief Of Staff	OC-01	COB	Added
Reason: New Position			
Chief Operating Officer	OC-01	COB	Unchanged
Clerk of the Board	OC-41	COB	Unchanged
Clinical Pharmacist	OC-20	COB	Unchanged

Conflict of Interest Code
EXHIBIT A (Working Draft)

Entity: **Other Misc Authorities, Districts and Commissions**

Agency: **CalOptima**

Position	Disclosure Category	Files With	Status
Consultant	OC-01	Agency	Unchanged
Consultant	OC-01	COB	Unchanged
Contract Administrator	OC-41	COB	Unchanged
Contracts Manager	OC-41	COB	Unchanged
Contracts Manager SR	OC-06	COB	Unchanged
Contracts Specialist	OC-41	COB	Unchanged
Contracts Specialist Int.	OC-41	COB	Unchanged
Contracts Specialist Sr.	OC-41	COB	Unchanged
Controller	OC-01	COB	Unchanged
Deputy Chief Counsel	OC-01	COB	Deleted
Reason: Job Title Eliminated			
Deputy Chief Medical Officer	OC-01	COB	Unchanged
Deputy Clerk of the Board	OC-06	COB	Category Changed
Reason: Revised Job Title			
Director I	OC-01	COB	Added
Reason: New Position			
Director II	OC-01	COB	Added
Reason: New Position			
Director III	OC-01	COB	Added
Reason: New Position			
Director IV	OC-01	COB	Added
Reason: New Position			
Director, Accounting	OC-01	COB	Deleted
Reason: Revised Job Title			
Director, Applications Management	OC-08	COB	Deleted
Reason: Revised Job Title			
Director, Audit and Oversight	OC-01	COB	Deleted
Reason: Revised Job Title			
Director, Behavioral Health Services	OC-41	COB	Deleted
Reason: Revised Job Title			
Director, Budget & Procurement	OC-01	COB	Deleted
Reason: Revised Job Title			
Director, Business Development	OC-41	COB	Deleted
Reason: Revised Job Title			

Conflict of Interest Code
EXHIBIT A (Working Draft)

Entity: **Other Misc Authorities, Districts and Commissions**

Agency: **CalOptima**

Position	Disclosure Category	Files With	Status
Director, Business Integration	OC-41	COB	Deleted
Reason: Revised Job Title			
Director, Case Management	OC-41	COB	Deleted
Reason: Revised Job Title			
Director, Claims Administration	OC-41	COB	Deleted
Reason: Revised Job Title			
Director, Clinical Outcomes	OC-01	COB	Deleted
Reason: Revised Job Title			
Director, Clinical Pharmacy	OC-01	COB	Deleted
Reason: Revised Job Title			
Director, Coding Initiatives	OC-41	COB	Deleted
Reason: Revised Job Title			
Director, Communications	OC-13	COB	Deleted
Reason: Revised Job Title			
Director, Community Relations	OC-41	COB	Deleted
Reason: Revised Job Title			
Director, Configuration & Coding	OC-41	COB	Deleted
Reason: Revised Job Title			
Director, Contracting	OC-01	COB	Deleted
Reason: Revised Job Title			
Director, COREC	OC-08	COB	Deleted
Reason: Revised Job Title			
Director, Customer Service	OC-41	COB	Deleted
Reason: Revised Job Title			
Director, Electronic Business	OC-41	COB	Deleted
Reason: Revised Job Title			
Director, Enterprise Analytics	OC-41	COB	Deleted
Reason: Revised Job Title			
Director, Facilities	OC-41	COB	Deleted
Reason: Revised Job Title			
Director, Finance & Procurement	OC-01	COB	Deleted
Reason: Revised Job Title			
Director, Financial Analysis	OC-01	COB	Deleted
Reason: Revised Job Title			
Director, Financial Compliance	OC-01	COB	Deleted

Conflict of Interest Code
EXHIBIT A (Working Draft)

Entity: **Other Misc Authorities, Districts and Commissions**

Agency: **CalOptima**

Position	Disclosure Category	Files With	Status
Reason: Revised Job Title			
Director, Fraud, Waste & Abuse and Privacy	OC-01	COB	Deleted
Reason: Revised Job Title			
Director, Government Affairs	OC-41	COB	Deleted
Reason: Revised Job Title			
Director, Grievance & Appeals	OC-41	COB	Deleted
Reason: Revised Job Title			
Director, Health Services	OC-41	COB	Deleted
Reason: Revised Job Title			
Director, Human Resources	OC-11	COB	Deleted
Reason: Revised Job Title			
Director, Information Services	OC-08	COB	Deleted
Reason: Revised Job Title			
Director, Long Term Support Services	OC-41	COB	Deleted
Reason: Revised Job Title			
Director, Medi-Cal Plan Operations	OC-41	COB	Deleted
Reason: Revised Job Title			
Director, Network Management	OC-41	COB	Deleted
Reason: Revised Job Title			
Director, OneCare Operations	OC-41	COB	Deleted
Reason: Revised Job Title			
Director, Organizational Training & Education	OC-11	COB	Deleted
Reason: Revised Job Title			
Director, PACE Program	OC-41	COB	Deleted
Reason: Revised Job Title			
Director, Population Health Management	OC-41	COB	Deleted
Reason: Revised Job Title			
Director, Process Excellence	OC-41	COB	Deleted
Reason: Revised Job Title			
Director, Program Implementation	OC-41	COB	Deleted
Reason: Revised Job Title			
Director, Project Management	OC-41	COB	Deleted
Reason: Revised Job Title			
Director, Provider Data Quality	OC-41	COB	Deleted
Reason: Revised Job Title			

Conflict of Interest Code
EXHIBIT A (Working Draft)

Entity: **Other Misc Authorities, Districts and Commissions**

Agency: **CalOptima**

Position	Disclosure Category	Files With	Status
Director, Provider Services	OC-41	COB	Deleted
Reason: Revised Job Title			
Director, Public Policy	OC-41	COB	Deleted
Reason: Revised Job Title			
Director, Quality (LTSS)	OC-41	COB	Deleted
Reason: Revised Job Title			
Director, Quality Analytics	OC-41	COB	Deleted
Reason: Revised Job Title			
Director, Quality Improvement	OC-41	COB	Deleted
Reason: Revised Job Title			
Director, Regulatory Affairs and Compliance	OC-01	COB	Deleted
Reason: Revised Job Title			
Director, Strategic Development	OC-41	COB	Deleted
Reason: Revised Job Title			
Director, Systems Development	OC-08	COB	Deleted
Reason: Revised Job Title			
Director, Utilization Management	OC-41	COB	Deleted
Reason: Revised Job Title			
Director, Vendor Management	OC-01	COB	Renamed
Reason: Needed to add a coma			
Enterprise Analytics Manager	OC-41	COB	Unchanged
Executive Director	OC-01	COB	Added
Reason: New Position			
Executive Director Quality & Population Health Management	OC-01	COB	Deleted
Reason: Revised Job Title			
Executive Director, Behavioral Health Integration	OC-41	COB	Deleted
Reason: Revised Job Title			
Executive Director, Clinical Operations	OC-01	COB	Deleted
Reason: Revised Job Title			
Executive Director, Compliance	OC-01	COB	Deleted
Reason: Revised Job Title			
Executive Director, Human Resources	OC-01	COB	Deleted
Reason: Revised Job Title			
Executive Director, Network Operations	OC-01	COB	Deleted
Reason: Revised Job Title			

Conflict of Interest Code
EXHIBIT A (Working Draft)

Entity: **Other Misc Authorities, Districts and Commissions**

Agency: **CalOptima**

Position	Disclosure Category	Files With	Status
Executive Director, Operations	OC-01	COB	Deleted
Reason: Revised Job Title			
Executive Director, Program Implementation	OC-01	COB	Deleted
Reason: Revised Job Title			
Executive Director, Public Affairs	OC-01	COB	Deleted
Reason: Revised Job Title			
Executive Director, Quality Analytics	OC-41	COB	Deleted
Reason: Revised Job Title			
Financial Analyst I	OC-01	COB	Renamed
Reason: Revised Job Title			
Financial Analyst II	OC-01	COB	Renamed
Reason: Revised Job Title			
Financial Analyst III	OC-01	COB	Added
Reason: New Position			
Financial Analyst IV	OC-01	COB	Added
Reason: New Position			
Financial Reporting Analyst	OC-01	COB	Unchanged
Litigation Support Specialist	OC-41	COB	Unchanged
Manager, Marketing & Outreach	OC-06	COB	Renamed
Reason: had to add a coma			
Manager, Accounting	OC-01	COB	Unchanged
Manager, Actuary	OC-01	COB	Unchanged
Manager, Applications Management	OC-08	COB	Deleted
Reason: Job Title Eliminated			
Manager, Audit and Oversight	OC-01	COB	Unchanged
Manager, Behavioral Health	OC-41	COB	Unchanged
Manager, Business Integration	OC-41	COB	Unchanged
Manager, Case Management	OC-41	COB	Unchanged
Manager, Claims	OC-41	COB	Unchanged
Manager, Clinic Operations	OC-41	COB	Unchanged
Manager, Clinical Pharmacists	OC-20	COB	Unchanged
Manager, Coding Quality	OC-41	COB	Unchanged
Manager, Communications	OC-13	COB	Unchanged
Manager, Community Relations	OC-41	COB	Unchanged

Conflict of Interest Code
EXHIBIT A (Working Draft)

Entity: **Other Misc Authorities, Districts and Commissions**

Agency: **CalOptima**

Position	Disclosure Category	Files With	Status
Manager, Contracting	OC-41	COB	Unchanged
Manager, Creative Branding	OC-13	COB	Unchanged
Manager, Cultural & Linguistics	OC-41	COB	Unchanged
Manager, Customer Service	OC-41	COB	Unchanged
Manager, Decision Support	OC-41	COB	Deleted
Reason: Job Title Eliminated			
Manager, Electronic Business	OC-41	COB	Unchanged
Manager, Employment Services	OC-11	COB	Deleted
Reason: Job Title Eliminated			
Manager, Encounters	OC-41	COB	Unchanged
Manager, Environmental Health & Safety	OC-41	COB	Unchanged
Manager, Facilities	OC-41	COB	Deleted
Reason: Job Title Eliminated			
Manager, Finance	OC-01	COB	Unchanged
Manager, Financial Analysis	OC-01	COB	Unchanged
Manager, Government Affairs	OC-41	COB	Unchanged
Manager, Grievance and Appeals	OC-41	COB	Unchanged
Manager, Health Education	OC-41	COB	Deleted
Reason: Job Title Eliminated			
Manager, HEDIS	OC-41	COB	Deleted
Reason: Job Title Eliminated			
Manager, Human Resources	OC-11	COB	Unchanged
Manager, Information Technology	OC-08	COB	Deleted
Reason: Job Elimination			
Manager, Integration Government Liaison	OC-41	COB	Deleted
Reason: Job Title Eliminated			
Manager, Long Term Support Services	OC-41	COB	Unchanged
Manager, Marketing and Enrollment (PACE)	OC-41	COB	Unchanged
Manager, Medical Data Management	OC-41	COB	Deleted
Reason: Job Title Eliminated			
Manager, Medi-Cal Program Operations	OC-41	COB	Deleted
Reason: Job Title Eliminated			
Manager, Member Liaison Program	OC-41	COB	Unchanged

Conflict of Interest Code
EXHIBIT A (Working Draft)

Entity: **Other Misc Authorities, Districts and Commissions**

Agency: **CalOptima**

Position	Disclosure Category	Files With	Status
Manager, Member Outreach & Education	OC-41	COB	Unchanged
Manager, Member Outreach, Education and Provider Relations	OC-41	COB	Deleted
Reason: Job Title Eliminated			
Manager, MSSP	OC-41	COB	Unchanged
Manager, One Care Clinical	OC-41	COB	Added
Reason: New Position			
Manager, OneCare (Clinical, Customer Service, or Sales)	OC-41	COB	Unchanged
Manager, OneCare Customer Service	OC-41	COB	Added
Reason: New Position			
Manager, OneCare Regulatory	OC-41	COB	Deleted
Reason: Job Title Eliminated			
Manager, Outreach & Enrollment	OC-41	COB	Category Changed
Reason: New Position			
Manager, PACE Center	OC-41	COB	Unchanged
Manager, Population Health Management	OC-41	COB	Unchanged
Manager, Process Excellence	OC-41	COB	Unchanged
Manager, Program Implementation	OC-41	COB	Unchanged
Manager, Project Management	OC-41	COB	Deleted
Reason: Job Title Eliminated			
Manager, Provider Data Management Services	OC-41	COB	Unchanged
Manager, Provider Network	OC-41	COB	Unchanged
Manager, Provider Relations	OC-41	COB	Unchanged
Manager, Provider Services	OC-41	COB	Deleted
Reason: Job Title Eliminated			
Manager, Purchasing	OC-01	COB	Unchanged
Manager, QI Initiatives	OC-41	COB	Unchanged
Manager, Quality Analytics	OC-41	COB	Unchanged
Manager, Quality Improvement	OC-41	COB	Unchanged
Manager, Regulatory Affairs and Compliance	OC-41	COB	Unchanged
Manager, Reporting & Financial Compliance	OC-01	COB	Unchanged
Manager, Strategic Development	OC-41	COB	Unchanged
Manager, Strategic Operations	OC-41	COB	Deleted

Conflict of Interest Code
EXHIBIT A (Working Draft)

Entity: **Other Misc Authorities, Districts and Commissions**

Agency: **CalOptima**

Position	Disclosure Category	Files With	Status
Reason: Job Title Eliminated			
Manager, Systems Development	OC-08	COB	Deleted
Reason: Job Title Eliminated			
Manager, Technology Services	OC-08	COB	Renamed
Reason: revised Job Title			
Manager, Utilization Management	OC-41	COB	Unchanged
Medical Case Manager	OC-41	COB	Unchanged
Medical Case Manager - LVN	OC-41	COB	Unchanged
Medical Director	OC-01	COB	Unchanged
Medical Services Case Manager	OC-01	COB	Unchanged
Nurse Practitioner (PACE)	OC-01	COB	Unchanged
OneCare Operations Manager	OC-41	COB	Unchanged
Pharmacy Resident	OC-20	COB	Unchanged
Pharmacy Services Specialist	OC-20	COB	Unchanged
Pharmacy Services Specialist, Int.	OC-20	COB	Unchanged
Pharmacy Services Specialist, Sr.	OC-20	COB	Unchanged
Policy Advisor, SR	OC-41	COB	Unchanged
Prinicipal Financial Analyst	OC-01	COB	Added
Reason: New Position			
Privacy Manager	OC-41	COB	Unchanged
Privacy Officer	OC-41	COB	Unchanged
Process Excellence Manager	OC-41	COB	Unchanged
Program Manager	OC-41	COB	Unchanged
Program Manager, Sr.	OC-41	COB	Unchanged
Project Manager	OC-41	COB	Unchanged
Project Manager, Lead	OC-41	COB	Unchanged
Project Manager, Sr.	OC-41	COB	Unchanged
QI Nurse Specialist (RN or LVN)	OC-41	COB	Unchanged
Records Manager	OC-06	COB	Added
Reason: New Position			
Regulatory Affairs and Compliance Analyst	OC-41	COB	Unchanged
Regulatory Affairs and Compliance Analyst Sr	OC-41	COB	Unchanged

Conflict of Interest Code
EXHIBIT A (Working Draft)

Entity: **Other Misc Authorities, Districts and Commissions**

Agency: **CalOptima**

Position	Disclosure Category	Files With	Status
Regulatory Affairs and Compliance Lead	OC-41	COB	Unchanged
RN Pace	OC-41	COB	Unchanged
Security Officer	OC-41	COB	Deleted
Reason: Job Title Eliminated			
Senior Manager, Government Affairs	OC-41	COB	Deleted
Reason: Revised Job Title			
Special Counsel	OC-01	COB	Deleted
Reason: Job Title Eliminated			
SR Director	OC-01	COB	Added
Reason: New Position			
Sr Manager I	OC-01	COB	Added
Reason: New Position			
Sr Manager II	OC-01	COB	Added
Reason: New Position			
Sr Manager III	OC-01	COB	Added
Reason: New Position			
Sr Manager IV	OC-01	COB	Added
Reason: New Position			
Sr. Director Regulatory Affairs and Compliance	OC-01	COB	Deleted
Reason: Revised Job Title			
Sr. Manager Financial Analysis	OC-01	COB	Deleted
Reason: Revised Job Title			
Sr. Manager Human Resources	OC-11	COB	Deleted
Reason: Revised Job Title			
Sr. Manager Information Services	OC-08	COB	Deleted
Reason: Revised Job Title			
Sr. Manager Provider Network	OC-41	COB	Deleted
Reason: Revised Job Title			
Staff Attorney	OC-01	COB	Deleted
Reason: Job Title Eliminated			
Staff Attorney Sr	OC-01	COB	Deleted
Reason: Job Title Eliminated			
Supervisor Encounters	OC-41	COB	Unchanged
Supervisor Member Outreach and Education	OC-06	COB	Unchanged
Supervisor, Accounting	OC-01	COB	Unchanged

Conflict of Interest Code
EXHIBIT A (Working Draft)

Entity: **Other Misc Authorities, Districts and Commissions**

Agency: **CalOptima**

Position	Disclosure Category	Files With	Status
Supervisor, Audit and Oversight	OC-01	COB	Unchanged
Supervisor, Behavioral Health	OC-41	COB	Unchanged
Supervisor, Budgeting	OC-01	COB	Unchanged
Supervisor, Case Management	OC-41	COB	Unchanged
Supervisor, Claims	OC-41	COB	Unchanged
Supervisor, Coding Initiatives	OC-41	COB	Unchanged
Supervisor, Credentialing	OC-41	COB	Unchanged
Supervisor, Customer Service	OC-41	COB	Unchanged
Supervisor, Data Entry	OC-41	COB	Unchanged
Supervisor, Day Center (PACE)	OC-41	COB	Unchanged
Supervisor, Dietary Services (Pace)	OC-41	COB	Unchanged
Supervisor, Encounters	OC-41	COB	Unchanged
Supervisor, Facilities	OC-41	COB	Unchanged
Supervisor, Finance	OC-01	COB	Unchanged
Supervisor, Grievance and Appeals	OC-41	COB	Unchanged
Supervisor, Health Education	OC-41	COB	Deleted
Reason: Job Title Eliminated			
Supervisor, Information Technology Services	OC-08	COB	Renamed
Reason: Revised Job Title			
Supervisor, Long Term Support Services	OC-41	COB	Unchanged
Supervisor, MSSP	OC-41	COB	Unchanged
Supervisor, Nursing Services (Pace)	OC-41	COB	Unchanged
Supervisor, OneCare Customer Service	OC-41	COB	Unchanged
Supervisor, Payroll	OC-41	COB	Unchanged
Supervisor, Pharmacist	OC-20	COB	Unchanged
Supervisor, Popluation Health Management	OC-41	COB	Unchanged
Supervisor, Provider Data Management Services	OC-41	COB	Renamed
Reason: Revised Job Title			
Supervisor, Provider Relations	OC-41	COB	Unchanged
Supervisor, Quality Analytics	OC-41	COB	Unchanged
Supervisor, Quality Improvement	OC-41	COB	Unchanged
Supervisor, Regulatory Affairs and Compliance	OC-41	COB	Unchanged

Conflict of Interest Code
EXHIBIT A (Working Draft)

Entity: **Other Misc Authorities, Districts and Commissions**

Agency: **CalOptima**

Position	Disclosure Category	Files With	Status
Supervisor, Social Work (PACE)	OC-41	COB	Unchanged
Supervisor, Systems Development	OC-08	COB	Deleted
Reason: Job Title Eliminated			
Supervisor, Therapy Services (PACE)	OC-41	COB	Unchanged
Supervisor, Utilization Management	OC-41	COB	Unchanged

Total: 249

OFFICIALS WHO ARE SPECIFIED IN GOVERNMENT CODE SECTION 87200

Officials who are specified in Government Code section 87200 (including officials who manage public investments, as defined by 2 Cal. Code of Regs. § 18700.3 (b)), are NOT subject to the Agency's Conflict of Interest Code, but are subject to the disclosure requirements of the Political Reform Act, Government Code section 87100, et seq. Gov't Code § 87203. These positions are listed here for informational purposes only.

The positions listed below are officials who are specified in Government Code section 87200:

Alternate Member of the Board of Directors	Files with	COB	Unchanged
Chief Executive Officer	Files with	COB	Unchanged
Chief Financial Officer	Files with	COB	Unchanged
Member of the Board of Directors	Files with	COB	Unchanged

The disclosure requirements for these positions are set forth in Government Code section 87200, et. seq. They require the disclosure of interests in real property in the agency's jurisdiction, as well as investments, business positions and sources of income (including gifts, loans and travel payments).

Disclosure Descriptions
EXHIBIT B (Working Draft)

Entity: **Other Misc Authorities, Districts and Commissions**

Agency: **CalOptima**

Disclosure Category	Disclosure Description	Status
87200 Filer	Form 87200 filers shall complete all schedules for Form 700 and disclose all reportable sources of income, interests in real property, investments and business positions in business entities, if applicable, pursuant to Government Code Section 87200 *et seq*..	Unchanged
OC-01	All interests in real property in Orange County, the authority or the District as applicable, as well as investments, business positions and sources of income (including gifts, loans and travel payments).	Unchanged
OC-06	All investments in, business positions with and income (including gifts, loans and travel payments) from sources that provide leased facilities and goods, supplies, equipment, vehicles, machinery or services (including training and consulting services) of the types used by the County Department, Authority or District, as applicable.	Unchanged
OC-08	All investments in, business positions with and income (including gifts, loans and travel payments) from sources that develop or provide computer hardware/software, voice data communications, or data processing goods, supplies, equipment, or services (including training and consulting services) used by the County Department, Authority or District, as applicable.	Unchanged
OC-11	All interests in real property in Orange County or located entirely or partly within the Authority or District boundaries as applicable, as well as investments in, business positions with and income (including gifts, loans and travel payments) from sources that are engaged in the supply of equipment related to recruitment, employment search & marketing, classification, training, or negotiation with personnel; employee benefits, and health and welfare benefits.	Unchanged
OC-13	All investments in, business positions with and income (including gifts, loans and travel payments) from sources that produce or provide promotional items for public outreach programs; present, facilitate, market or otherwise act as agent for media relations with regard to public relations; provide printing, copying, or mail services; or provide training for or development of customer service representatives.	Unchanged
OC-20	All investments in, business positions with and income (including gifts, loans and travel payments) from sources that provide pharmaceutical services, supplies, materials or equipment.	Unchanged
OC-41	All interests in real property in Orange County, the District or Authority, as applicable, as well as investments in, business positions with and income (including gifts, loans and travel payments) from sources that provide services, supplies, materials, machinery, vehicles, or equipment (including training and consulting services) used by the County Department, Authority or District, as applicable.	Unchanged

Grand Total: 8

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 01, 2022
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

17. Adopt Resolution No. 22-1201-03 Approving Revised 2023 CalOptima Health Compliance Plan, 2023 CalOptima Health Code of Conduct, 2023 CalOptima Health Anti-Fraud, Waste and Abuse Plan, and Authorizing Approval of Revised CalOptima Health Office of Compliance Policies and Procedures

Contact

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

Recommended Actions

Adopt Resolution No. 22-1201-03 approving:

1. The revised 2023 CalOptima Health Compliance Plan; 2023 CalOptima Health Code of Conduct; and 2023 CalOptima Health Anti-Fraud, Waste and Abuse Plan; and
2. 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 those pertaining to its federal and state health care program requirements. As part of that commitment, the CalOptima Health Board of Directors (the "Board") is annually presented with CalOptima Health's Compliance Program and associated documents for review and approval. The 2023 CalOptima Health Compliance Plan, 2023 CalOptima Health Code of Conduct, and 2023 CalOptima Health Anti-Fraud, Waste and Abuse (FWA) Plan, 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 and detecting violations of standards or law. CalOptima Health's Compliance Program addresses each of the seven fundamental elements of an effective Compliance Program, in addition to FWA detection, prevention 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 2023 CalOptima Health Compliance Plan, 2023 CalOptima Health Code of Conduct, 2023 CalOptima Health FWA Plan, and written policies and procedures, as further detailed in the 2023 CalOptima Health Compliance Plan. The 2023 CalOptima Health Compliance Plan incorporates all the elements of an effective Compliance Program, as recommended by the OIG and required by CMS regulations. The Compliance Program also includes a comprehensive FWA Plan, which establish guidelines and procedures designed to detect, prevent, and remediate FWA in CalOptima Health programs.

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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 2023 CalOptima Health Compliance Plan. The Audit & Oversight Committee (AOC), a subcommittee of the Compliance Committee, is responsible for overseeing the internal business operations and delegated activities.

Training and Education
Utilizing web-based courses, as well as distribution of guidelines and publications, the Compliance Program incorporates training and education regarding CalOptima Health's compliance standards and requirements, as well as specialized educational courses assigned to individuals based on their respective roles within CalOptima Health's departments and programs. Upon appointment, hire or commencement of a contract, and annually thereafter, the Board, employees and FDRs receive CalOptima Health's Code of Conduct and are required to complete comprehensive training covering compliance obligations and applicable laws, FWA (where applicable), and Health Insurance Portability and Accountability Act privacy and security requirements.

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, and suspected or actual non-compliance issues and FWA incidents through one of CalOptima Health's multiple reporting mechanisms. These reporting options, which are outlined in greater detail below, 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 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 CalOptima Health's policies and procedures on performance and behavior standards, corrective action plans, and sanctions. CalOptima Health implements consistent, timely, and effective enforcement of standards when non-compliance or unethical behavior is determined, including any appropriate disciplinary action to address improper conduct, activity, and behavior.

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Monitoring, Auditing and Identification of Risks
CalOptima Health has implemented and continues to implement comprehensive monitoring and auditing activities, which are performed by the Audit & Oversight 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 2023 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 2023 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, and FWA Plan, 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 2023 CalOptima Health Compliance Plan, 2023 CalOptima Health Code of Conduct, 2023 CalOptima Health FWA Plan, and Office of Compliance policies and procedures to ensure consistency with applicable federal and state health care program laws, regulations, and guidance.

Summary of Changes
The 2023 CalOptima Health Compliance Plan, 2023 CalOptima Health Code of Conduct, and 2023 CalOptima Health FWA Plan have been updated and revised as follows:

- The ***2023 CalOptima Health Compliance Plan*** was edited to create a streamlined and concise document removing duplicative language. Additionally, the Code of Conduct and FWA Plan were removed from the Compliance Plan as stand-alone documents.
- The ***2023 CalOptima Health Code of Conduct*** has undergone minimal updates for this year to align with CalOptima Health's current mission, vision, and values.
- The ***2023 CalOptima FWA Plan*** was created from content removed from the Compliance Plan used as the foundation for creation of a stand-alone FWA Plan. The primary edits to the FWA Plan included adding references to the regulations and guidance used in the development of the FWA Plan. Additionally, a section was added to the end of the FWA Plan to provide reference to the many CalOptima Health policies and procedures through which the FWA Plan is effectuated.

Policies and Procedures
Consistent with applicable federal and state health care program laws, regulations, and 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 as Attachment 5. That summary contains a list of substantive changes to the policies and procedures, which are reflected in the attached redlines. *See,* Attachment 6. The list does not include non-substantive changes that may also be reflected in the redlines (i.e., formatting, spelling, punctuation, capitalization, minor clarifying language and/or grammatical changes).

Fiscal Impact
The recommended actions have no anticipated fiscal impact. To the extent that there is any fiscal impact due to increases in Compliance Program resources, such impact will be addressed in separate Board action 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 approve and adopt the updated 2023 CalOptima Health Compliance Plan, 2023 CalOptima Health Code of Conduct, 2023 CalOptima Health FWA Plan, and related policies and procedures. The updated 2023 CalOptima Health Compliance Plan will supersede CalOptima Health's 2022 Compliance Plan and 2022 CalOptima Code of Conduct approved on December 20, 2021.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Resolution No. 22-1201-03, Resolution Approving the 2023 CalOptima Health Compliance Plan, 2023 CalOptima Health Code of Conduct, 2023 CalOptima Health Anti-Fraud, Waste & Abuse Plan and revised Policies and Procedures
2. 2023 CalOptima Health Compliance Plan_Draft
3. 2023 CalOptima Health Code of Conduct_Draft
4. 2023 CalOptima Health Anti-Fraud, Waste & Abuse Plan_Draft
5. 2023 Summary of Proposed Actions to CalOptima Health Office of Compliance Policies and Procedures
6. 2023 Revised Office of Compliance Policies and Procedures (redlined and clean versions)_Draft

/s/ Michael Hunn *11/23/2022*
Authorized Signature **Date**

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RESOLUTION NO. 22-1201-03

RESOLUTION OF THE BOARD OF DIRECTORS OF ORANGE COUNTY HEALTH AUTHORITY dba CalOptima Health

APPROVING THE 2023 CALOPTIMA HEALTH COMPLIANCE PLAN, 2023 CALOPTIMA HEALTH CODE OF CONDUCT AND 2023 CALOPTIMA HEALTH ANTI-FRAUD, WASTE AND ABUSE (FWA) PLAN, 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 December 20, 2021, including the Compliance Plan, Code of Conduct, 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 2023 CalOptima Health Compliance Plan, 2023 CalOptima Health Code of Conduct, and 2023 CalOptima Health Anti-Fraud, Waste and Abuse (FWA) Plan.

Section 2. The Board of Directors hereby approves and adopts the revised Office of Compliance Policies and Procedures as detailed in the attachment to this resolution, "Attachment 5: Summary of Proposed Actions for Office of Compliance Policies and Procedures"

Section 3. The Chief Executive Officer or his/her designee is hereby authorized and directed to implement, monitor, and enforce the 2023 CalOptima Health Compliance Plan, 2023 CalOptima Health Code of Conduct, and 2023 CalOptima Health Anti-Fraud, Waste and Abuse (FWA) Plan.

Section 4. These actions are effective upon the date of adoption of this Resolution.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, dba CalOptima Health, this 1st day of December 2022.

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AYES:
NOES:
ABSENT:
ABSTAIN:

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

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

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Attachment 5: 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]:
FF.2014: Delegation and Oversight of Claims Activities *Audit & Oversight – External*	**B – REVISED:** This policy was reviewed pursuant to the CalOptima Health Regulatory Affairs and Compliance policy review process to ensure definitions, references, attachments, operational alignment with regulatory requirements and removal of the OneCare Connect program. Ownership of this policy was transferred from the Claims Administration department to the Audit & Oversight department to align with current processes including updates to timing, monitoring and audit processes. **Program(s)**: Medi-Cal; OneCare	
GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities *Audit & Oversight – External*	**B – REVISED:** This policy was reviewed pursuant to the CalOptima Health Regulatory Affairs and Compliance policy review process to ensure definitions, references, attachments, operational alignment with regulatory requirements and removal of the OneCare Connect program. Ownership of this policy was transferred from Utilization Management to Audit & Oversight and includes the clarification of language specifying the monitoring transition. **Program(s)**: Medi-Cal; OneCare	
HH.4002: CalOptima Health Internal Oversight *Audit & Oversight – Internal*	**B – REVISED:** This policy was reviewed pursuant to the CalOptima Health Regulatory Affairs and Compliance policy review process to ensure definitions, references, attachments, and operational alignment with regulatory requirements. This policy was also updated to provide operational language clarification regarding conduction and review of assessments. **Program(s)**: Administrative	
HH.5000: Provider Overpayment Investigation and Determination *Fraud, Waste, Abuse – Special Investigations Unit*	**B – REVISED:** This policy was reviewed pursuant to the CalOptima Health Regulatory Affairs and Compliance policy review process to ensure definitions, references, attachments, operational alignment with regulatory requirements and removal of the OneCare Connect program. Policy detail was added to support the overpayment identification process, investigation protocols and timing clarifications. **Program(s)**: Medi-Cal; OneCare; PACE	

POLICY & DEPARTMENT	REVISION & PROGRAM	A – NEW B – REVISED C – RETIREMENT D – REVISED [MINOR EDITS]: E – ANNUAL REVIEW [NO EDITS]:
HH.3007: Member Rights to Request Restrictions on Use and Disclosure of Protected Health Information (PHI) *Privacy*	**B – REVISED:** This policy was reviewed pursuant to the CalOptima Health Regulatory Affairs and Compliance policy review process to ensure definitions, references, attachments, operational alignment with regulatory requirements and removal of the OneCare Connect program. Policy updates include clarification regarding requests for restrictions on use and disclosure in alignment with DMHC compliance and filing requirements. **Program(s)**: Medi-Cal; OneCare; PACE	
HH.3008: Member Right to Request Confidential Communications *Privacy*	**B – REVISED:** This policy was reviewed pursuant to the CalOptima Health Regulatory Affairs and Compliance policy review process to ensure definitions, references, attachments, operational alignment with regulatory requirements and removal of the OneCare Connect program. Policy updates include clarification regarding request requirements and allowances in alignment with DMHC compliance and filing requirements. **Program(s)**: Medi-Cal; OneCare; PACE	
AA.1270: Certification of Document and Data Submissions *Regulatory Affairs & Compliance*	**B – REVISED:** This policy was reviewed pursuant to the CalOptima Health Regulatory Affairs and Compliance policy review process to ensure definitions, references, attachments, operational alignment with regulatory requirements and removal of the OneCare Connect program. Policy updates include adding the number of Dual Eligible Special Needs Plan (D-SNP) members enrolled monthly to certification reporting elements, submission process updates, attestation processes and FAQ attachment updates. **Program(s)**: Medi-Cal, OneCare	
HH.2002: Sanctions *Regulatory Affairs & Compliance*	**B – REVISED:** This policy was reviewed pursuant to the CalOptima Health Regulatory Affairs and Compliance policy review process to ensure definitions, references, attachments, operational alignment with regulatory requirements and removal of the OneCare Connect program. Policy language was added enhancing findings for determination of sanction severity, types of sanctions, details regarding monetary sanctions, penalty assessments and calculations. **Program(s)**: Medi-Cal; OneCare; PACE	
HH.2005: Corrective Action Plan *Regulatory Affairs & Compliance*	**B – REVISED:** This policy was reviewed pursuant to the CalOptima Health Regulatory Affairs and Compliance policy review process to ensure definitions, references, attachments, operational alignment with regulatory requirements and removal of the OneCare Connect program. Policy language was added to include the acknowledgement of separate processes by internal departments and FDRs to identify issues of non-compliance through monitoring, investigation and corrective action processes. **Program(s)**: Medi-Cal; OneCare; PACE	

POLICY & DEPARTMENT	REVISION & PROGRAM	A – NEW B – REVISED C – RETIREMENT D – REVISED [MINOR EDITS]: E – ANNUAL REVIEW [NO EDITS]:
HH.2020: Conducting Compliance Investigations *Regulatory Affairs & Compliance*	**B – REVISED:** This policy was reviewed pursuant to the CalOptima Health Regulatory Affairs and Compliance policy review process to ensure definitions, references, attachments, operational alignment with regulatory requirements and removal of the OneCare Connect program. Policy updates were made to preliminary investigation options to include, a Corrective Action Plan (CAP), educational letter, warning letter or other appropriate actions. **Program(s)**: Medi-Cal; OneCare; PACE	
MA.9124: CMS Self-Disclosure *Regulatory Affairs & Compliance*	**B – REVISED:** This policy was reviewed pursuant to the CalOptima Health Regulatory Affairs and Compliance policy review process to ensure definitions, references, attachments, operational alignment with regulatory requirements and removal of the OneCare Connect program. Additional language was added to the policy to clarify the process regarding escalation of findings to senior management prior to self-disclosure. **Program(s)**: Medi-Cal; OneCare; PACE	

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
GG.1619: Delegation Oversight	*Audit & Oversight – External*
HH.2025: Health Network Subdelegation and Subcontracting	*Audit & Oversight – External*
HH.2027: Annual Risk Assessment (FDR)	*Audit & Oversight – External*
HH.4001: Audit & Oversight Committee	*Audit & Oversight – External*
HH.4003: Annual Risk Assessment	*Audit & Oversight – Internal*
HH.1105: Fraud, Waste, and Abuse Detection	*Fraud, Waste, Abuse – Special Investigations Unit*
HH.1107: Fraud, Waste, and Abuse Investigation and Reporting	*Fraud, Waste, Abuse – Special Investigations Unit*
HH.5004: False Claims Act Education	*Fraud, Waste, Abuse – Special Investigations Unit*
HH.3000: Notice of Privacy Practices	*Privacy*
HH.3001: Member Access to Designated Record Set	*Privacy*
HH.3002: Minimum Necessary Uses and Disclosure of Protected Health Information (PHI) and Document Controls	*Privacy*
HH.3003: Verification of Identity for Disclosure of Protected Health Information	*Privacy*
HH.3004: Member Request to Amend Records	*Privacy*
HH.3005: Member Request for Accounting of Disclosures	*Privacy*
HH.3006: Tracking and Reporting Disclosures of Protected Health Information (PHI)	*Privacy*
HH.3009: Access by Member's Authorized Representative	*Privacy*
HH.3010: Protected Health Information (PHI) Disclosures Required by Law	*Privacy*
HH.3011: Use and Disclosure of PHI for Treatment, Payment, and Health Care Operations	*Privacy*

POLICY	DEPARTMENT
HH.3014: Use of Electronic Mail with Protected Health Information (PHI)	*Privacy*
HH.3015: Member Authorization for the Use and Disclosure of Protected Health Information (PHI)	*Privacy*
HH.3016: Guidelines for Handling Protected Health Information (PHI) Offsite	*Privacy*
HH.3019: De-identification of Protected Health Information (PHI)	*Privacy*
HH.3020: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI, or Other Unauthorized Use or Disclosure of PHI/PI	*Privacy*
HH.3022: Business Associates Agreements	*Privacy*
GA.7501: Regulatory Communications	*Regulatory Affairs & Compliance*
GA.7505: Regulatory Liaison Responsibilities	*Regulatory Affairs & Compliance*
HH.2007: Compliance Committee	*Regulatory Affairs & Compliance*
HH.2014: Compliance Program	*Regulatory Affairs & Compliance*
HH.2018: Compliance and Ethics Hotline	*Regulatory Affairs & Compliance*
HH.2019: Reporting Suspected or Actual Fraud, Waste, or Abuse (FWA) and Violations of Applicable Laws and Regulations and/or CalOptima Health Policies	*Regulatory Affairs & Compliance*
HH.2021: Exclusion and Preclusion Monitoring	*Regulatory Affairs & Compliance*
HH.2022: Record Retention and Access	*Regulatory Affairs & Compliance*
HH.2023: Compliance Training	*Regulatory Affairs & Compliance*
HH.2028: Code of Conduct	*Regulatory Affairs & Compliance*
HH.2029: Annual Compliance Program Effectiveness Audit	*Regulatory Affairs & Compliance*
HH.3012: Non-Retaliation for Reporting Violations	*Regulatory Affairs & Compliance*

Orange County Health Authority
dba CalOptima Health

2023 Compliance Plan

(Revised December 2022)

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 relies on compliance. 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 Board Member, Employee, or First Tier, Downstream, and Related Entity (FDR), are the most important element 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 concern for 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 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 without disclosing any identifying information if that is what you choose. **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 a framework for compliance in your work at CalOptima Health.

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. CalOptima Health makes this Compliance Plan available to the CalOptima Health Board of Directors, Employees, and FDRs. All CalOptima Health Board of Directors, Employees, 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 the 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, below referencing these materials and FDRs, 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.

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 CalOptima Health Board of Directors, Employees, 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, and FDRs **promptly report** any suspected FWA or noncompliance with applicable regulations and CalOptima Health policies. This can be accomplished by reporting directly to your supervisor or management, or the Compliance Department or 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 _____or on the CalOptima Health website at _____. The Code of Conduct is approved by the CalOptima Health Board of Directors and distributed to Board Members, Employees, and FDRs upon appointment, hire, or the commencement of the contract, and annually thereafter. New Board Members, Employees, 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 CalOptima Health Board of Directors, Employees, and FDRs. This Compliance Plan also includes a comprehensive 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. 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, 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, 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, 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.

The 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, meets regularly to review, and approve proposed changes and additions to CalOptima Health's Policies and Procedures. Board Members, Employees, and FDRs receive notice when Policies and Procedures are updated via a monthly memorandum. All CalOptima Health Policies and Procedures are available on InfoNet and a separate web portal accessible to Board Members, Employees, and FDRs.

II. COMPLIANCE OFFICER, COMPLIANCE COMMITTEE, HIGH LEVEL OVERSIGHT

a. Governing Body

The CalOptima Health Board of Directors, as the Governing authority, is responsible for approving, implementing, and Monitoring the Compliance Program governing CalOptima Health's operations. The CalOptima Health Board of Directors delegates the Compliance Program oversight and day-to-day compliance activities to the Chief Executive Officer (CEO), who then delegates such oversight and activities to the Chief Compliance Officer. The Chief Compliance Officer is an Employee of CalOptima Health, who handles compliance oversight and activities full-time. The Chief Compliance Officer, in 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 CalOptima Health Board of Directors 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.

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 of Directors on the activities and status of the Compliance Program. The Chief Compliance Officer has the authority to specifically escalate issues of concern directly to the Board of Directors. 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 CalOptima Health Board of Directors, 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 and FDR 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 to 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 CalOptima Health Board of Directors 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 CalOptima Health Board of Directors.
- 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 within 90 days of employment or appointment and annually thereafter:

- **Code of Conduct**
- **General Compliance**
- **FWA**
- **HIPAA Privacy Compliance**

Employees must complete the required compliance training courses within ninety (90) calendar days of hire, and annually thereafter. Adherence to the Compliance Program requirements, including training requirements, shall be a condition of continued employment and a factor in the annual performance evaluation of each Employee. Board Members and FDRs are required to complete the required compliance training courses within ninety (90) calendar days of appointment or commencement of the contract, as applicable, and annually thereafter.

Specialized education courses are assigned to individuals based on their respective roles or positions within or with CalOptima Health's departments and its programs, which may 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 enrollees, Medicare Part D, are to complete compliance and FWA training through their own internal compliance program or by using training materials supplied by CalOptima Health.

b. Tracking Required Compliance Training

The Chief Compliance Officer, or his/her Designee, is responsible for coordinating compliance education and training programs, and ensuring that records evidencing an individual's/FDR's completion of the training requirements are documented and maintained, such as sign-in sheets, attestations, or electronic certifications, as required by

law. The Chief Compliance Officer and the CalOptima Health Executive Staff, Management and Clerk of the Board are responsible for ensuring that Board Members, Employees, 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 which courses are updated 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 compliance by outlining the regulatory requirements and reinforcing company expectations of 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, 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, 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

- Online at caloptima.org
- 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

c. Confidentiality and Non-Retaliation

CalOptima Health maintains and supports a non-retaliation policy governing good faith reports of suspected, or actual, non-compliance and/or FWA. Every effort will be made to keep reports confidential to the extent permitted by applicable law and circumstances, but there may be some instances where the identity of the individual making the report will have to be disclosed. As a result, CalOptima Health has implemented and enforces a non-retaliation policy to protect individuals who report suspected or actual non-compliance, or FWA, issues in good faith. This non-retaliation policy extends to reports received from FDRs and Members. CalOptima Health's non-retaliation policy is communicated along with reporting instructions by posting information on the CalOptima Health InfoNet and website, as well as sending periodic Member notifications.

CalOptima Health also takes violations of CalOptima Health's non-retaliation policy seriously, and the Chief Compliance Officer will review and enforce disciplinary and/or other CAPs for violations, as appropriate, with the approval of the Compliance Committee.

V. ENFORCEMENT AND DISCIPLINARY STANDARDS

a. Conduct Subject to Enforcement and Discipline

Board Members, Employees, 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, 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 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 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 serve as a guide for which Monitoring and Auditing activities to perform to assess ongoing levels 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 as well as the operations of FDRs. 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
4) Cross departmental interdependencies
5) The OIG Work Plan
6) Monitoring dashboard trends

The Chief Compliance Officer, 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 Chief Compliance Officer, 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 and external Auditing and Monitoring Activities are employed to test and verify compliance with all applicable regulations, guidance, contractual agreements, and federal and state laws, as well as CalOptima Health Policies and Procedures. The AWP includes:

1. Audits to be performed including estimated time frames
2. Audit methodologies
3. Necessary resources
4. Person(s) responsible
5. Final audit reports
6. Follow-up activities from findings including CAPs (when applicable)

The Audit and Oversight (A&O) team manages a dashboard of key compliance metrics that serves as a Monitoring tool to track compliant performance for such items as coverage determinations, complaints, appeals, grievances, regulatory communications, credentialing, customer service, transition of coverage (TOC), and claims. A&O also performs audits as per the AWP. The Monitoring and Auditing results are communicated to Executive Management, the Compliance Committee, and the CalOptima Health Board of Directors.

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 CalOptima Health Board of Directors.

c. FDR Annual Risk Assessment

The Chief Compliance Officer, or his/her designee, will conduct an annual comprehensive risk assessment to determine FDRs' 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 includes 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 Compliance Department for a suggested follow-up audit. 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 Chief Compliance Officer, 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 A&O team manages a dashboard of key compliance metrics that serves as a Monitoring tool to track compliant performance of FDRs credentialling, claims, and UM. A&O also performs audits as per the FDR AWP. The Monitoring and Auditing results are communicated to Executive Management, the Compliance Committee, and the CalOptima Health Board of Directors.

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, 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, 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 when Board Members, Employees, Providers and FDRs receive 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, in conjunction with the Office of Compliance, FWA/Privacy team and other key staff, are responsible for reviewing cases of non-compliance and suspect activity, and for disclosing such issues to the appropriate authority, when applicable. Because of the complex nature of some issues that may be reported or identified, the investigation may be delegated to the appropriate internal expert.

When a material issue of non-compliance is discovered or a department's process or system results in non-compliance with regulatory requirements, the business area may be required to implement a formal CAP which is overseen by the Office of Compliance. The CAP promotes the correction of the identified issue in a timely manner. Corrective actions may include revising processes, updating policies or procedures, retraining staff, reviewing systems edits and/or addressing other root causes. The CAP must achieve sustained compliance with the overall requirements for that specific operational department.

The status of open CAPs is reviewed by the Office of Compliance on a monthly basis, or at a frequency determined by the Chief Compliance Officer. The Office of Compliance monitors CAP implementation and requires that business departments regularly report the completion of all interim actions. The Office of Compliance tracks the duration of open CAPs and intervenes as appropriate to promote timely completion. Once a CAP is 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 management and the Compliance Committee.

CalOptima Health's oversight of FDRs includes a requirement that FDRs submit a CAP when material deficiencies are identified through compliance 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.

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, in conjunction with other compliance activities, and 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 CalOptima Health Board of Directors, 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 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.

Code of Conduct

Principle	Standard
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
Compliance with the Law CalOptima Health is committed to conducting all activities and operations in compliance with applicable law.	**Transparent, Legal, and Ethical Business Conduct** CalOptima Health is committed to conducting its business with integrity, honesty, and fairness and in compliance with all laws and regulations 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** 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, 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

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Principle	Standard
	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.
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. **Cultural and Linguistic Services** CalOptima Health and contractors shall provide culturally, linguistically, and sensory appropriate services to CalOptima Health

Principle	Standard
	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.
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**

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Principle	Standard
	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.

Principle	Standard
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.

Principle	Standard
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 limitation, Medi-Cal license, Medicare numbers, social security numbers, and other identifying numbers.
Business Relationships	**Business Inducements**

Principle	Standard
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.	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 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

Principle	Standard
	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.
Conflicts of Interests Board members and employees owe a duty of undivided and unqualified loyalty to CalOptima Health.	**Conflict of Interest Code** Designated employees, including Board members, shall comply with the requirements of the CalOptima Health Conflict of Interest Code and applicable laws. Board members and employees 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. **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 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 contractor or association of contractors.

Principle	Standard
Discrimination CalOptima Health acknowledges that fair and equitable treatment of employees, 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.
Participation Status CalOptima Health requires that employees, contractors, providers, and suppliers meet Government requirements for participation in CalOptima Health's programs.	**Federal and State Health Care Program Participation Status** Board members, employees, and contractors shall not be currently suspended, terminated, debarred, or otherwise ineligible to participate in any Federal or State health care program, including the Medi-Cal program and Medicare programs. **CalOptima Health Screening** CalOptima Health will Monitor the participation status of employees, individuals and entities doing business with CalOptima Health by conducting regular Exclusion and Preclusion screening reviews in accordance with CalOptima Health policies. **Disclosure of Participation Status** Board members, employees and contractors shall disclose to CalOptima Health whether they are currently suspended, terminated, debarred, or otherwise ineligible to participate in any Federal and/or State health care program. Employees, individuals, and entities that do business with CalOptima Health shall disclose to CalOptima Health any pending investigation, disciplinary action, or other matter that could potentially result in their Exclusion or Preclusion from participation in any Federal or State health care program.

Principle	Standard
	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.
Government Inquiries/Legal Disputes Employees 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 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 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 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.

Principle	Standard
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** 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 also be made to CalOptima Health's hotline number below. Persons making reports to the hotline can do so on an anonymous basis. **Compliance and Ethics Hotline: 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, and FDRs. Timely completion of compliance and HIPAA training is mandatory for all CalOptima Health employees. **No-Retaliation Policy** CalOptima Health prohibits retaliation against any individual who reports discrimination, harassment, or compliance concerns, or participates in an investigation of such reports. Employees involved in any retaliatory acts may be subject to discipline, up to and including termination of employment.

Principle	Standard
	Referrals of FWA to Government Agencies CalOptima Health is obligated to coordinate compliance activities with federal and state regulators. Employees 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.

Orange County Health Authority
dba CalOptima Health

2023 Anti-Fraud, Waste, and Abuse (FWA) Plan

(Revised December 2022)

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, CEO, 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. 438.08
- 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 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 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 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 and Employees as part of the overall compliance training courses in order to help detect, prevent, and remediate FWA. First-tier, downstream and related parties (FDRs) are also required to complete FWA training. CalOptima Health's FWA training provides guidance to Board Members, Employees, 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, or enrolling, individuals in the CalOptima Health Programs, 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, high-volume prescriptions of a

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particular manufacturer's drugs, submission of false claims or false data for prescription drug claims, 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, 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, law enforcement and Regulatory Agencies, and others may contact CalOptima Health by phone, mail, and email if they suspect any individual, or entity, is engaged in inappropriate practices. Furthermore, the sources identified below can be used to identify problem areas within CalOptima Health, such as enrollment, finance, or other relevant data.

Sources used to detect FWA include, but are not limited to:

- CalOptima Health's Compliance and Ethics Hotline or other reporting mechanisms;
- Claims data history;
- Encounter data;
- Medical record Audits;
- Member and provider complaints, appeals, and grievance reviews;
- Utilization Management reports;
- Provider utilization profiles;
- Pharmacy data;
- Auditing and Monitoring Activities;
- Monitoring external health care FWA cases and determining if CalOptima Health's FWA Program can be strengthened with information gleaned from the case activity; and/or
- Internal and external surveys, reviews, and Audits.

b. Data Analytics

CalOptima Health uses technology and data analyses to reduce FWA externally. Using a combination of industry standard edits and CalOptima Health-specific edits, CalOptima Health identifies claims for which procedures have been unbundled or upcoded. CalOptima Health also identifies suspect FDRs based on billing patterns.

CalOptima Health also uses the services of an external Medicare Secondary Payer (MSP) Vendor to reduce costs associated with its Medicare-Medicaid programs, such as the OneCare, and/or PACE programs, by ensuring that federal and state funds are not used where certain health insurance, or coverage, is primarily responsible.

c. Analysis and Identification of Risk Areas Using Claims Data

Claims data are analyzed in numerous ways to uncover fraudulent billing schemes. Routine review of claims data will be conducted in order to identify unusual patterns, outliers in billing and utilization, and identify the population of providers and pharmacies that will be further investigated and/or audited. Any medical claim can be pended and reviewed, in accordance with applicable state or federal law if they meet certain criteria that warrant additional review. Payments for pharmacy claims may also be pended and reviewed in accordance with applicable 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 PBM will conduct data mining activities in order to identify potential issues of FWA.

The following trends will be 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 will go through the same risk assessment process. The analysis may be focused on the following characteristics:

- Prescription drug shorting, which occurs when pharmacy staff provides less than the prescribed quantity and intentionally does not inform the Member or arranges to provide the balance but bills for the prescribed amount.
- Bait and switch pricing, which occurs when a Member is led to believe that a drug will cost one (1) price, but at the point of sale, they are charged a higher amount. An example of this type of scheme is when the pharmacy switches the prescribed medication to a form that increases the pharmacy's reimbursement.
- Prescription forging, or altering, which occurs when existing prescriptions are altered to increase the quantity or the number of refills, without the prescriber's authorization. Usually, the medications are diverted after being billed to the Medicare Part D program.
- Dispensing expired, or adulterated, prescription drugs, which occurs when pharmacies dispense drugs after the expiration date on the package. This also includes drugs that are intended as samples not for sale or have not been stored or handled in accordance with manufacturer and FDA requirements.
- Prescription refill errors, which occur when pharmacy staff deliberately provides several refills different from the number prescribed by the provider.
- Failure to offer negotiated prices, which occurs when a pharmacy charges a Member the wrong amount.

d. Sample Indicators

No one 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.
- 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 database and a report is generated and submitted to 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, as necessary;
- Review of Member enrollment applications and other documents, 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

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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. 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, 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 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.

b. 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

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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;
- 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.

c. Cooperation with regulatory investigations or prosecutions

Should there be any investigation or prosecution conducted by the Office of the Attorney General, Division of Medi-Cal Fraud and Elder Abuse (DMFEA), or the U.S. DOJ, CalOptima Health shall cooperate with the investigation, which may include, but is not limited to, providing information and access to records upon request.

VI. ANNUAL FWA EVALUATION

CalOptima Health's Compliance Committee shall periodically review and evaluate the FWA work plan, FWA activities, and its effectiveness as part of the overall Compliance Program Audit and Monitoring Activities. Revisions should be made based on industry changes, trends in FWA activities (locally and nationally), the OIG Work Plan, the CalOptima Health Compliance Plan, and other input from applicable sources.

VII. POLICIES AND PROCEDURES (P&Ps)

The CalOptima Health Policies and Procedures listed below are the primary means by which the Anti-Fraud, Waste and Abuse Plan is effectuated at CalOptima Health.

- GA.8022: Performance and Behavior Standards
- GG.1408: Pharmacy Audits and Reviews
- GG.1428: Pharmacy Management Medi-Cal Rx Responsibilities
- GG.1615: Corrective Action Plan for Practitioners
- HH.1105: Fraud, Waste, and Abuse Detection
- HH.1107: Fraud, Waste, and Abuse Investigation and Reporting
- HH.2002: Sanctions

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- HH.2005: Corrective Action Plan
- HH.2018: Compliance and Ethics Hotline
- HH.2019: Reporting Suspected or Actual FWA, Violations of Applicable Laws, and/or CalOptima Policies
- HH.2020: Conducting Compliance Investigations
- HH.2028: Code of Conduct
- HH.3012: Non-retaliation for Reporting Violations
- HH.5000: Provider Overpayment Investigation and Determination
- HH.5004: False Claims Act Education
- MA.1615: Corrective Action Plan for Practitioners
- MA.6104: Opioid Medication Utilization Management

Attachment 5: 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]:
FF.2014: Delegation and Oversight of Claims Activities *Audit & Oversight – External*	**B – REVISED:** This policy was reviewed pursuant to the CalOptima Health Regulatory Affairs and Compliance policy review process to ensure definitions, references, attachments, operational alignment with regulatory requirements and removal of the OneCare Connect program. Ownership of this policy was transferred from the Claims Administration department to the Audit & Oversight department to align with current processes including updates to timing, monitoring and audit processes. **Program(s)**: Medi-Cal; OneCare	
GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities *Audit & Oversight – External*	**B – REVISED:** This policy was reviewed pursuant to the CalOptima Health Regulatory Affairs and Compliance policy review process to ensure definitions, references, attachments, operational alignment with regulatory requirements and removal of the OneCare Connect program. Ownership of this policy was transferred from Utilization Management to Audit & Oversight and includes the clarification of language specifying the monitoring transition. **Program(s)**: Medi-Cal; OneCare	
HH.4002: CalOptima Health Internal Oversight *Audit & Oversight – Internal*	**B – REVISED:** This policy was reviewed pursuant to the CalOptima Health Regulatory Affairs and Compliance policy review process to ensure definitions, references, attachments, and operational alignment with regulatory requirements. This policy was also updated to provide operational language clarification regarding conduction and review of assessments. **Program(s)**: Administrative	
HH.5000: Provider Overpayment Investigation and Determination *Fraud, Waste, Abuse – Special Investigations Unit*	**B – REVISED:** This policy was reviewed pursuant to the CalOptima Health Regulatory Affairs and Compliance policy review process to ensure definitions, references, attachments, operational alignment with regulatory requirements and removal of the OneCare Connect program. Policy detail was added to support the overpayment identification process, investigation protocols and timing clarifications. **Program(s)**: Medi-Cal; OneCare; PACE	

POLICY & DEPARTMENT	REVISION & PROGRAM	A – NEW B – REVISED C – RETIREMENT D – REVISED [MINOR EDITS]: E – ANNUAL REVIEW [NO EDITS]:
HH.3007: Member Rights to Request Restrictions on Use and Disclosure of Protected Health Information (PHI) *Privacy*	**B – REVISED:** This policy was reviewed pursuant to the CalOptima Health Regulatory Affairs and Compliance policy review process to ensure definitions, references, attachments, operational alignment with regulatory requirements and removal of the OneCare Connect program. Policy updates include clarification regarding requests for restrictions on use and disclosure in alignment with DMHC compliance and filing requirements. **Program(s)**: Medi-Cal; OneCare; PACE	
HH.3008: Member Right to Request Confidential Communications *Privacy*	**B – REVISED:** This policy was reviewed pursuant to the CalOptima Health Regulatory Affairs and Compliance policy review process to ensure definitions, references, attachments, operational alignment with regulatory requirements and removal of the OneCare Connect program. Policy updates include clarification regarding request requirements and allowances in alignment with DMHC compliance and filing requirements. **Program(s)**: Medi-Cal; OneCare; PACE	
AA.1270: Certification of Document and Data Submissions *Regulatory Affairs & Compliance*	**B – REVISED:** This policy was reviewed pursuant to the CalOptima Health Regulatory Affairs and Compliance policy review process to ensure definitions, references, attachments, operational alignment with regulatory requirements and removal of the OneCare Connect program. Policy updates include adding the number of Dual Eligible Special Needs Plan (D-SNP) members enrolled monthly to certification reporting elements, submission process updates, attestation processes and FAQ attachment updates. **Program(s)**: Medi-Cal, OneCare	
HH.2002: Sanctions *Regulatory Affairs & Compliance*	**B – REVISED:** This policy was reviewed pursuant to the CalOptima Health Regulatory Affairs and Compliance policy review process to ensure definitions, references, attachments, operational alignment with regulatory requirements and removal of the OneCare Connect program. Policy language was added enhancing findings for determination of sanction severity, types of sanctions, details regarding monetary sanctions, penalty assessments and calculations. **Program(s)**: Medi-Cal; OneCare; PACE	
HH.2005: Corrective Action Plan *Regulatory Affairs & Compliance*	**B – REVISED:** This policy was reviewed pursuant to the CalOptima Health Regulatory Affairs and Compliance policy review process to ensure definitions, references, attachments, operational alignment with regulatory requirements and removal of the OneCare Connect program. Policy language was added to include the acknowledgement of separate processes by internal departments and FDRs to identify issues of non-compliance through monitoring, investigation and corrective action processes. **Program(s)**: Medi-Cal; OneCare; PACE	

POLICY & DEPARTMENT	REVISION & PROGRAM	A – NEW B – REVISED C – RETIREMENT D – REVISED [MINOR EDITS]: E – ANNUAL REVIEW [NO EDITS]:
HH.2020: Conducting Compliance Investigations *Regulatory Affairs & Compliance*	**B – REVISED:** This policy was reviewed pursuant to the CalOptima Health Regulatory Affairs and Compliance policy review process to ensure definitions, references, attachments, operational alignment with regulatory requirements and removal of the OneCare Connect program. Policy updates were made to preliminary investigation options to include, a Corrective Action Plan (CAP), educational letter, warning letter or other appropriate actions. **Program(s)**: Medi-Cal; OneCare; PACE	
MA.9124: CMS Self-Disclosure *Regulatory Affairs & Compliance*	**B – REVISED:** This policy was reviewed pursuant to the CalOptima Health Regulatory Affairs and Compliance policy review process to ensure definitions, references, attachments, operational alignment with regulatory requirements and removal of the OneCare Connect program. Additional language was added to the policy to clarify the process regarding escalation of findings to senior management prior to self-disclosure. **Program(s)**: Medi-Cal; OneCare; PACE	

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
GG.1619: Delegation Oversight	*Audit & Oversight – External*
HH.2025: Health Network Subdelegation and Subcontracting	*Audit & Oversight – External*
HH.2027: Annual Risk Assessment (FDR)	*Audit & Oversight – External*
HH.4001: Audit & Oversight Committee	*Audit & Oversight – External*
HH.4003: Annual Risk Assessment	*Audit & Oversight – Internal*
HH.1105: Fraud, Waste, and Abuse Detection	*Fraud, Waste, Abuse – Special Investigations Unit*
HH.1107: Fraud, Waste, and Abuse Investigation and Reporting	*Fraud, Waste, Abuse – Special Investigations Unit*
HH.5004: False Claims Act Education	*Fraud, Waste, Abuse – Special Investigations Unit*
HH.3000: Notice of Privacy Practices	*Privacy*
HH.3001: Member Access to Designated Record Set	*Privacy*
HH.3002: Minimum Necessary Uses and Disclosure of Protected Health Information (PHI) and Document Controls	*Privacy*
HH.3003: Verification of Identity for Disclosure of Protected Health Information	*Privacy*
HH.3004: Member Request to Amend Records	*Privacy*
HH.3005: Member Request for Accounting of Disclosures	*Privacy*
HH.3006: Tracking and Reporting Disclosures of Protected Health Information (PHI)	*Privacy*
HH.3009: Access by Member's Authorized Representative	*Privacy*
HH.3010: Protected Health Information (PHI) Disclosures Required by Law	*Privacy*
HH.3011: Use and Disclosure of PHI for Treatment, Payment, and Health Care Operations	*Privacy*

POLICY	DEPARTMENT
HH.3014: Use of Electronic Mail with Protected Health Information (PHI)	*Privacy*
HH.3015: Member Authorization for the Use and Disclosure of Protected Health Information (PHI)	*Privacy*
HH.3016: Guidelines for Handling Protected Health Information (PHI) Offsite	*Privacy*
HH.3019: De-identification of Protected Health Information (PHI)	*Privacy*
HH.3020: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI, or Other Unauthorized Use or Disclosure of PHI/PI	*Privacy*
HH.3022: Business Associates Agreements	*Privacy*
GA.7501: Regulatory Communications	*Regulatory Affairs & Compliance*
GA.7505: Regulatory Liaison Responsibilities	*Regulatory Affairs & Compliance*
HH.2007: Compliance Committee	*Regulatory Affairs & Compliance*
HH.2014: Compliance Program	*Regulatory Affairs & Compliance*
HH.2018: Compliance and Ethics Hotline	*Regulatory Affairs & Compliance*
HH.2019: Reporting Suspected or Actual Fraud, Waste, or Abuse (FWA) and Violations of Applicable Laws and Regulations and/or CalOptima Health Policies	*Regulatory Affairs & Compliance*
HH.2021: Exclusion and Preclusion Monitoring	*Regulatory Affairs & Compliance*
HH.2022: Record Retention and Access	*Regulatory Affairs & Compliance*
HH.2023: Compliance Training	*Regulatory Affairs & Compliance*
HH.2028: Code of Conduct	*Regulatory Affairs & Compliance*
HH.2029: Annual Compliance Program Effectiveness Audit	*Regulatory Affairs & Compliance*
HH.3012: Non-Retaliation for Reporting Violations	*Regulatory Affairs & Compliance*

Policy:	FF.2014
Title:	**Delegation and Oversight of Claims Activities**
Department:	~~Claims Administration~~Office of Compliance
Section:	~~Not Applicable~~Audit & Oversight
CEO Approval:	*/s/*
Effective Date:	12/20/2021
Revised Date:	12/31/2022
Applicable to:	☒ Medi-Cal ☒ OneCare ~~☒ OneCare Connect~~ ☐ PACE ☐ Administrative

I. PURPOSE

This policy outlines the processes by which CalOptima Health ensures claims activities delegated to Health Networks are conducted in compliance with statutory, regulatory, and contractual requirements and CalOptima Health policies and procedures.

II. POLICY

A. CalOptima Health may delegate the processing and adjudication of claims to a Health Network for services rendered to Members, that are the Health Network's financial responsibility as set forth in the CalOptima Health Division of Financial Responsibility (DOFR), attached to the CalOptima Health, Health Network Contract for Health Care Services.

B. CalOptima Health shall maintain oversight responsibility for all delegated claims activities, such as ensuring that its delegated health Networks are in compliance with applicable Medi-Cal and/or Medicare program requirements, State and federal laws and regulations, contractual requirements in accordance with this Policy and CalOptima Health Policy GG.1619: Delegation Oversight.

C. CalOptima Health shall conduct ongoing monitoring of a delegated Health Network, including an annual performance review, as set forth in this Policy and CalOptima Health Policy HH.2015: Health Networks Claims Processing to ensure a Health Network's compliance with claims processing standards, statutory, regulatory, and contractual requirements, and CalOptima Health policies and procedures.

III. PROCEDURE

A. Monitoring & Auditing

1. The ~~Claims~~Audit & Oversight Department shall monitor a delegated Health Network's claims activity throughroutine audits, reports, and continuous improvement activities.

2. A Health Network shall submit reports to CalOptima Health on a periodic basis, as specified by CalOptima Health, including, but not limited to, those reports specified in the CalOptima

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Health, Health Network Contract for Health Care Services and CalOptima Health Policy HH.2003: Health Network and Delegated Entity Reporting.

3. Pursuant to the audit process as outlined in Section III.~~B~~C. of this Policy, a Health Network shall forward copies of selected claims notices to CalOptima Health for review. CalOptima Health Claims Department shall review the notice of denial of payment letters for appropriate denial language.

4. On ~~a monthly~~an annual basis, the CalOptima ~~Claims~~Health Audit & Oversight Department shall pull claims from the audit as outlined in Section III.~~B~~C. of this Policy, and monitor Health Network claims and dispute resolution processes for:

   a. Acknowledgment;

   b. Accuracy;

   c. Timeliness;

   d. Accurate and clear Explanation of Benefits (EOB);

   e. Filing deadlines and misdirected claims;

   f. Provider acknowledgment;

   g. Appropriate Provider dispute resolution upheld/overturned; and

   h. Interest/penalty accuracy.

B. ~~Auditing~~Monitoring Process

1. ~~On a monthly basis, claims files submitted by a~~ The Audit & Oversight Department (A&O) shall monitor the Health Network XML Dashboards on a monthly basis. The A&O Department shall monitor and identify any non-compliant measures or trends. If any area of deficiency or non-compliance measure or trend is identified a Corrective Action Plan will be issued in accordance with CalOptima Health's Policy HH.2005: Corrective Action Plan.

2. On a monthly basis, Health Networks will submit claims universes and Providers will submit Provider Data Records (~~PDR) supplied by CalOptima, are submitted~~PDRs) on the second (2nd) business day of the month to CalOptima Health's Information Technology Services (~~IS). The IS algorithm shall select ten (10) files for paid and denied claims for each of the Health Networks' programs. Selected files are sent~~ ITS).

C. Auditing Process

1. Audit & Oversight shall review universes submitted to ITS by the Health Network ~~on~~and request selected files on an ad hoc basis from the ~~third (3rd) of every month~~Health Network.

2. A Heath Network shall ensure that the documents are organized in the order of the selection provided by CalOptima Health and accessible on the day of the claims audit. ~~CalOptima~~Audit & Oversight Department may request copies of the documents from the Health Network.

3. Submissions shall include elements pertaining to the validity and accuracy of claims adjudication (payment, denial, or contest), including:

a. Dispute resolution, which includes, but is not limited to, accuracy and appropriateness of claims payment, including automatic payment of interest as applicable.

b. Validity of denial reasons documentation and written notification; accuracy, validity and appropriateness of adjustments, including applicability and payment of interest and notifications; mandatory disclosures and notification language denials, adjusted claims and disputes; accuracy and appropriateness of notifications, resolution and written determination and other regulatory or contractual requirements as it pertains to the resolution of disputes; or other measures that may constitute unfair payment practices.

4. A Health Network shall ensure that at least eighty percent (80%) of checks clear a banking institution within fourteen (14) calendar days after the date ~~of~~ the check is mailed.

5. If a Health Network and its delegates, and subcontractors, are unable to furnish all required documents requested by CalOptima~~, CalOptima~~ Health, Audit & Oversight may score missing documents as non-compliant.

6. A Health Network shall make staff available during the claims audit to answer questions and provide necessary information to ~~CalOptima~~Audit & Oversight in order to complete the claims audit.

7. CalOptima Health may require a Health Network to submit a Corrective Action Plan (CAP) addressing all areas of deficiency as determined by ~~CalOptima~~Audit & Oversight in accordance with CalOptima Health Policy HH.2005: Corrective Action Plan.

8. CalOptima Health may impose remedies such as, but not limited to, de-delegation of claims payment, or may impose Sanctions against a Health Network pursuant to CalOptima Health Policy HH.2002: Sanctions.

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 Compliance Plan
~~C.~~D. CalOptima Health, Health Network Contract for Healthcare Services
~~D.~~E. CalOptima Health, Health Network Delegation Agreement
~~E. CalOptima Compliance Plan~~
F. CalOptima Health Policy FF.2001: Claims Processing for Covered Services ~~Rendered to~~for which CalOptima ~~Direct Administrative Members,~~ Health is Financially Responsible
~~F.~~ CalOptima ~~Community Network Members, or Members Enrolled in a Shared Risk Group~~
G. ~~CalOptima~~Health Policy GG.1619: Delegation Oversight
H. CalOptima Health Policy HH.2002: Sanctions
I. CalOptima Health Policy HH.2003: Health Network and Delegated Entity Reporting
J. CalOptima Health Policy HH.2005: Corrective Action Plan
K. CalOptima Health Policy HH.2015: Health Networks Claims Processing

VI. REGULATORY AGENCY APPROVAL(S)

~~None to Date~~

Date	Regulatory Agency	Response
02/11/2022	Department of Health Care Services (DHCS)	Approved as Submitted
TBD	Department of Health Care Services (DHCS)	TBD

VII. BOARD ACTION(S)

Date	Meeting
12/20/2021	Special Meeting of CalOptima Board of Directors
TBD	Regular Meeting of CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	12/20/2021	FF.2014	Delegation and Oversight of Claims Activities	Medi-Cal OneCare OneCare Connect
Revised	12/31/2022	FF.2014	Delegation and Oversight of Claims Activities	Medi-Cal OneCare

IX. GLOSSARY

Term	Definition
Auditing	A formal, systematic, and disciplined approach designed to evaluate and improve the effectiveness of processes and related controls. Auditing is governed by professional standards, completed by individuals independent of the process being audited and normally performed by individuals with one of several acknowledged certifications.
Compliance Committee	The CalOptima Health committee that consists of executive officers, managers of key operating divisions, and legal counsel that oversees implementation of ~~CalOptima's~~CalOptima Health's Compliance Program.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima Health, the Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima Health departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima Health and its regulators.

Term	Definition
Covered Services	Medi-Cal: Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with ~~section~~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~~Section 14094.4) under the Whole-Child Model program, to the extent those services are included as Covered Services under ~~CalOptima's~~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 ~~Health Homes Program (HHP) services~~Enhanced Care Management and Community Supports as part of the California Advancing and Innovating Medi-Cal (CalAIM) Initiative (as set forth in the CalAIM 1115 Demonstration & 1915(b) Waiver, DHCS All Plan Letter ~~18~~(APL) 21-012: Enhanced Care Management Requirements and APL 21-017: Community Supports Requirements, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article ~~3.9~~5.51, beginning with ~~section 14127) for HHP Members with eligible physical chronic conditions and substance use disorders,~~Section 14184.100), or other services as authorized by the CalOptima Health Board of Directors, which shall be covered for Members ~~not withstanding~~notwithstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program. OneCare: Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Centers for Medicare & Medicaid Services (CMS) Contract. ~~OneCare Connect: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Three-Way Contract with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS).~~
Explanation of Benefits (EOB)	An ad hoc communication that provides Members with clear and timely information about their medical claims to support informed decisions about their healthcare options.
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
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: ~~A~~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, ~~pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician,~~ non-physician ~~assistant, hospital,~~ provider, laboratory, ~~health maintenance~~supplier, etc.) providing Covered Services under Medicare Part B. Any organization, ~~Health Network, or other person or~~ institution ~~who furnishes Covered Services.~~ ~~OneCare Connect: A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Health Network, physician group, or other person or institution who furnishes~~, 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.

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Policy:	FF.2014
Title:	**Delegation and Oversight of Claims Activities**
Department:	Office of Compliance
Section:	Audit & Oversight
CEO Approval:	*/s/*
Effective Date:	12/20/2021
Revised Date:	12/31/2022
Applicable to:	☒ Medi-Cal ☒ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy outlines the processes by which CalOptima Health ensures claims activities delegated to Health Networks are conducted in compliance with statutory, regulatory, and contractual requirements and CalOptima Health policies and procedures.

II. POLICY

A. CalOptima Health may delegate the processing and adjudication of claims to a Health Network for services rendered to Members, that are the Health Network's financial responsibility as set forth in the CalOptima Health Division of Financial Responsibility (DOFR), attached to the CalOptima Health, Health Network Contract for Health Care Services.

B. CalOptima Health shall maintain oversight responsibility for all delegated claims activities, such as ensuring that its delegated health Networks are in compliance with applicable Medi-Cal and/or Medicare program requirements, State and federal laws and regulations, contractual requirements in accordance with this Policy and CalOptima Health Policy GG.1619: Delegation Oversight.

C. CalOptima Health shall conduct ongoing monitoring of a delegated Health Network, including an annual performance review, as set forth in this Policy and CalOptima Health Policy HH.2015: Health Networks Claims Processing to ensure a Health Network's compliance with claims processing standards, statutory, regulatory, and contractual requirements, and CalOptima Health policies and procedures.

III. PROCEDURE

A. Monitoring & Auditing

1. The Audit & Oversight Department shall monitor a delegated Health Network's claims activity throughroutine audits, reports, and continuous improvement activities.

2. A Health Network shall submit reports to CalOptima Health on a periodic basis, as specified by CalOptima Health, including, but not limited to, those reports specified in the CalOptima Health, Health Network Contract for Health Care Services and CalOptima Health Policy HH.2003: Health Network and Delegated Entity Reporting.

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3. Pursuant to the audit process as outlined in Section III.C. of this Policy, a Health Network shall forward copies of selected claims notices to CalOptima Health for review. CalOptima Health Claims Department shall review the notice of denial of payment letters for appropriate denial language.

4. On an annual basis, the CalOptima Health Audit & Oversight Department shall pull claims from the audit as outlined in Section III.C. of this Policy, and monitor Health Network claims and dispute resolution processes for:

    a. Acknowledgment;

    b. Accuracy;

    c. Timeliness;

    d. Accurate and clear Explanation of Benefits (EOB);

    e. Filing deadlines and misdirected claims;

    f. Provider acknowledgment;

    g. Appropriate Provider dispute resolution upheld/overturned; and

    h. Interest/penalty accuracy.

B. Monitoring Process

1. The Audit & Oversight Department (A&O) shall monitor the Health Network XML Dashboards on a monthly basis. The A&O Department shall monitor and identify any non-compliant measures or trends. If any area of deficiency or non-compliance measure or trend is identified a Corrective Action Plan will be issued in accordance with CalOptima Health's Policy HH.2005: Corrective Action Plan.

2. On a monthly basis, Health Networks will submit claims universes and Providers will submit Provider Data Records (PDRs) on the second (2nd) business day of the month to CalOptima Health's Information Technology Services (ITS).

C. Auditing Process

1. Audit & Oversight shall review universes submitted to ITS by the Health Network and request selected files on an ad hoc basis from the Health Network.

2. A Heath Network shall ensure that the documents are organized in the order of the selection provided by CalOptima Health and accessible on the day of the claims audit. Audit & Oversight Department may request copies of the documents from the Health Network.

3. Submissions shall include elements pertaining to the validity and accuracy of claims adjudication (payment, denial, or contest), including:

    a. Dispute resolution, which includes, but is not limited to, accuracy and appropriateness of claims payment, including automatic payment of interest as applicable.

b. Validity of denial reasons documentation and written notification; accuracy, validity and appropriateness of adjustments, including applicability and payment of interest and notifications; mandatory disclosures and notification language denials, adjusted claims and disputes; accuracy and appropriateness of notifications, resolution and written determination and other regulatory or contractual requirements as it pertains to the resolution of disputes; or other measures that may constitute unfair payment practices.

4. A Health Network shall ensure that at least eighty percent (80%) of checks clear a banking institution within fourteen (14) calendar days after the date the check is mailed.

5. If a Health Network and its delegates, and subcontractors, are unable to furnish all required documents requested by CalOptima Health, Audit & Oversight may score missing documents as non-compliant.

6. A Health Network shall make staff available during the claims audit to answer questions and provide necessary information to Audit & Oversight in order to complete the claims audit.

7. CalOptima Health may require a Health Network to submit a Corrective Action Plan (CAP) addressing all areas of deficiency as determined by Audit & Oversight in accordance with CalOptima Health Policy HH.2005: Corrective Action Plan.

8. CalOptima Health may impose remedies such as, but not limited to, de-delegation of claims payment, or may impose Sanctions against a Health Network pursuant to CalOptima Health Policy HH.2002: Sanctions.

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 Compliance Plan
D. CalOptima Health, Health Network Contract for Healthcare Services
E. CalOptima Health, Health Network Delegation Agreement
F. CalOptima Health Policy FF.2001: Claims Processing for Covered Services for which CalOptima Health is Financially Responsible
G. CalOptima Health Policy GG.1619: Delegation Oversight
H. CalOptima Health Policy HH.2002: Sanctions
I. CalOptima Health Policy HH.2003: Health Network and Delegated Entity Reporting
J. CalOptima Health Policy HH.2005: Corrective Action Plan
K. CalOptima Health Policy HH.2015: Health Networks Claims Processing

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
02/11/2022	Department of Health Care Services (DHCS)	Approved as Submitted
TBD	Department of Health Care Services (DHCS)	TBD

VII. BOARD ACTION(S)

Date	Meeting
12/20/2021	Special Meeting of CalOptima Board of Directors
TBD	Regular Meeting of CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	12/20/2021	FF.2014	Delegation and Oversight of Claims Activities	Medi-Cal OneCare OneCare Connect
Revised	12/31/2022	FF.2014	Delegation and Oversight of Claims Activities	Medi-Cal OneCare

IX. GLOSSARY

Term	Definition
Auditing	A formal, systematic, and disciplined approach designed to evaluate and improve the effectiveness of processes and related controls. Auditing is governed by professional standards, completed by individuals independent of the process being audited and normally performed by individuals with one of several acknowledged certifications.
Compliance Committee	The CalOptima Health committee that consists of executive officers, managers of key operating divisions, and legal counsel that oversees implementation of CalOptima Health's Compliance Program.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima Health, the Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima Health departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima Health and its regulators.
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 for Medicare & Medicaid Services (CMS) Contract.
Explanation of Benefits (EOB)	An ad hoc communication that provides Members with clear and timely information about their medical claims to support informed decisions about their healthcare options.
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
Member	A beneficiary enrolled in a CalOptima Health program.
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.

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Policy:	GG.1605
Title:	**Delegation and Oversight of Credentialing and Recredentialing Activities**
Department:	~~Medical Management~~Office of Compliance
Section:	~~Quality Improvement~~Audit & Oversight
CEO Approval:	*/s/*
Effective Date:	12/01/1995
Revised Date:	12/31/2022
Applicable to:	☒ Medi-Cal ☒ OneCare ~~☒ OneCare Connect~~ ☐ PACE ☐ Administrative

I. PURPOSE

This policy outlines the processes by which CalOptima Health shall ensure Credentialing and Recredentialing activities are performed by Delegated Entities in accordance with quality, state, and federal standards.

II. POLICY

A. CalOptima Health may ~~Delegate~~delegate authority to perform screening and enrollment activities to a Health Network or other Delegated Entity. If CalOptima Health chooses to delegate this function, the following shall occur:

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

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

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

4. CalOptima Health shall notify DHCS sixty (60) calendar days prior to delegating the screening and enrollment to a Health Network or Delegated Entity and shall submit P&Ps that outline the delegation authority, as well as CalOptima's monitoring and oversight activities.

5. CalOptima Health may accept evidence of NCQA Provider Organization Certification (POC) in lieu of a monitoring site visit at delegated physician organizations.

~~A.~~B. C
alOptima Health may delegate Credentialing and Recredentialing of a Practitioner and/or

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Assessment and Re-Assessment of an Organizational Provider to a Delegated Entity, in accordance with this Policy.

~~B.~~C. CalOptima Health shall comply with California rules of Delegation of Quality Improvement Activities.

~~C.~~D. CalOptima Health shall remain accountable for Credentialing and Recredentialing of its Practitioners and Assessment and Re-Assessment of its Organizational Providers, even if CalOptima ~~Delegates~~Health delegates all or part of these activities.

1. Delegated activities may include, but are not limited to, processing ~~Credentialing~~ credentialing applications, credentialing decision-making, development of decision-making criteria, ~~Credentialing~~credentialing policiesand procedures, ~~Credentialing~~credentialing verification, ~~Credentialing~~credentialing systems control, credentialing file management, and monitoring of Sanctions and exclusions.~~—~~

E. CalOptima Health may delegate their authority to perform credentialing reviews to a professional credentialing verification organization (CVO).

1. The delegation must be in a written subcontract or agreement and comply with the requirements set forth in Department of Health Care Services (DHCS) All Plan Letter (APL) 17-004: Subcontractual Relationships and Delegation and any subsequent APL.

2. CalOptima Health shall remain contractually responsible for the completeness and accuracy of these activities and must establish a system that:

   a. Evaluates the CVO's ability to perform delegated activities that includes an initial review to assure that the CVO has the administrative capacity, experience, and budgetary resources to fulfill its responsibilities.

   b. Ensures that the CVO meets CalOptima, CMS and DHCS standards.

   c. Continuously monitors, evaluates, and approves the delegated functions.

F. CalOptima Health may delegate Credentialing and Recredentialing of a Practitioner and/or Assessment and Re-Assessment of an Organizational Provider to a health network, medical groups or independent physician organization.

~~2.~~1. CalOptima~~CalOptima~~ Health shall be responsible to perform a Readiness Assessment ~~for CalOptima Community Network (CCN) Delegated Entities~~ before implementing Delegation. This assessment ~~will~~shall include verification that the Delegated Entity has devoted sufficient resources and appropriately qualified staff to perform the functions. The following shall be mutually agreed upon between CalOptima Health and the Delegated ~~party:~~ Entity:

a. A written Delegation Acknowledgment and Acceptance Agreement Document (hereafter Delegation Agreement) describing all the ~~Delegated~~delegated Credentialing activities; and

b. CalOptima Health shall retain the right to approve, suspend, and terminate individual ~~Practitioners~~practitioners, providers, and sites in situations where CalOptima Health has ~~Delegated~~delegated decision making, as addressed in the Delegation Agreement.

~~D.~~G. CalOptima Health shall monitor the performance of a Delegated Entity at least annually which includes anaudit of Credentialing written policies and processes as well as Credentialing file review. ~~CalOptima shall evaluate required reports as agreed upon in the Delegation Agreement. Delegate agrees to submit reports, data, and documentation to in accordance with CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting.~~

H. CalOptima Health shall evaluate required reports as agreed upon in the Delegation Agreement. Delegated Entity shall submit reports, data, and documentation in accordance with CalOptima Health Policy HH.2003: Health Network and Delegated Entity Reporting.

~~E.~~I. CalOptima Health shall identify and follow-up on opportunities for improvement, if applicable.

~~F.~~J. CalOptima Health shall require a Delegated Entity to respond to a Corrective Action Plan (CAP), based onany deficiency or area of non-compliance determined during the Readiness Assessment, ~~monthly file review, or~~ annual audit, or other monitoring activity in accordance with CalOptima Health Policy HH.~~2005A~~2005: Corrective Action Plan.

~~G.~~K. CalOptima ~~will~~Health shall perform the Readiness Assessment and ~~annual audit~~Annual Audit of ~~Health Network and~~ Delegated ~~Entities~~Entity for Health Networks, medical groups and independent physician organizations in accordance with CalOptima Health Policy GG.1619: Delegation Oversight.

III. PROCEDURE

A. Subject to ~~CalOptima's~~CalOptima Health's approval of the ~~Delegated~~delegated Credentialing and Recredentialing of Practitioner and/or Assessment and Re-Assessment of an Organizational Provider activities for health networks, medical groups and independent physician organizations, thewritten Delegation Agreement shall include the following:

1. Mutual agreement demonstrated by signatures from both CalOptima Health and the Delegated Entity,and a description of:

   a. Delegated activities;

   b. CalOptima Health and the Delegated Entity responsibilities, which at a minimum include:

      i. Acceptance of applications, reapplications, and attestations;

      ii. Collection of all data elements from the National Committee for Quality Assurance (NCQA) or other appropriate sources, in accordance with CalOptima Health Policies;

      iii. Collection and evaluation of ongoing monitoring information; and

      iv. Decision-making in respect to oversight of Credentialing activities.

   c. Reporting responsibilities and reporting frequency, which shall indicate reporting requirements, unless specified otherwise. The reporting responsibilities shall be noted onthe

Timely and Appropriate Submissions Grid, and include:

i. A list of Credentialed, Recredentialed, and Terminated Practitioners submitted to CalOptima Health by the Delegated Entity.

ii. Reporting of Providers denied credentialing in accordance with CalOptima Health Policies GG.1657:Medical Board of California and the National Practitioner Data Bank (NPDB) Reporting, and GG.1658: Summary Suspension or Restriction of Practitioner Participation in ~~CalOptima's~~CalOptima Health's Network.

d. The process by which CalOptima Health evaluates the Delegated Entity's performance, which includes:

i. Readiness Assessment;

ii. Monitoring via File review;

iii. Annual audit; and

iv. Reporting requirements

e. Remedies available to CalOptima Health if the Delegated Entity does not fulfill its obligations,including revocation of the Delegation Agreement, and Sanctions as referenced in CalOptima Health Policy HH.~~2002A~~2002: Sanctions;

f. ~~CalOptima's~~CalOptima Health's right to approve, suspend and terminate individual Practitioners, providers,and sites in situations where CalOptima Health has Delegated decision-making; and

g. ~~CalOptima's~~CalOptima Health's right to reject a Practitioner upon reason that the Practitioner has failed to meetthe Credentialing or Recredentialing and/or Assessment and Re-assessment requirements, as outlined in the Delegation Agreementand CalOptima Health Policies.

B. Readiness Assessment of ~~CalOptima Community Network (CCN)~~ Delegated Entities

1. CalOptima Health shall conduct a Readiness Assessment of a Delegated Entity to determine the Delegated Entity's ability to implement ~~Delegated~~delegated Credentialing and Recredentialing and/or Assessment and Re-assessment activitiesbefore entering into and implementing a Delegation Agreement.

2. The Readiness Assessment shall consist of a comprehensive desk review via electronic document submission and/or on-site evaluation as required, utilizing the delegation oversight audit tool, which ~~will~~shall evaluate a Delegated Entity's capacity to provide all Delegated functions. Additional documentation may need to be provided to complete the audit. The evaluation shall include:

a. Written review of the Delegated Entity's understanding of applicable standards;

b. Delegated tasks;

c. Review of policies and procedures;

d. Staffing capabilities;

e. Performance records;

f. Review of Credentialing system; and

g. Credentialing and Recredentialing file review.

3. Upon completion of the Readiness Assessment, ~~CalOptima's Director of~~Audit & Oversight or Quality Improvement Department shall report the Readiness Assessment results to the ~~Audit &~~Delegation Oversight Committee (D~~A~~OC) ~~meeting~~.

4. The ~~AOC~~DOC shall determine if the Delegated Entity meets ~~CalOptima's~~CalOptima Health's criteria for ~~Delegation~~delegation ofCredentialing and Recredentialing activities based on the results of the Readiness Assessment.

a. If the ~~AOC~~DOC determines that a Delegated Entity does not meet ~~CalOptima's~~CalOptima Health's criteria for ~~Delegation~~delegation of Credentialing and Recredentialing activities, CalOptima Health may reassess suchDelegated Entity no earlier than three (3) months after the initial Readiness Assessment.

C. Delegated Entity Responsibilities

1. A Delegated Entity shall:

a. Develop and implement processes, in accordance with this Policy, for the Credentialing and Recredentialing of Practitioners and the Assessment and Re-Assessment of Organizational Providers with whom it contracts or employs, as applicable per delegate;

b. Develop policies and procedures that are consistent with the CalOptima Health Policies GG.1650~~A~~:Credentialing and Recredentialing of Practitioners and GG.1651~~A~~: Assessment and Re- Assessment of Organizational Providers, ~~as~~where applicable, and include:

i. The process to ~~Delegate~~delegate Credentialing or Recredentialing and/or Assessment and Re-assessment activities;

ii. The medical director or other designated physician's direct responsibility and participation in the Credentialing program;

iii. The process used to ensure the confidentiality of all information obtained in the Credentialing process, except as otherwise provided by law;

iv. The process for including Practitioner Rights; and

v. Address ongoing monitoring following CalOptima Health Policy GG.1607: Monitoring Adverse Actions.

c. Develop policies and procedures to verify the participation status of the Delegated Entity's providers to ensure that they shall:

i. Disclose to ~~CalOptima's~~CalOptima Health's Quality Improvement Department any pending investigationinvolving, or any determination of, suspension, exclusion, preclusion or debarment bythe Delegated Entity or its agents, occurring or discovered during the term of the Contract for Health Care Services; and

ii. Take action to remove any Delegated Entity agent who does not meet participation status requirements from furnishing items or services related to the Health Network Service Agreement (whether medical or administrative) to Members.

d. Designate dedicated staff responsible for the timely Credentialing and Recredentialing of all Practitioners and Assessment and Re-Assessment of all Organizational Providers.

e. Credential and recredential Practitioners and assess and re-assess Organizational Providers, in accordance with DHCS, CMS and NCQA Credentialing Standards and CalOptima Health Policies.

D. Sub-Delegation

1. A Delegated Entity shall not ~~Delegate~~delegate any Credentialing or Recredentialing activity without prior written approval from CalOptima~~.~~ Health.

2. If a Delegated Entity ~~Delegates~~delegates to a ~~credentialing verification organization (~~CVO~~),~~, CalOptima Health requires that the CVO be certified by the National Committee for Quality Assurance (NCQA).The Delegated Entity shall retain ultimate responsibility for any Delegated activities.

3. Prior to delegating Credentialing activities, a Delegated Entity shall evaluate the potential Sub-Delegate's capacity to perform such activities, according to CalOptima Health Credentialing and Recredentialing standards.

4. The Delegated activities shall be described in a written Delegation Agreement with the Sub-Delegate.~~-~~ The agreement between the Delegated Entity and a Sub-Delegate shall include all of the following:

a. The responsibilities of each party;

b. The Delegated activities;

c. The process by which a Delegated Entity shall evaluate the Sub-Delegate's performance;

d. The remedies, including revocation of Delegation, available to the Delegated Entity if the Sub-Delegate does not fulfill its obligations;

e. A process for submission of regular reports by the Sub-Delegate to the Delegated Entity;

f. The Delegated Entity shall provide ongoing monitoring of the Sub-Delegate's activities under the agreement;

g. Both CalOptima Health and the Delegated Entity's Peer Review Body shall retain the right to approve, terminate or suspend individual practitioners, providers or sites based upon quality issues;

h. Agreement as to the exchange of information between the Delegated Entity and the Sub-Delegate, including a definition of peer review or confidential information, and a processfor sharing information with each other and with third parties;

i. A process for handling Protected Health Information (PHI), in accordance with the Health Insurance Portability and Accountability Act (HIPAA) as amended; and

j. A monitoring and auditing schedule.

5. A Delegated Entity shall be responsible for providing oversight for all ~~Delegated~~delegated Credentialing activities.

6. At least annually, Delegated Entity shall evaluate the Sub-Delegate's Credentialing process. Theevaluation shall ensure that the Delegated activities are conducted in accordance with ~~CalOptima's Credentialing standards.~~ CalOptima Health's Credentialing standards.

7. The Delegated Entity shall submit to CalOptima Health an annual report documenting the DelegatedEntity's evaluation process of the ~~Delegated~~delegated function.

8. CalOptima Health shall monitor the Delegated Entity's oversight process of the Sub-Delegate through~~CalOptima's~~ CalOptima Health's annual oversight of the Delegated Entity's Credentialing and Recredentialing and Assessment and Re-assessment process.

E. Annual Audit of ~~CCN~~ Delegated Entities

1. At least annually, CalOptima Health shall perform an audit of written policies and procedures as well as a review of Credentialing files to ensure compliance with all applicable NCQA, regulatory and contractual standards for each year that the Delegation is in effect. The annual audit shall bebased on the responsibilities stated in the Delegation Agreement and performance of ~~Delegated~~delegated activities, as well as the appropriate NCQA, regulatory and contractual standards. This audit may be performed on-site and/or via desktop review. Additional documentation may need to be provided to complete the audit.

2. The annual audit shall include the review of policies and procedures utilizing the delegation oversight annual audit tool. This audit will include, but not be limited to:

a. A review of Delegated Entity's Peer Review Body meeting minutes, which shall be conducted for Credentialing and Recredentialing activities;

b. A review to confirm the Delegated Entity's reporting procedure to CalOptima Health when there isaction taken against a practitioner that relates to professional behavior or clinical competence, and suspensions, terminations, restrictions, or limitations placed upon a Practitioner due to quality of care issues or any other decisions made by the Delegated Entity's Peer Review Body that are reportable to a regulatory agency (e.g., Medical Board of California (MBOC), Office of the Inspector General (OIG), or the National Practitioner Data Bank (NPDB).)

3. An annual file review is also conducted utilizing the Credentialing and Recredentialing file review tool:

a. CalOptima Health shall apply a targeted approach or select files with potential issue(s) of non- compliance when conducting the annual file review and will provide the organization withthe file selection.

i. The number of files selected for each file type will vary depending on the audit area,its associated risk level, and/or the number of files available. Credentialing requirements applicable to both file types are scored for all files.

ii. CalOptima Health will select files based upon the NCQA 8/30 methodology of both credentialing and recredentialing files. ~~–~~If fewer than eight (8) Practitioners were credentialed or recredentialed since the last annual audit, CalOptima Health will audit theuniverse of files rather than a sample.

b. If the requirement applies only to initial Credentialing files (e.g., work history) or to Recredentialing files (e.g., Recredentialing cycle length), the requirement is scored 'Not Applicable' for the file type that does not apply.

~~b.~~c. CalOptima Health shall review documentation of substantive evaluation and action plans, if needed.

~~c.~~d. If the Delegated Entity does not have any files for Credentialing or Recredentialing between audit cycles, CalOptima Health will not perform an annual audit, but instead shall require the Delegated Entity to meet all other delegation oversight requirements and provide documentation that the Delegated Entity did not Credential or Recredential Practitioners between audit cycles.

4. An annual audit shall include the review of the delegate's policies and procedures and the delegates internal audit of their credentialing system security controls to protect data from unauthorized modifications. The audit shall include, but is not limited to:

a. CalOptima Health shall monitor the delegates credentialing system security controls to ensure that the Delegated Entity monitors its compliance with the delegation agreement or with the delegate's policies and procedures.

b. CalOptima Health shall ensure that the Delegated Entity acted on all findings if applicable during their annual audit and that it implemented a quarterly monitoring process until the Delegated Entity demonstrates improvement for at least one finding over three consecutive quarters.

i. Delegated Entity must provide documentation (i.e., a report or other type of evidence that it completed the monitoring process at least annually), which include a review of all modifications made in all delegates' credentialing systems. Documentation must include the staff roles or departments involved in the audit.

c. Auditing may be used if the Delegated Entity does not use a credentialing system that can identify all noncompliant modifications.

~~4.~~5. Based on the results of the annual audit, CalOptima Health may take the following actions:

a. Require a Delegated Entity to respond to and submit a CAP addressing all areas of deficiency as determined by CalOptima Health in accordance with CalOptima Health Policy HH.~~2005A~~2005:Corrective Action Plan;

b. Audit the Delegated Entity's implementation and completion of an approved CAP, and any performance area(s) addressed in the CAP;

c. ~~c.~~ Impose Sanctions against a Delegated Entity, in accordance with CalOptima Health Policy HH.~~2002A~~2002: Sanctions;

d. Initiate the de-delegation process in accordance with Section III.F. of this Policy.

~~5.~~6. Annual audit findings and CAPs will be reported by the Audit & Oversight or Quality Improvement Department tothe ~~AOC~~DOC with recommendations for follow-up activities and subsequently to the Compliance Committee for approval~~.~~.

F. De-Delegation of ~~CCN~~ Delegated Entities

1. The Audit & Oversight or Quality Improvement Department shall review CAPs that do not meet the compliance threshold or are classified as 'deficient' and shall make appropriate recommendations to the ~~AOC~~DOC.

2. The ~~AOC~~DOC shall review a Delegated Entity's ~~Delegation~~delegation status based on the CAP timeline andlevel of achievement.

3. If a Delegated Entity fails to achieve compliance within the timeframes set forth in the CAP, the~~AOC~~DOC may recommend de-delegation of Credentialing and Recredentialing.

4. If the ~~AOC~~DOC recommends de-delegation of Credentialing and Recredentialing activities from theDelegated Entity, and Compliance Committee approves the recommendation, ~~CalOptima~~ shall:

a. Provide the Delegated Entity with thirty (30) calendar days written notice of ~~CalOptima's~~CalOptima Health's intent to de-~~Delegate~~delegate;

b. Inform Practitioners of the de-delegation and instructions for continued services;

c. Adjust the Delegated Entity's payments, as appropriate, to the de-~~Delegated~~delegated status ofCredentialing and Recredentialing activities;

d. Prepare appropriate CalOptima Health departments to perform the de-~~Delegated~~delegated Credentialing and Recredentialing activities; and

e. CalOptima Health shall inform the Delegated Entity and Practitioners of their right to file anAppeal.

5. A Delegated Entity shall cooperate with CalOptima Health to ensure a smooth transition and continuous care for Members during the de-delegation transition period.

6. CalOptima Health may re-evaluate a Delegated Entity's ability to perform ~~Delegated~~delegated Credentialing and Recredentialing activities no sooner than twelve (12) months after de-delegation.

a. CalOptima Health shall utilize the Readiness Assessment process, as described in Section III.B ofthis Policy.

b. CalOptima Health shall ~~Delegate~~delegate Credentialing and Recredentialing activities to Delegated Entitybased on the Readiness Assessment results.

c. ~~The Director of~~Audit & Oversight or Quality Improvement Department shall present the re-audit Readiness Assessment tothe ~~AOC~~DOC.

d. If the ~~AOC~~DOC recommends approval of delegation of Credentialing and Recredentialing activities to the Delegated Entity, and the Compliance Committee approves the recommendation, CalOptima Health shall re-~~Delegate~~delegate such activities~~,~~ and adjust the DelegatedEntity's payment accordingly.

e. If the ~~AOC~~DOC recommends denial of re-delegation of Credentialing and Recredentialing activities to the Delegated Entity, it may also recommend additional Sanctions on the Delegated Entity, up to and including termination of the Contract for Health Care Services, to the Compliance Committee for final action ~~and if~~. If the Compliance Committee concurs, CalOptima Health will not re-establish the ~~Delegation~~delegation of Credentialing and Recredentialing activities to the Delegated Entity. ~~-~~CalOptima ~~H~~Health shall inform the Delegated Entity and Practitioners of their right to file an Appeal.

~~1. CalOptima shall inform the Delegated Entity and Practitioners of their right to file an Appeal.~~

G. Exchange of Information

1. CalOptima Health may, at its discretion, share copies of a report received from a Delegated Entity regarding an adverse action, if CalOptima Health deems that such report may protect the medical careof a Member.

a. Such reports may include, but are not limited to, action taken against a Practitioner that relates to professional behavior or clinical competence, suspensions, terminations, legal actions, restrictions, or limitations placed upon a Practitioner due to quality of care issues orany other decisions made by the Delegated Entity's Peer Review Body that are reportable toa regulatory agency (e.g., Medical Board of California (MBOC), Office of the Inspector General (OIG) or the National Practitioner Data Bank (NPDB)).

b. The provision of any such report to another Delegated Entity shall not relieve the Delegated Entity of an independent duty to comply with Credentialing procedures or to query or file a report with state or federal regulatory agencies.

2. CalOptima Health retains the right to review all components of a Delegated Entity's file.

H. Monitoring of Delegated Entities

1. CalOptima Health's Audit & Oversight or Quality Improvement Department shall monitor a Delegated Entity's Credentialing and Recredentialing activities through reports~~, file reviews,~~ and ~~continuous improvement~~other monitoring activities.

Audit & Oversight or Quality Improvement Department shall

a. ~~CalOptima will~~ review ~~Monthly~~the monthly Credentialing universe for each Delegated Entity. ~~-~~These universes will be validated and scores populated onto a dashboard, as applicable.

b. ~~Upon~~If concerns are identified upon review of ~~submitted Universes, CalOptima~~the universes and dashboard scores, Audit & Oversight or Quality Improvement may elect to perform intensive monitoring of the Delegated Entity's Credentialing files.

~~b.~~c. Audit & Oversight or Quality Improvement Auditor shall apply a targeted approach to select files with potential or identified issues of non-compliance.

i. The number of files selected for each file type will vary depending on the monitoring activity, its associated risk level, and/or the number of files available.

ii. File selection may include up to ~~eight (8~~ten (10) Credentialing Files and up to ~~eight (8)~~ten (10) Recredentialing files~~.~~.

iii. The frequency of monitoring activities may vary based upon Delegated Entity's performance or identified areas of concern.

~~c.~~d. ~~The~~ CalOptima ~~auditor~~Health's Audit & Oversight or Quality Improvement Department's Auditor will notify the Delegated Entity via email if file selection is required.

~~d.~~e. The Delegated Entity shall submit the selected Credentialing and Recredentialing files within ten (10) business days of e-mail receipt.

~~e.~~f. CalOptima Health's Audit & Oversight or Quality Improvement Department may require a ~~Health Network~~Delegated Entity to submit a CAP addressing all areas of deficiency as determined by CalOptima Health, in accordance with CalOptima Health Policy HH.2005: Corrective Action Plan.

~~f.~~g. CalOptima Health may impose remedies such as, but not limited to, de-delegation or may impose~~sanctions~~Sanctions against a ~~Health Network~~Delegated Entity pursuant to CalOptima Health Policy HH.2002: Sanctions.

~~g.~~h. Findings and CAP(s) from a ~~Health Network's~~Delegated Entity's audit shall be reported to the ~~Audit and~~Delegation Oversight Committee with recommendations for follow up activities and shared as neededwith the Compliance Committee.

IV. ATTACHMENT(S)

A. Monthly Credentialing Universe

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
~~CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect~~CalOptima Health

C. ~~CalOptima~~ Compliance Plan

D. NCQA Standards for the Accreditation

E. California Business and Professions Code, Section 805

F. CalOptima Health Policy GG.1607: Monitoring Adverse Actions

~~A.~~ CalOptima ~~Policy GG.1616: Fair Hearing Plan for Practitioners~~
G. ~~CalOptima~~Health Policy GG.1619: Delegation Oversight
H. CalOptima Health Policy GG.~~1650A~~1650: Credentialing and Recredentialing of Practitioners
I. CalOptima Health Policy GG.1651: Assessment and Re-Assessment of Organizational Providers
~~I.~~J. CalOptima Health Policy HH.~~2002A~~2002: Sanctions
K. CalOptima Health Policy HH.~~2005A~~2005: Corrective Action Plan
~~J.~~L. Department of Health Care Services (DHCS) All Plan Letter (APL) 17-004: Subcontractual Relationships and Delegation
M. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-013: Provider Credentialing/ Recredentialing and Screening/Enrollment
~~K.~~N. Health Network Service Agreement
~~L.~~O. Medicare Managed Care Manual, Chapter 11, Section 110.2
~~M.~~P. Medicare Managed Care Manual, Chapter 21, and Prescription Drug Benefit Plan, Chapter 9, Section 50.6.4
~~N.~~Q. Title 28, California Code of Regulations, §§1300.70(b)(1)(D) and (E)
~~O.~~R. Title 42, Code of Federal Regulations, §438.230

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
06/29/2015	Department of Health Care Services (DHCS)	Approved as Submitted
01/19/2022	Department of Health Care Services (DHCS)	File and Use
10/26/2022	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
12/06/2018	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
TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. ~~REVIEW/~~ REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	12/01/1995	GG.1605	Credentialing, Monitoring Health Network Compliance	Medi-Cal
Revised	08/01/1998	GG.1605	Credentialing, Monitoring Health Network Compliance	Medi-Cal
Revised	02/01/2001	GG.1605	Delegation and Oversight of Credentialing and Recredentialing Activities	Medi-Cal
Effective	08/01/2005	MA.7008	Delegation and Oversight of Credentialing and Recredentialing Activities	OneCare

Action	Date	Policy	Policy Title	Program(s)
Revised	03/01/2007	MA.7008	Delegation and Oversight of Credentialing and Recredentialing Activities	OneCare
Revised	07/01/2007	GG.1605	Delegation and Oversight of Credentialing and Recredentialing Activities	Medi-Cal
Revised	09/01/2011	MA.7008	Delegation and Oversight of Credentialing and Recredentialing Activities	OneCare
Revised	06/01/2014	GG.1605	Delegation Oversight of Credentialing and Recredentialing	Medi-Cal
Revised	09/01/2015	GG.1605	Delegation Oversight of Credentialing and Recredentialing	Medi-Cal OneCare OneCare Connect
Revised	09/01/2015	MA.7008	Delegation and Oversight of Credentialing and Recredentialing Activities	OneCare OneCare Connect
Revised	12/07/2017	GG.1605	Delegation and Oversight of Credentialing and Recredentialing	Medi-Cal OneCare OneCare Connect
Retired	12/07/2017	MA.7008	Delegation and Oversight of Credentialing and Recredentialing Activities	OneCare OneCare Connect
Revised	12/06/2018	GG.1605	Delegation and Oversight of Credentialing and Recredentialing	Medi-Cal OneCare OneCare Connect
Revised	12/05/2019	GG.1605	Delegation and Oversight of Credentialing and Recredentialing	Medi-Cal OneCare OneCare Connect
Revised	12/03/2020	GG.1605	Delegation and Oversight of Credentialing and Recredentialing	Medi-Cal OneCare OneCare Connect
Revised	12/20/2021	GG.1605	Delegation and Oversight of Credentialing and Recredentialing	Medi-Cal OneCare OneCare Connect
Revised	12/31/2022	GG.1605	Delegation and Oversight of Credentialing and Recredentialing	Medi-Cal OneCare

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IX. GLOSSARY

Term	Definition
CalOptima Health Community Network (CCN)	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.
Centers for Medicare & Medicaid Services (CMS)	The federal agency within the United States Department of Health and Human Services (DHHS) that administers the Federal Medicare program and works in partnership with state governments to administer Medicaid programs.
Compliance Committee	The committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out the provisions of this Compliance Plan. The composition of the Compliance Committee shall consist of senior management staff who may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Executive Director of Compliance Officer; and Executive Director of Human Resources.
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. First Tier, Downstream and Related Entities and/or CalOptima Health departments may be required to complete CAPs to ensure they are in compliance with statutory, regulatory, contractual, CalOptima Health policy, and other requirements identified by CalOptima Health and its regulators.
Credentialing	The process of obtaining, verifying, assessing, and monitoring the qualifications of a Practitioner to provide quality and safe patient care services.
Delegated Entity	For purposes of this Policy, an entity, such as a Health Network, Pharmacy Benefits Manager (PBM), Managed Behavioral Health Organization (MBHO) or other entity to whom CalOptima Health delegates Member care or administrative responsibilities. Additionally, any party that enters into an acceptable written arrangement below the level of the arrangement between CalOptima Health and a First Tier Entity. Also, medical groups delegated for credentialing their own participating providers. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services. Functions may be delegated by written contract only and only as permitted by CMS and/or State governmental agencies, as applicable to the specific program.
Delegation	A legal assignment to another party of the responsibility for particular functions, tasks, and decisions on behalf of the original party. The original party remains liable for compliance and fulfillment of any and all rules, requirements and obligations pertaining to the delegated functions.
Delegation Oversight Committee (DOC)	A subcommittee of the Compliance Committee chaired by the Director of Audit & 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.
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Health program benefit, below the level of the arrangement between CalOptima Health and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

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.
Health Network	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.
National Committee for Quality Assurance (NCQA)	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.
Organizational Provider	Organizations or institutions that are contracted to provide medical services such as hospitals, home health agencies, nursing facilities (includes skilled nursing, long term care, and sub-acute), free standing ambulatory surgical centers, hospice services, community clinics including Federally Qualified Health Centers, urgent care centers, End-Stage renal disease services (dialysis centers), Residential Care Facility for the Elderly (RCFE), Community Based Adult Services (CBAS), durable medical equipment suppliers, radiology centers, clinical laboratories, outpatient rehabilitation facilities, outpatient physical therapy and speech pathology providers, diabetes centers, and portable x-ray suppliers.
Recredentialing	The process by which the qualifications of Practitioners are verified in order to make determinations relating to their continued eligibility for participation in the CalOptima Health program.
Practitioner	An individual who provides covered services pursuant to a state license, 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.
Readiness Assessment	An assessment conducted by a Review Team prior to the effective date of a Health Network's or other contracted entity's Contract with CalOptima Health of a Health Network or contracted entity's compliance with all or a specified number of operational functional areas as determined by CalOptima Health.
Related Entity	Any entity that is related to CalOptima Health by common ownership or control and that: performs some of ~~CalOptima's~~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.
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, Downstream or Related Entity's (FDR) or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima Health Programs.

Term	Definition
Sub-Delegate	An entity that has entered into a written agreement with a Health Network or other delegated Provider to perform certain operational functions that would otherwise be required to be performed by CalOptima Health, the Health Network or other delegated Provider, in order to meet contractual and/or regulatory obligations. Examples of a Sub-Delegate may include, but are not limited to, a management services organization (MSO) or a credentials verification organization (CVO).

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Policy:	GG.1605
Title:	**Delegation and Oversight of Credentialing and Recredentialing Activities**
Department:	Office of Compliance
Section:	Audit & Oversight
CEO Approval:	*/s/*
Effective Date:	12/01/1995
Revised Date:	12/31/2022
Applicable to:	☒ Medi-Cal ☒ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy outlines the processes by which CalOptima Health shall ensure Credentialing and Recredentialing activities are performed by Delegated Entities in accordance with quality, state, and federal standards.

II. POLICY

A. CalOptima Health may delegate authority to perform screening and enrollment activities to a Health Network or other Delegated Entity. If CalOptima Health chooses to delegate this function, the following shall occur:

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

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

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

4. CalOptima Health shall notify DHCS sixty (60) calendar days prior to delegating the screening and enrollment to a Health Network or Delegated Entity and shall submit P&Ps that outline the delegation authority, as well as CalOptima's monitoring and oversight activities.

5. CalOptima Health may accept evidence of NCQA Provider Organization Certification (POC) in lieu of a monitoring site visit at delegated physician organizations.

B. CalOptima Health may delegate Credentialing and Recredentialing of a Practitioner and/or Assessment and Re-Assessment of an Organizational Provider to a Delegated Entity, in accordance with this Policy.

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C. CalOptima Health shall comply with California rules of Delegation of Quality Improvement Activities.

D. CalOptima Health shall remain accountable for Credentialing and Recredentialing of its Practitioners and Assessment and Re-Assessment of its Organizational Providers, even if CalOptima Health delegates all or part of these activities.

1. Delegated activities may include, but are not limited to, processing credentialing applications, credentialing decision-making, development of decision-making criteria, credentialing policies and procedures, credentialing verification, credentialing systems control, credentialing file management, and monitoring of Sanctions and exclusions.

E. CalOptima Health may delegate their authority to perform credentialing reviews to a professional credentialing verification organization (CVO).

1. The delegation must be in a written subcontract or agreement and comply with the requirements set forth in Department of Health Care Services (DHCS) All Plan Letter (APL) 17-004: Subcontractual Relationships and Delegation and any subsequent APL.

2. CalOptima Health shall remain contractually responsible for the completeness and accuracy of these activities and must establish a system that:

a. Evaluates the CVO's ability to perform delegated activities that includes an initial review to assure that the CVO has the administrative capacity, experience, and budgetary resources to fulfill its responsibilities.

b. Ensures that the CVO meets CalOptima, CMS and DHCS standards.

c. Continuously monitors, evaluates, and approves the delegated functions.

F. CalOptima Health may delegate Credentialing and Recredentialing of a Practitioner and/or Assessment and Re-Assessment of an Organizational Provider to a health network, medical groups or independent physician organization.

1. CalOptima Health shall be responsible to perform a Readiness Assessment before implementing Delegation. This assessment shall include verification that the Delegated Entity has devoted sufficient resources and appropriately qualified staff to perform the functions. The following shall be mutually agreed upon between CalOptima Health and the Delegated Entity:

a. A written Delegation Acknowledgment and Acceptance Agreement Document (hereafter Delegation Agreement) describing all the delegated Credentialing activities; and

b. CalOptima Health shall retain the right to approve, suspend, and terminate individual practitioners, providers, and sites in situations where CalOptima Health has delegated decision making, as addressed in the Delegation Agreement.

G. CalOptima Health shall monitor the performance of a Delegated Entity at least annually which includes anaudit of Credentialing written policies and processes as well as Credentialing file review.

H. CalOptima Health shall evaluate required reports as agreed upon in the Delegation Agreement. Delegated Entity shall submit reports, data, and documentation in accordance with CalOptima Health Policy HH.2003: Health Network and Delegated Entity Reporting.

I. CalOptima Health shall identify and follow-up on opportunities for improvement, if applicable.

J. CalOptima Health shall require a Delegated Entity to respond to a Corrective Action Plan (CAP), based onany deficiency or area of non-compliance determined during the Readiness Assessment, annual audit, or other monitoring activity in accordance with CalOptima Health Policy HH.2005: Corrective Action Plan.

K. CalOptima Health shall perform the Readiness Assessment and Annual Audit of Delegated Entity for Health Networks, medical groups and independent physician organizations in accordance with CalOptima Health Policy GG.1619: Delegation Oversight.

III. PROCEDURE

A. Subject to CalOptima Health's approval of the delegated Credentialing and Recredentialing of Practitioner and/or Assessment and Re-Assessment of an Organizational Provider activities for health networks, medical groups and independent physician organizations, thewritten Delegation Agreement shall include the following:

1. Mutual agreement demonstrated by signatures from both CalOptima Health and the Delegated Entity,and a description of:

a. Delegated activities;

b. CalOptima Health and the Delegated Entity responsibilities, which at a minimum include:

i. Acceptance of applications, reapplications, and attestations;

ii. Collection of all data elements from the National Committee for Quality Assurance (NCQA) or other appropriate sources, in accordance with CalOptima Health Policies;

iii. Collection and evaluation of ongoing monitoring information; and

iv. Decision-making in respect to oversight of Credentialing activities.

c. Reporting responsibilities and reporting frequency, which shall indicate reporting requirements, unless specified otherwise. The reporting responsibilities shall be noted onthe Timely and Appropriate Submissions Grid, and include:

i. A list of Credentialed, Recredentialed, and Terminated Practitioners submitted to CalOptima Health by the Delegated Entity.

ii. Reporting of Providers denied credentialing in accordance with CalOptima Health Policies GG.1657:Medical Board of California and the National Practitioner Data Bank (NPDB) Reporting, and GG.1658: Summary Suspension or Restriction of Practitioner Participation in CalOptima Health's Network.

d. The process by which CalOptima Health evaluates the Delegated Entity's performance,

which includes:

i. Readiness Assessment;

ii. Monitoring via File review;

iii. Annual audit; and

iv. Reporting requirements

e. Remedies available to CalOptima Health if the Delegated Entity does not fulfill its obligations,including revocation of the Delegation Agreement, and Sanctions as referenced in CalOptima Health Policy HH.2002: Sanctions;

f. CalOptima Health's right to approve, suspend and terminate individual Practitioners, providers,and sites in situations where CalOptima Health has Delegated decision-making; and

g. CalOptima Health's right to reject a Practitioner upon reason that the Practitioner has failed to meetthe Credentialing or Recredentialing and/or Assessment and Re-assessment requirements, as outlined in the Delegation Agreementand CalOptima Health Policies.

B. Readiness Assessment of Delegated Entities

1. CalOptima Health shall conduct a Readiness Assessment of a Delegated Entity to determine the Delegated Entity's ability to implement delegated Credentialing and Recredentialing and/or Assessment and Re-assessment activitiesbefore entering into and implementing a Delegation Agreement.

2. The Readiness Assessment shall consist of a comprehensive desk review via electronic document submission and/or on-site evaluation as required, utilizing the delegation oversight audit tool, which shall evaluate a Delegated Entity's capacity to provide all Delegated functions. Additional documentation may need to be provided to complete the audit. The evaluation shall include:

a. Written review of the Delegated Entity's understanding of applicable standards;

b. Delegated tasks;

c. Review of policies and procedures;

d. Staffing capabilities;

e. Performance records;

f. Review of Credentialing system; and

g. Credentialing and Recredentialing file review.

3. Upon completion of the Readiness Assessment, Audit & Oversight or Quality Improvement Department shall report the Readiness Assessment results to the Delegation Oversight Committee (DOC).

4. The DOC shall determine if the Delegated Entity meets CalOptima Health's criteria for delegation ofCredentialing and Recredentialing activities based on the results of the Readiness Assessment.

    a. If the DOC determines that a Delegated Entity does not meet CalOptima Health's criteria for delegation of Credentialing and Recredentialing activities, CalOptima Health may reassess suchDelegated Entity no earlier than three (3) months after the initial Readiness Assessment.

C. Delegated Entity Responsibilities

1. A Delegated Entity shall:

    a. Develop and implement processes, in accordance with this Policy, for the Credentialing and Recredentialing of Practitioners and the Assessment and Re-Assessment of Organizational Providers with whom it contracts or employs, as applicable per delegate;

    b. Develop policies and procedures that are consistent with the CalOptima Health Policies GG.1650:Credentialing and Recredentialing of Practitioners and GG.1651: Assessment and Re- Assessment of Organizational Providers, where applicable, and include:

        i. The process to delegate Credentialing or Recredentialing and/or Assessment and Re-assessment activities;

        ii. The medical director or other designated physician's direct responsibility and participation in the Credentialing program;

        iii. The process used to ensure the confidentiality of all information obtained in the Credentialing process, except as otherwise provided by law;

        iv. The process for including Practitioner Rights; and

        v. Address ongoing monitoring following CalOptima Health Policy GG.1607: Monitoring Adverse Actions.

    c. Develop policies and procedures to verify the participation status of the Delegated Entity's providers to ensure that they shall:

        i. Disclose to CalOptima Health's Quality Improvement Department any pending investigationinvolving, or any determination of, suspension, exclusion, preclusion or debarment bythe Delegated Entity or its agents, occurring or discovered during the term of the Contract for Health Care Services; and

        ii. Take action to remove any Delegated Entity agent who does not meet participation status requirements from furnishing items or services related to the Health Network Service Agreement (whether medical or administrative) to Members.

    d. Designate dedicated staff responsible for the timely Credentialing and Recredentialing of all Practitioners and Assessment and Re-Assessment of all Organizational Providers.

    e. Credential and recredential Practitioners and assess and re-assess Organizational Providers,

in accordance with DHCS, CMS and NCQA Credentialing Standards and CalOptima Health Policies.

D. Sub-Delegation

1. A Delegated Entity shall not delegate any Credentialing or Recredentialing activity without prior written approval from CalOptima Health.

2. If a Delegated Entity delegates to a CVO, CalOptima Health requires that the CVO be certified by the National Committee for Quality Assurance (NCQA).The Delegated Entity shall retain ultimate responsibility for any Delegated activities.

3. Prior to delegating Credentialing activities, a Delegated Entity shall evaluate the potential Sub-Delegate's capacity to perform such activities, according to CalOptima Health Credentialing and Recredentialing standards.

4. The Delegated activities shall be described in a written Delegation Agreement with the Sub-Delegate. The agreement between the Delegated Entity and a Sub-Delegate shall include all of the following:

   a. The responsibilities of each party;

   b. The Delegated activities;

   c. The process by which a Delegated Entity shall evaluate the Sub-Delegate's performance;

   d. The remedies, including revocation of Delegation, available to the Delegated Entity if the Sub-Delegate does not fulfill its obligations;

   e. A process for submission of regular reports by the Sub-Delegate to the Delegated Entity;

   f. The Delegated Entity shall provide ongoing monitoring of the Sub-Delegate’s activities under the agreement;

   g. Both CalOptima Health and the Delegated Entity’s Peer Review Body shall retain the right to approve, terminate or suspend individual practitioners, providers or sites based upon quality issues;

   h. Agreement as to the exchange of information between the Delegated Entity and the Sub-Delegate, including a definition of peer review or confidential information, and a processfor sharing information with each other and with third parties;

   i. A process for handling Protected Health Information (PHI), in accordance with the Health Insurance Portability and Accountability Act (HIPAA) as amended; and

   j. A monitoring and auditing schedule.

5. A Delegated Entity shall be responsible for providing oversight for all delegated Credentialing activities.

6. At least annually, Delegated Entity shall evaluate the Sub-Delegate's Credentialing process.

Theevaluation shall ensure that the Delegated activities are conducted in accordance with CalOptima Health's Credentialing standards.

7. The Delegated Entity shall submit to CalOptima Health an annual report documenting the DelegatedEntity's evaluation process of the delegated function.

8. CalOptima Health shall monitor the Delegated Entity's oversight process of the Sub-Delegate through CalOptima Health's annual oversight of the Delegated Entity's Credentialing and Recredentialing and Assessment and Re-assessment process.

E. Annual Audit of Delegated Entities

1. At least annually, CalOptima Health shall perform an audit of written policies and procedures as well as a review of Credentialing files to ensure compliance with all applicable NCQA, regulatory and contractual standards for each year that the Delegation is in effect. The annual audit shall bebased on the responsibilities stated in the Delegation Agreement and performance of delegated activities, as well as the appropriate NCQA, regulatory and contractual standards. This audit may be performed on-site and/or via desktop review. Additional documentation may need to be provided to complete the audit.

2. The annual audit shall include the review of policies and procedures utilizing the delegation oversight annual audit tool. This audit will include, but not be limited to:

   a. A review of Delegated Entity's Peer Review Body meeting minutes, which shall be conducted for Credentialing and Recredentialing activities;

   b. A review to confirm the Delegated Entity's reporting procedure to CalOptima Health when there isaction taken against a practitioner that relates to professional behavior or clinical competence, and suspensions, terminations, restrictions, or limitations placed upon a Practitioner due to quality of care issues or any other decisions made by the Delegated Entity's Peer Review Body that are reportable to a regulatory agency (e.g., Medical Board of California (MBOC), Office of the Inspector General (OIG), or the National Practitioner Data Bank (NPDB).)

3. An annual file review is also conducted utilizing the Credentialing and Recredentialing file review tool:

   a. CalOptima Health shall apply a targeted approach or select files with potential issue(s) of non- compliance when conducting the annual file review and will provide the organization withthe file selection.

      i. The number of files selected for each file type will vary depending on the audit area,its associated risk level, and/or the number of files available. Credentialing requirements applicable to both file types are scored for all files.

      ii. CalOptima Health will select files based upon the NCQA 8/30 methodology of both credentialing and recredentialing files. If fewer than eight (8) Practitioners were credentialed or recredentialed since the last annual audit, CalOptima Health will audit theuniverse of files rather than a sample.

   b. If the requirement applies only to initial Credentialing files (e.g., work history) or to Recredentialing files (e.g., Recredentialing cycle length), the requirement is scored 'Not

Applicable' for the file type that does not apply.

c. CalOptima Health shall review documentation of substantive evaluation and action plans, if needed.

d. If the Delegated Entity does not have any files for Credentialing or Recredentialing between audit cycles, CalOptima Health will not perform an annual audit, but instead shall require the Delegated Entity to meet all other delegation oversight requirements and provide documentation that the Delegated Entity did not Credential or Recredential Practitioners between audit cycles.

4. An annual audit shall include the review of the delegate's policies and procedures and the delegates internal audit of their credentialing system security controls to protect data from unauthorized modifications. The audit shall include, but is not limited to:

   a. CalOptima Health shall monitor the delegates credentialing system security controls to ensure that the Delegated Entity monitors its compliance with the delegation agreement or with the delegate's policies and procedures.

   b. CalOptima Health shall ensure that the Delegated Entity acted on all findings if applicable during their annual audit and that it implemented a quarterly monitoring process until the Delegated Entity demonstrates improvement for at least one finding over three consecutive quarters.

      i. Delegated Entity must provide documentation (i.e., a report or other type of evidence that it completed the monitoring process at least annually), which include a review of all modifications made in all delegates' credentialing systems. Documentation must include the staff roles or departments involved in the audit.

   c. Auditing may be used if the Delegated Entity does not use a credentialing system that can identify all noncompliant modifications.

5. Based on the results of the annual audit, CalOptima Health may take the following actions:

   a. Require a Delegated Entity to respond to and submit a CAP addressing all areas of deficiency as determined by CalOptima Health in accordance with CalOptima Health Policy HH.2005:Corrective Action Plan;

   b. Audit the Delegated Entity's implementation and completion of an approved CAP, and any performance area(s) addressed in the CAP;

   c. Impose Sanctions against a Delegated Entity, in accordance with CalOptima Health Policy HH.2002: Sanctions;

   d. Initiate the de-delegation process in accordance with Section III.F. of this Policy.

6. Annual audit findings and CAPs will be reported by the Audit & Oversight or Quality Improvement Department tothe DOC with recommendations for follow-up activities and subsequently to the Compliance Committee for approval.

F. De-Delegation of Delegated Entities

1. The Audit & Oversight or Quality Improvement Department shall review CAPs that do not meet the compliance threshold or are classified as 'deficient' and shall make appropriate recommendations to the DOC.

2. The DOC shall review a Delegated Entity's delegation status based on the CAP timeline and level of achievement.

3. If a Delegated Entity fails to achieve compliance within the timeframes set forth in the CAP, theDOC may recommend de-delegation of Credentialing and Recredentialing.

4. If the DOC recommends de-delegation of Credentialing and Recredentialing activities from the Delegated Entity, and Compliance Committee approves the recommendation, shall:

   a. Provide the Delegated Entity with thirty (30) calendar days written notice of CalOptima Health's intent to de-delegate;

   b. Inform Practitioners of the de-delegation and instructions for continued services;

   c. Adjust the Delegated Entity's payments, as appropriate, to the de-delegated status of Credentialing and Recredentialing activities;

   d. Prepare appropriate CalOptima Health departments to perform the de-delegated Credentialing and Recredentialing activities; and

   e. CalOptima Health shall inform the Delegated Entity and Practitioners of their right to file anAppeal.

5. A Delegated Entity shall cooperate with CalOptima Health to ensure a smooth transition and continuous care for Members during the de-delegation transition period.

6. CalOptima Health may re-evaluate a Delegated Entity's ability to perform delegated Credentialing and Recredentialing activities no sooner than twelve (12) months after de-delegation.

   a. CalOptima Health shall utilize the Readiness Assessment process, as described in Section III.B ofthis Policy.

   b. CalOptima Health shall delegate Credentialing and Recredentialing activities to Delegated Entitybased on the Readiness Assessment results.

   c. Audit & Oversight or Quality Improvement Department shall present the re-audit Readiness Assessment tothe DOC.

   d. If the DOC recommends approval of delegation of Credentialing and Recredentialing activities to the Delegated Entity, and the Compliance Committee approves the recommendation, CalOptima Health shall re-delegate such activities and adjust the DelegatedEntity's payment accordingly.

   e. If the DOC recommends denial of re-delegation of Credentialing and Recredentialing activities to the Delegated Entity, it may also recommend additional Sanctions on the Delegated Entity, up to and including termination of the Contract for Health Care Services, to the Compliance Committee for final action. If the Compliance Committee concurs,

CalOptima Health will not re-establish the delegation of Credentialing and Recredentialing activities to the Delegated Entity. CalOptima Health shall inform the Delegated Entity and Practitioners of their right to file an Appeal.

G. Exchange of Information

1. CalOptima Health may, at its discretion, share copies of a report received from a Delegated Entity regarding an adverse action, if CalOptima Health deems that such report may protect the medical careof a Member.

   a. Such reports may include, but are not limited to, action taken against a Practitioner that relates to professional behavior or clinical competence, suspensions, terminations, legal actions, restrictions, or limitations placed upon a Practitioner due to quality of care issues orany other decisions made by the Delegated Entity's Peer Review Body that are reportable toa regulatory agency (e.g., Medical Board of California (MBOC), Office of the Inspector General (OIG) or the National Practitioner Data Bank (NPDB)).

   b. The provision of any such report to another Delegated Entity shall not relieve the Delegated Entity of an independent duty to comply with Credentialing procedures or to query or file a report with state or federal regulatory agencies.

2. CalOptima Health retains the right to review all components of a Delegated Entity's file.

H. Monitoring of Delegated Entities

1. CalOptima Health's Audit & Oversight or Quality Improvement Department shall monitor a Delegated Entity's Credentialing and Recredentialing activities through reports and other monitoring activities.

   a. Audit & Oversight or Quality Improvement Department shall review the monthly Credentialing universe for each Delegated Entity. These universes will be validated and scores populated onto a dashboard, as applicable.

   b. If concerns are identified upon review of the universes and dashboard scores, Audit & Oversight or Quality Improvement may elect to perform intensive monitoring of the Delegated Entity's Credentialing files.

   c. Audit & Oversight or Quality Improvement Auditor shall apply a targeted approach to select files with potential or identified issues of non-compliance.

      i. The number of files selected for each file type will vary depending on the monitoring activity, its associated risk level, and/or the number of files available.

      ii. File selection may include up to ten (10) Credentialing Files and up to ten (10) Recredentialing files.

      iii. The frequency of monitoring activities may vary based upon Delegated Entity's performance or identified areas of concern.

   d. CalOptima Health's Audit & Oversight or Quality Improvement Department's Auditor will notify the Delegated Entity via email if file selection is required.

e. The Delegated Entity shall submit the selected Credentialing and Recredentialing files within ten (10) business days of e-mail receipt.

f. CalOptima Health's Audit & Oversight or Quality Improvement Department may require a Delegated Entity to submit a CAP addressing all areas of deficiency as determined by CalOptima Health, in accordance with CalOptima Health Policy HH.2005:Corrective Action Plan.

g. CalOptima Health may impose remedies such as, but not limited to, de-delegation or may impose Sanctions against a Delegated Entity pursuant to CalOptima Health Policy HH.2002: Sanctions.

h. Findings and CAP(s) from a Delegated Entity's audit shall be reported to the Delegation Oversight Committee with recommendations for follow up activities and shared as needed with the Compliance Committee.

IV. ATTACHMENT(S)

A. Monthly Credentialing Universe

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 Compliance Plan
D. NCQA Standards for the Accreditation
E. California Business and Professions Code, Section 805
F. CalOptima Health Policy GG.1607: Monitoring Adverse Actions
G. CalOptima Health Policy GG.1619: Delegation Oversight
H. CalOptima Health Policy GG.1650: Credentialing and Recredentialing of Practitioners
I. CalOptima Health Policy GG.1651: Assessment and Re-Assessment of Organizational Providers
J. CalOptima Health Policy HH.2002: Sanctions
K. CalOptima Health Policy HH.2005: Corrective Action Plan
L. Department of Health Care Services (DHCS) All Plan Letter (APL) 17-004: Subcontractual Relationships and Delegation
M. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-013: Provider Credentialing/ Recredentialing and Screening/Enrollment
N. Health Network Service Agreement
O. Medicare Managed Care Manual, Chapter 11, Section 110.2
P. Medicare Managed Care Manual, Chapter 21, and Prescription Drug Benefit Plan, Chapter 9,Section 50.6.4
Q. Title 28, California Code of Regulations, §§1300.70(b)(1)(D) and (E)
R. Title 42, Code of Federal Regulations, §438.230

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
06/29/2015	Department of Health Care Services (DHCS)	Approved as Submitted
01/19/2022	Department of Health Care Services (DHCS)	File and Use

Date	Regulatory Agency	Response
10/26/2022	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
12/06/2018	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
TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	12/01/1995	GG.1605	Credentialing, Monitoring Health Network Compliance	Medi-Cal
Revised	08/01/1998	GG.1605	Credentialing, Monitoring Health Network Compliance	Medi-Cal
Revised	02/01/2001	GG.1605	Delegation and Oversight of Credentialing and Recredentialing Activities	Medi-Cal
Effective	08/01/2005	MA.7008	Delegation and Oversight of Credentialing and Recredentialing Activities	OneCare
Revised	03/01/2007	MA.7008	Delegation and Oversight of Credentialing and Recredentialing Activities	OneCare
Revised	07/01/2007	GG.1605	Delegation and Oversight of Credentialing and Recredentialing Activities	Medi-Cal
Revised	09/01/2011	MA.7008	Delegation and Oversight of Credentialing and Recredentialing Activities	OneCare
Revised	06/01/2014	GG.1605	Delegation Oversight of Credentialing and Recredentialing	Medi-Cal
Revised	09/01/2015	GG.1605	Delegation Oversight of Credentialing and Recredentialing	Medi-Cal OneCare OneCare Connect
Revised	09/01/2015	MA.7008	Delegation and Oversight of Credentialing and Recredentialing Activities	OneCare OneCare Connect
Revised	12/07/2017	GG.1605	Delegation and Oversight of Credentialing and Recredentialing	Medi-Cal OneCare OneCare Connect
Retired	12/07/2017	MA.7008	Delegation and Oversight of Credentialing and Recredentialing Activities	OneCare OneCare Connect

Action	Date	Policy	Policy Title	Program(s)
Revised	12/06/2018	GG.1605	Delegation and Oversight of Credentialing and Recredentialing	Medi-Cal OneCare OneCare Connect
Revised	12/05/2019	GG.1605	Delegation and Oversight of Credentialing and Recredentialing	Medi-Cal OneCare OneCare Connect
Revised	12/03/2020	GG.1605	Delegation and Oversight of Credentialing and Recredentialing	Medi-Cal OneCare OneCare Connect
Revised	12/20/2021	GG.1605	Delegation and Oversight of Credentialing and Recredentialing	Medi-Cal OneCare OneCare Connect
Revised	12/31/2022	GG.1605	Delegation and Oversight of Credentialing and Recredentialing	Medi-Cal OneCare

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IX. GLOSSARY

Term	Definition
CalOptima Health Community Network (CCN)	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.
Centers for Medicare & Medicaid Services (CMS)	The federal agency within the United States Department of Health and Human Services (DHHS) that administers the Federal Medicare program and works in partnership with state governments to administer Medicaid programs.
Compliance Committee	The committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out the provisions of this Compliance Plan. The composition of the Compliance Committee shall consist of senior management staff who may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Executive Director of Compliance Officer; and Executive Director of Human Resources.
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. First Tier, Downstream and Related Entities and/or CalOptima Health departments may be required to complete CAPs to ensure they are in compliance with statutory, regulatory, contractual, CalOptima Health policy, and other requirements identified by CalOptima Health and its regulators.
Credentialing	The process of obtaining, verifying, assessing, and monitoring the qualifications of a Practitioner to provide quality and safe patient care services.
Delegated Entity	For purposes of this Policy, an entity, such as a Health Network, Pharmacy Benefits Manager (PBM), Managed Behavioral Health Organization (MBHO) or other entity to whom CalOptima Health delegates Member care or administrative responsibilities. Additionally, any party that enters into an acceptable written arrangement below the level of the arrangement between CalOptima Health and a First Tier Entity. Also, medical groups delegated for credentialing their own participating providers. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services. Functions may be delegated by written contract only and only as permitted by CMS and/or State governmental agencies, as applicable to the specific program.
Delegation	A legal assignment to another party of the responsibility for particular functions, tasks, and decisions on behalf of the original party. The original party remains liable for compliance and fulfillment of any and all rules, requirements and obligations pertaining to the delegated functions.
Delegation Oversight Committee (DOC)	A subcommittee of the Compliance Committee chaired by the Director of Audit & 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.
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Health program benefit, below the level of the arrangement between CalOptima Health and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

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.
Health Network	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.
National Committee for Quality Assurance (NCQA)	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.
Organizational Provider	Organizations or institutions that are contracted to provide medical services such as hospitals, home health agencies, nursing facilities (includes skilled nursing, long term care, and sub-acute), free standing ambulatory surgical centers, hospice services, community clinics including Federally Qualified Health Centers, urgent care centers, End-Stage renal disease services (dialysis centers), Residential Care Facility for the Elderly (RCFE), Community Based Adult Services (CBAS), durable medical equipment suppliers, radiology centers, clinical laboratories, outpatient rehabilitation facilities, outpatient physical therapy and speech pathology providers, diabetes centers, and portable x-ray suppliers.
Recredentialing	The process by which the qualifications of Practitioners are verified in order to make determinations relating to their continued eligibility for participation in the CalOptima Health program.
Practitioner	An individual who provides covered services pursuant to a state license, 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.
Readiness Assessment	An assessment conducted by a Review Team prior to the effective date of a Health Network's or other contracted entity's Contract with CalOptima Health of a Health Network or contracted entity's compliance with all or a specified number of operational functional areas as determined by CalOptima Health.
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.
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, Downstream or Related Entity's (FDR) or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima Health Programs.

Term	Definition
Sub-Delegate	An entity that has entered into a written agreement with a Health Network or other delegated Provider to perform certain operational functions that would otherwise be required to be performed by CalOptima Health, the Health Network or other delegated Provider, in order to meet contractual and/or regulatory obligations. Examples of a Sub-Delegate may include, but are not limited to, a management services organization (MSO) or a credentials verification organization (CVO).

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CalOptima Health

Delegate Name: _____

Reporting Month/Year: M/2022

Initial Credentialing	0
Recredentialing	0
Termination	0

Credentialing Universe

Data ID (IC/RC/TM)	License #	Last Name	First name	Middle Initial	License Type	Contract Type	Primary Contracted Specialty	Current Credentialing Decision Date MM/DD/YYYY	Previous Credentialing Decision Date MM/DD/YYYY	Board Certification (Y, N or N/A)	Board Certified Specialty	Board Cert Iss Date MM/DD/YYYY	Board Cert Exp Date MM/DD/YYYY (Lifetime = N/A)	Facility Site Review Date MM/DD/YYYY	Current, Signed Attestation MM/DD/YYYY	Termination Date MM/DD/YYYY	Reasons for Termination	Date ACT Form Submitted MM/DD/YYYY

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Policy:	HH.4002
Title:	~~CalOptima~~CalOptima Health **Internal Oversight**
Department:	Office of Compliance
Section:	Audit & Oversight
CEO Approval:	/s/
Effective Date:	12/01/2016
Revised Date:	12/31/2022
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ PACE ☒ Administrative

I. PURPOSE

This policy defines the process for internal Monitoring and oversight of ~~CalOptima~~CalOptima Health to ensure compliance with statutory, regulatory, contractual, and ~~CalOptima~~CalOptima Health policy requirements.

II. POLICY

A. The Audit & Oversight Department shall establish protocols to ensure compliance risks are identified and conduct effective Auditing and Monitoring of internal department processes, and outcomes within ~~CalOptima~~CalOptima Health to ensure continuous improvement of Member care, administrative processes, and management.

B. The Audit & Oversight Department shall perform an annual risk assessment, as outlined in ~~CalOptima~~CalOptima Health Policy HH.4003: Annual Risk Assessment (Internal)~~,~~ and develop an annual Internal Audit and Monitoring Work Plan.

1. The risk assessment and Internal Audit and Monitoring Work Plan shall incorporate, at minimum, current Centers for Medicare & Medicaid Services (CMS) and Department of Health Care Services (DHCS) contractual and regulatory requirements, Department of Managed Health Care (DMHC) Technical Assistance Guides, CMS program audit process and protocols, National Committee for Quality Assurance (NCQA) standards, and any identified high-risk areas related to the ~~CalOptima~~CalOptima Health Medi-Cal, OneCare~~, OneCare Connect,~~ and PACE programs.

C. Audit & Oversight Department shall assess each of the ~~Every CalOptima~~CalOptima Health departments identified on the Internal Audit and Monitoring Work Plan (hereinafter, the Work Plan). Each ~~may~~will be subject to Audit and/or routine Monitoring, and Focused Reviews.

D. The Work Plan shall identify the functional area(s) subject to Audit and describe the schedule of Audits to be conducted by the Audit & Oversight Department in the coming year. The Work Plan shall also identify specific functional areas that require continuous Monitoring. The Work Plan may be subject to revision during the year in response to changing circumstances; these changes will require approval of the Delegation Oversight Committee (DOC)~~AOC~~ and the Compliance Committee~~.~~

E. The Audit & Oversight Department shall identify functional areas requiring improvement through internal Audits and Monitoring activities, risk assessments, or regulatory Audits, and shall Monitor performance to ensure performance meets applicable regulatory and industry standards. In the event Monitoring results reveal deficiencies, the internal department(s) will be subject to a Focused Review.

~~F. CalOptima~~CalOptima Health shall continually assess a functional area's ability to perform functions through initial reviews, on-going Monitoring, performance reviews, and analysis of data and reports against industry, regulatory, and/or quality benchmarks, when available.

F.

~~G.~~

G. Audits of ~~CalOptima~~CalOptima Health's internal functional areas will be conducted, at minimum, annually ~~by~~ by desktop review and by on-site review and/or webinar. ~~CalOptima~~CalOptima Health shall ensure audits are conducted at reasonable times

~~H. desktop review.~~

~~I.~~H. ~~CalOptima~~CalOptima Health's Audit & Oversight Department shall maintain documentation of Internal Oversight activities described herein.

~~J.~~I. The Auditing and Monitoring results shall be reported to the ~~Audit & Oversight Committee (AOC~~DOC~~)~~, and the Compliance Committee for review and recommendations. When appropriate, ~~CalOptima~~CalOptima Health's Regulatory Affairs & Compliance Department shall inform the CMS, DHCS, DMHC, National Benefit Integrity Medicare Drug Contractor (NBI MEDIC), or law enforcement of aberrant findings that may cause ~~harm, or~~harm or impact the delivery of care to ~~CalOptima~~CalOptima Health Members.

~~K.~~J. Failure by an internal department to respond accurately, timely, and in compliance with statutory, regulatory, contractual, ~~CalOptima~~CalOptima Health policies, or other requirements to ~~CalOptima~~CalOptima Health's Office of Compliance's Immediate Corrective Action Plan (ICAP) or Corrective Action Plan (CAP) request shall lead to further action, in accordance with ~~CalOptima~~CalOptima Health Policy HH.2005~~A~~: Corrective Action Plan.

III. PROCEDURE

A. ~~CalOptima~~CalOptima Health shall conduct activities in accordance with the terms and conditions of ~~CalOptima~~CalOptima Health regulatory requirements, ~~CalOptima~~CalOptima Health policies and procedures, ~~CalOptima~~CalOptima Health contracts with the CMS and/or the DHCS, DMHC Full Service Technical Assistance Guides, and NCQA Accreditation.

B. ~~CalOptima~~CalOptima Health shall provide Internal Oversight using, without limit, the following components:

1. Desktop reviews;

2. Focused and ad hoc reviews, and Audits and Monitoring;

3. Periodic reviews and Audits; and

4. On-going monitoring.

C. Functional areas shall include, without limit:

1. Credentialing, recredentialing, and facility site review;

2. Utilization Management; ~~(e.g., program structure, workplan, committee composition, criteria, consistent application of criteria, adherence to established criteria of medical necessity, Member and provider notification, rates of admissions and readmissions, emergency room visits, under and over utilization, second opinions, expedited and standard review process, daily census for planned and unplanned admissions, screening Members admitted for potential transition of care issues, discharge planning, retrospective review, out-of-network process, urgent care services, timeliness, clinical decisions, denial notices, Over/Under Utilization, Potential Quality Issues (PQI), Used/Expired Referrals, and emergency services, structure);;~~

3. Claims processing/adjudication and payment timeliness;

4. Provider disputes and claim appeals;

5. Member rights;

6. Customer service;

7. Exclusion monitoring oversight;

8. Care coordination;

9. Grievance and appeals;

10. Provider network adequacy;

11. Pharmacy;

12. Communication services, including but not limited to, cultural & linguistic services, and alternative formats;

13. Access and availability, including compliance with the Americans with Disabilities Act (ADA);

14. Systems utilized to carry out business functions; ~~an~~and~~d~~

~~D.~~ Reporting and Monitoring.

15. ~~The~~

~~E.~~D. The Audit & Oversight Department shall develop comprehensive audit tools for Internal Oversight of the focus areas as described in Section III.C. of this Policy, in consultation with subject matter experts including ~~CalOptima~~CalOptima Health operational departments, Regulatory Affairs & Compliance, and Legal Affairs, as necessary. The Audit & Oversight Department shall review and update audit tools in collaboration with the respective subject matter experts annually, or more often, based upon regulatory, contractual, and accreditation changes.

~~F.~~E. Annual Audit Oversight Process

1. At least annually, the Audit & Oversight Department shall identify and schedule ~~an~~ Audits as a result of the annual risk assessment, focused Audit findings, deficient Monitoring results, Fraud, Waste, and Abuse (FWA), or program Audit findings. ~~Internal Oversight Audits are required annually and shall be conducted as desktop Audits.~~

2. The Audit will evaluate, at a minimum, performance with applicable statutes, regulations, and compliance with ~~CalOptima~~CalOptima Health policies and procedures.

3. Two (2) weeks prior to the scheduled Audit, the Audit & Oversight Department will send, via email, the ~~CalOptima~~CalOptima Health department management staff a notice confirming the date and scope of the Audit. The notice will include a description of any universes required, the Audit period, the due date, method of delivery, and Audit format. The Audit & Oversight Department shall utilize industry standard Audit protocols and appropriate methods for Auditing with respect to tools, sample size, data mining, etc.

4. Upon receipt of the requested universe(s), the assigned Audit & Oversight auditor shall select a sample size, as determined by Audit & Oversight, that is appropriate for the type of Audit being conducted, such as:

    a. Processes considered to be high-risk and/or have potential Member harm;

    b. Compliance with CMS, DHCS, DMHC, and NCQA-mandated elements, or contractual obligations; and

    c. Areas identified as deficient in previous Audits.

5. If the minimum number of cases is not available in the universe the auditor may elect to expand the Audit period or request additional information, or documentation.

6. The Audit & Oversight auditor will notify the ~~CalOptima~~CalOptima Health department of samples selected, and documentation required seven (7) calendar days prior to the Audit when provided in electronic format, or when sample files are supplied in alternate formats.

    a. The Audit & Oversight auditor shall review sample cases and functional areas shall submit samples and documentation electronically whenever possible.

    b. The Audit & Oversight auditor may, at his or her discretion, request additional materials during the review.

7. The Audit will include validation of documentation, including but not limited to ~~CalOptima~~CalOptima Health policies and procedures, training, reports, systems, and file review(s) and universe (s).

8. The Audit & Oversight auditor shall discuss findings from the annual Audit with the respective ~~CalOptima~~CalOptima Health department and document such findings in an Audit findings report. If any ~~CalOptima~~CalOptima Health department receives a score of less than the established passing score for an individual audit element, the department will be required to develop a Corrective Action Plan in accordance with ~~CalOptima~~CalOptima Health Policy HH.2005~~A~~: Corrective Action Plan.

    a. The Audit & Oversight auditor is responsible for confirming remediation~~,~~ or interacting with the leadership of the audited department to ensure the department has documented and completed the remediation. ~~shall have ultimate responsibility for remediation, monitoring,~~

~~and reporting of the CAP to the AOC.~~ The Audit & Oversight manage~~n~~ment or auditor shall report the findings of the audit, CAPs, if any, and the timeline for CAP remediation to the ~~AOC~~DOC.

9. Audit findings will be presented to the ~~AOC~~DOC by the Audit & Oversight Department for the respective functional area reviewed. The Audit & Oversight Department shall determine any follow up activities, process improvement, and/or additional review based on the recommendations of the Audit & Oversight auditor.

10. A department must resolve the elements of the CAP in accordance with ~~CalOptima~~CalOptima Health Policy HH.2005~~A~~: Corrective Action Plan.

11. In the event the elements of the CAP are not successfully completed within ~~ninety (90) calendar~~the established timeframe ~~days,~~, the Director of Audit & Oversight shall report status to the ~~AOC~~DOC following the CAP period. The ~~AOC~~DOC will review the outstanding CAP items to determine, at its discretion, whether the CAP deadline should be extended.

    a. The Audit & Oversight Department must demonstrate to the ~~AOC~~DOC the appropriateness for an extension and provide a detailed action plan to ensure that the items for correction are being addressed in a timely manner.

12. The Audit & Oversight Department shall determine whether ad hoc audits, reviews, and or other remediation or actions are necessary to confirm remediation of ~~resolve~~ identified issues. Issues escalated will be reviewed by the Audit & Oversight Department, ~~AOC~~DOC, and the Compliance Committee, as applicable.

~~G.~~F. Ongoing Internal Oversight Process

1. The Audit & Oversight Department will conduct on-going Internal Oversight of the business areas outlined in Section III.C. of this policy based on the risk level determined during the annual risk assessment, and as outlined on the Internal Audit and Monitoring Work Plan.

2. Internal Dashboard Reporting: On a monthly basis, data shall be used to Monitor areas for processing timeliness and accuracy of business activities.

    a. The ~~AOC~~DOC shall Monitor dashboard results and may make recommendations for corrective action if performance falls below the standard defined by the ~~AOC~~DOC.

    b. If there is a consistent pattern of non-compliance, the Audit & Oversight Department shall conduct a Focused Review.

        i. If the results of the Focused Review are unfavorable, the auditor will escalate for further action. This includes, but is not limited to, reporting the issue up to the Compliance Committee for disciplinary action and/or development of remediation plan.

~~H.~~G. Corrective Action Plan

1. If any area of deficiency or non-compliance is identified, including but not limited to, Member or Provider Complaints, readiness assessment reviews, regular reports, oversight reviews, and ongoing Monitoring, the Audit & Oversight Department will be required to issue a Corrective Action Plan (CAP) request, in accordance with ~~CalOptima~~CalOptima Health Policy HH.2005~~A~~: Corrective Action Plan.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. ~~CalOptima~~CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. ~~CalOptima~~CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
~~C. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect~~
~~D.~~C. ~~CalOptima~~CalOptima Health PACE Program Agreement
~~E.~~D. ~~CalOptima~~CalOptima Health Compliance Plan
~~F.~~E. ~~CalOptima~~CalOptima Health Policy HH.2005~~A~~: Corrective Action Plan
~~G.~~F. ~~CalOptima~~CalOptima Health Policy HH.4003: Annual Risk Assessment
~~H.~~G. Title 42, Code of Federal Regulations (C.F.R.), §455.2
~~I.~~H. Welfare and Institutions Code, §14043.1(a)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the ~~CalOptima~~CalOptima ~~Health~~ Board of Directors
12/07/2017	Regular Meeting of the ~~CalOptima~~CalOptima ~~Health~~ Board of Directors
12/06/2018	Regular Meeting of the ~~CalOptima~~CalOptima ~~Health~~ Board of Directors
12/05/2019	Regular Meeting of the ~~CalOptima~~CalOptima ~~Health~~ Board of Directors
12/03/2020	Regular Meeting of the ~~CalOptima~~CalOptima ~~Health~~ Board of Directors
12/20/2021	Special Meeting of the ~~CalOptima~~CalOptima ~~Health~~ Board of Directors
TBD	Regular Meeting of the ~~CalOptima~~CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	12/01/2016	HH.4002	~~CalOptima~~CalOptima ~~Health~~ Internal Oversight	Administrative
Revised	12/07/2017	HH.4002	~~CalOptima~~CalOptima ~~Health~~ Internal Oversight	Administrative
Revised	12/06/2018	HH.4002	~~CalOptima~~CalOptima ~~Health~~ Internal Oversight	Administrative
Revised	12/05/2019	HH.4002	~~CalOptima~~CalOptima ~~Health~~ Internal Oversight	Administrative
Revised	12/03/2020	HH.4002	~~CalOptima~~CalOptima ~~Health~~ Internal Oversight	Administrative
Revised	12/20/2021	HH.4002	~~CalOptima~~CalOptima ~~Health~~ Internal Oversight	Administrative
Revised	TBD	HH.4002	CalOptima Health Internal Oversight	Administrative

IX. GLOSSARY

Term	Definition
Abuse	Actions that may, directly or indirectly, result in: unnecessary costs to a ~~CalOptima~~CalOptima Health program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.
Audit	A formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being audited and normally performed by individuals with one of several acknowledged certifications.
Business Owner	~~CalOptima~~CalOptima Health management and staff vested in the compliance of their respective ~~CalOptima~~CalOptima Health functional area in accordance with statutory, regulatory, contractual, and ~~CalOptima~~CalOptima Health policy requirements.
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 senior management 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 Executive Director of Human Resources.
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~~CalOptima Health, the Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or ~~CalOptima~~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~~CalOptima Health and its regulators.
Delegation Oversight Committee (DOC)	A subcommittee of the Compliance Committee chaired by the Director of Audit & 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.
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.
Department of Managed Health Care (DMHC)	The California Department of Managed Health Care that oversees California's managed care system. DMHC regulates health maintenance organizations licensed under the Knox-Keene Act, Health & Safety Code, Sections 1340 *et seq*.
Focused Review	An audit that specifically targets areas of potential deficiency.

Term	Definition
Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with Title 42 Code of Federal Regulations section 455.2, Welfare and Institutions Code section 14043.1(i).~~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.)~~
Internal Audit and Monitoring Work Plan	An outline of goals and objectives to define the audit scope for internal functional areas to ensure health plan compliance, as well as conduct on-going performance measurements to determine opportunities for improvement and/or the effectiveness of interventions.
Internal Oversight	The process by which ~~CalOptima~~CalOptima Health's Audit and Oversight Department conducts audits to monitor internal functional areas in accordance with regulatory, statutory, contractual, and ~~CalOptima~~CalOptima Health policy requirements to ensure health plan compliance.
Member	A beneficiary enrolled in a ~~CalOptima~~CalOptima Health Program.
Monitoring	Regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.
National Committee for Quality Assurance (NCQA)	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.
Waste	The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a ~~CalOptima~~CalOptima Health Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Policy:	HH.4002
Title:	**CalOptima Health Internal Oversight**
Department:	Office of Compliance
Section:	Audit & Oversight
CEO Approval:	*/s/*
Effective Date:	12/01/2016
Revised Date:	12/31/2022
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ PACE ☒ Administrative

I. PURPOSE

This policy defines the process for internal Monitoring and oversight of CalOptima Health to ensure compliance with statutory, regulatory, contractual, and CalOptima Health policy requirements.

II. POLICY

A. The Audit & Oversight Department shall establish protocols to ensure compliance risks are identified and conduct effective Auditing and Monitoring of internal department processes, and outcomes within CalOptima Health to ensure continuous improvement of Member care, administrative processes, and management.

B. The Audit & Oversight Department shall perform an annual risk assessment, as outlined in CalOptima Health Policy HH.4003: Annual Risk Assessment (Internal) and develop an annual Internal Audit and Monitoring Work Plan.

1. The risk assessment and Internal Audit and Monitoring Work Plan shall incorporate, at minimum, current Centers for Medicare & Medicaid Services (CMS) and Department of Health Care Services (DHCS) contractual and regulatory requirements, Department of Managed Health Care (DMHC) Technical Assistance Guides, CMS program audit process and protocols, National Committee for Quality Assurance (NCQA) standards, and any identified high-risk areas related to the CalOptima Health Medi-Cal, OneCare, and PACE programs.

C. Audit & Oversight Department shall assess each of the CalOptima Health departments identified on the Internal Audit and Monitoring Work Plan (hereinafter, the Work Plan). Each maybe subject to Audit and/or routine Monitoring, and Focused Reviews.

D. The Work Plan shall identify the functional area(s) subject to Audit and describe the schedule of Audits to be conducted by the Audit & Oversight Department in the coming year. The Work Plan shall also identify specific functional areas that require continuous Monitoring. The Work Plan may be subject to revision during the year in response to changing circumstances; these changes will require approval of the Delegation Oversight Committee (DOC) and the Compliance Committee

E. The Audit & Oversight Department shall identify functional areas requiring improvement through internal Audits and Monitoring activities, risk assessments, or regulatory Audits, and shall Monitor performance to ensure performance meets applicable regulatory and industry standards. In the event

Monitoring results reveal deficiencies, the internal department(s) will be subject to a Focused Review.

F. CalOptima Health shall continually assess a functional area's ability to perform functions through initial reviews, on-going Monitoring, performance reviews, and analysis of data and reports against industry, regulatory, and/or quality benchmarks, when available.

G. Audits of CalOptima Health's internal functional areas will be conducted, at minimum, annually by desktop review and by on-site review and/or webinar. CalOptima Health shall ensure audits are conducted at reasonable times

H. CalOptima Health's Audit & Oversight Department shall maintain documentation of Internal Oversight activities described herein.

I. The Auditing and Monitoring results shall be reported to the DOC, and the Compliance Committee for review and recommendations. When appropriate, CalOptima Health's Regulatory Affairs & Compliance Department shall inform the CMS, DHCS, DMHC, National Benefit Integrity Medicare Drug Contractor (NBI MEDIC), or law enforcement of aberrant findings that may cause harm or impact the delivery of care to CalOptima Health Members.

J. Failure by an internal department to respond accurately, timely, and in compliance with statutory, regulatory, contractual, CalOptima Health policies, or other requirements to CalOptima Health's Office of Compliance's Immediate Corrective Action Plan (ICAP) or Corrective Action Plan (CAP) request shall lead to further action, in accordance with CalOptima Health Policy HH.2005: Corrective Action Plan.

III. PROCEDURE

A. CalOptima Health shall conduct activities in accordance with the terms and conditions of CalOptima Health regulatory requirements, CalOptima Health policies and procedures, CalOptima Health contracts with the CMS and/or the DHCS, DMHC Full Service Technical Assistance Guides, and NCQA Accreditation.

B. CalOptima Health shall provide Internal Oversight using, without limit, the following components:

1. Desktop reviews;

2. Focused and ad hoc reviews, and Audits and Monitoring;

3. Periodic reviews and Audits; and

4. On-going monitoring.

C. Functional areas shall include, without limit:

1. Credentialing, recredentialing, and facility site review;

2. Utilization Management;

3. Claims processing/adjudication and payment timeliness;

4. Provider disputes and claim appeals;

5. Member rights;

6. Customer service;

7. Exclusion monitoring oversight;

8. Care coordination;

9. Grievance and appeals;

10. Provider network adequacy;

11. Pharmacy;

12. Communication services, including but not limited to, cultural & linguistic services, and alternative formats;

13. Access and availability, including compliance with the Americans with Disabilities Act (ADA);

14. Systems utilized to carry out business functions; and

15. Reporting and Monitoring.

D. The Audit & Oversight Department shall develop comprehensive audit tools for Internal Oversight of the focus areas as described in Section III.C. of this Policy, in consultation with subject matter experts including CalOptima Health operational departments, Regulatory Affairs & Compliance, and Legal Affairs, as necessary. The Audit & Oversight Department shall review and update audit tools in collaboration with the respective subject matter experts annually, or more often, based upon regulatory, contractual, and accreditation changes.

E. Annual Audit Oversight Process

1. At least annually, the Audit & Oversight Department shall identify and schedule Audits as a result of the annual risk assessment, focused Audit findings, deficient Monitoring results, Fraud, Waste, and Abuse (FWA), or program Audit findings.

2. The Audit will evaluate, at a minimum, performance with applicable statutes, regulations, and compliance with CalOptima Health policies and procedures.

3. Two (2) weeks prior to the scheduled Audit, the Audit & Oversight Department will send, via email, the CalOptima Health department management staff a notice confirming the date and scope of the Audit. The notice will include a description of any universes required, the Audit period, the due date, method of delivery, and Audit format. The Audit & Oversight Department shall utilize industry standard Audit protocols and appropriate methods for Auditing with respect to tools, sample size, data mining, etc.

4. Upon receipt of the requested universe(s), the assigned Audit & Oversight auditor shall select a sample size, as determined by Audit & Oversight, that is appropriate for the type of Audit being conducted, such as:

a. Processes considered to be high-risk and/or have potential Member harm;

b. Compliance with CMS, DHCS, DMHC, and NCQA-mandated elements, or contractual obligations; and

c. Areas identified as deficient in previous Audits.

5. If the minimum number of cases is not available in the universe the auditor may elect to expand the Audit period or request additional information, or documentation.

6. The Audit & Oversight auditor will notify the CalOptima Health department of samples selected, and documentation required seven (7) calendar days prior to the Audit when provided in electronic format, or when sample files are supplied in alternate formats.

   a. The Audit & Oversight auditor shall review sample cases and functional areas shall submit samples and documentation electronically whenever possible.

   b. The Audit & Oversight auditor may, at his or her discretion, request additional materials during the review.

7. The Audit will include validation of documentation, including but not limited to CalOptima Health policies and procedures, training, reports, systems, and file review(s) and universe (s).

8. The Audit & Oversight auditor shall discuss findings from the annual Audit with the respective CalOptima Health department and document such findings in an Audit findings report. If any CalOptima Health department receives a score of less than the established passing score for an individual audit element, the department will be required to develop a Corrective Action Plan in accordance with CalOptima Health Policy HH.2005: Corrective Action Plan.

   a. The Audit & Oversight auditor is responsible for confirming remediation or interacting with the leadership of the audited department to ensure the department has documented and completed the remediation. The Audit & Oversight management or auditor shall report the findings of the audit, CAPs, if any, and the timeline for CAP remediation to the DOC.

9. Audit findings will be presented to the DOC by the Audit & Oversight Department for the respective functional area reviewed. The Audit & Oversight Department shall determine any follow up activities, process improvement, and/or additional review based on the recommendations of the Audit & Oversight auditor.

10. A department must resolve the elements of the CAP in accordance with CalOptima Health Policy HH.2005: Corrective Action Plan.

11. In the event the elements of the CAP are not successfully completed within the established timeframe, the Director of Audit & Oversight shall report status to the DOC following the CAP period. The DOC will review the outstanding CAP items to determine, at its discretion, whether the CAP deadline should be extended.

    a. The Audit & Oversight Department must demonstrate to the DOC the appropriateness for an extension and provide a detailed action plan to ensure that the items for correction are being addressed in a timely manner.

12. The Audit & Oversight Department shall determine whether ad hoc audits, reviews, and or other remediation or actions are necessary to confirm remediation of identified issues. Issues escalated will be reviewed by the Audit & Oversight Department, DOC, and the Compliance Committee, as applicable.

F. Ongoing Internal Oversight Process

1. The Audit & Oversight Department will conduct on-going Internal Oversight of the business areas outlined in Section III.C. of this policy based on the risk level determined during the annual risk assessment, and as outlined on the Internal Audit and Monitoring Work Plan.

2. Internal Dashboard Reporting: On a monthly basis, data shall be used to Monitor areas for processing timeliness and accuracy of business activities.

   a. The DOC shall Monitor dashboard results and may make recommendations for corrective action if performance falls below the standard defined by the DOC.

   b. If there is a consistent pattern of non-compliance, the Audit & Oversight Department shall conduct a Focused Review.

      i. If the results of the Focused Review are unfavorable, the auditor will escalate for further action. This includes, but is not limited to, reporting the issue up to the Compliance Committee for disciplinary action and/or development of remediation plan.

G. Corrective Action Plan

1. If any area of deficiency or non-compliance is identified, including but not limited to, Member or Provider Complaints, readiness assessment reviews, regular reports, oversight reviews, and ongoing Monitoring, the Audit & Oversight Department will be required to issue a Corrective Action Plan (CAP) request, in accordance with CalOptima Health Policy HH.2005: Corrective Action Plan.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health 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 HH.2005: Corrective Action Plan
F. CalOptima Health Policy HH.4003: Annual Risk Assessment
G. Title 42, Code of Federal Regulations (C.F.R.), §455.2
H. Welfare and Institutions Code, §14043.1(a)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	12/01/2016	HH.4002	CalOptima Internal Oversight	Administrative
Revised	12/07/2017	HH.4002	CalOptima Internal Oversight	Administrative
Revised	12/06/2018	HH.4002	CalOptima Internal Oversight	Administrative
Revised	12/05/2019	HH.4002	CalOptima Internal Oversight	Administrative
Revised	12/03/2020	HH.4002	CalOptima Internal Oversight	Administrative
Revised	12/20/2021	HH.4002	CalOptima Internal Oversight	Administrative
Revised	TBD	HH.4002	CalOptima Health Internal Oversight	Administrative

IX. GLOSSARY

Term	Definition
Abuse	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.
Audit	A formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being audited and normally performed by individuals with one of several acknowledged certifications.
Business Owner	CalOptima Health management and staff vested in the compliance of their respective CalOptima Health functional area in accordance with statutory, regulatory, contractual, and CalOptima Health policy requirements.
Compliance Committee	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 senior management 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 Executive Director of Human Resources.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima Health, the Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima Health departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima Health and its regulators.
Delegation Oversight Committee (DOC)	A subcommittee of the Compliance Committee chaired by the Director of Audit & 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.
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.
Department of Managed Health Care (DMHC)	The California Department of Managed Health Care that oversees California's managed care system. DMHC regulates health maintenance organizations licensed under the Knox-Keene Act, Health & Safety Code, Sections 1340 *et seq.*
Focused Review	An audit that specifically targets areas of potential deficiency.

Term	Definition
Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with Title 42 Code of Federal Regulations section 455.2, Welfare and Institutions Code section 14043.1(i).
Internal Audit and Monitoring Work Plan	An outline of goals and objectives to define the audit scope for internal functional areas to ensure health plan compliance, as well as conduct on-going performance measurements to determine opportunities for improvement and/or the effectiveness of interventions.
Internal Oversight	The process by which CalOptima Health's Audit and Oversight Department conducts audits to monitor internal functional areas in accordance with regulatory, statutory, contractual, and CalOptima Health policy requirements to ensure health plan compliance.
Member	A beneficiary enrolled in a CalOptima Health Program.
Monitoring	Regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.
National Committee for Quality Assurance (NCQA)	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.
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.

1

Policy:	HH.5000~~A~~
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:	12/31/2022
Applicable to:	☒ Medi-Cal ☒ OneCare ~~☒ OneCare Connect~~ ☒ 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~~CalOptima Health program, in accordance with federal and state regulations, and to identify resulting Overpayments for recoupment.

II. POLICY

A. The ~~CalOptima~~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. ~~CalOptima~~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;
8. ~~Audit &~~Delegation Oversight Committee (D~~A~~OC);

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9. Internal department referrals;

~~9.~~10. Claims auditors who review Provider claims through the claims review software system;

~~10.~~11. Internal and external claims and compliance audits; and

~~11.~~12. Any other source that identifies potential FWA.

III. PROCEDURE

A. Identification of Overpayments

1. ~~CalOptima~~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. ~~Upon referral to CalOptima~~CalOptima Health's ~~SIU team, the~~ SIU team shall utilize investigation software~~/tools~~ or internal data reports to identify suspicious billing patterns, or industry ~~-~~identified FWA trends, to determine whether ~~CalOptima~~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 ~~Bill an unusually large percentage of~~ 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 ~~after being advised of the error~~;

      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);

      ~~iv.~~v. Bill a large proportion of high-level Evaluation and Management (E/M) Codes; or

      ~~v.~~vi. Prescribe an unusual amount of Schedule II Medications in relation to their peers.

~~3. During the course of an investigation, the SIU team shall review claims and/or billing activity, to either verify if services were rendered, or if services were appropriately billed, as applicable.~~

B. Investigation Protocol of Overpayments

~~During the course of an investigation, CalOptima~~CalOptima Health~~'s SIU team may identify actual or potential Overpayments that are suspected to be the result of inappropriate and/or inaccurate activity.~~

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 Centers for Medicaid & Medicare Services (CMS) Health Plan Management System (HPMS) memoranda.

2. ~~CalOptima~~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~~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 ten (10) business days~~.~~

      ii. Second Request – records must be returned within four (4) business days

      iii. Final warning – records must be returned within one (1) business day

      ~~iii.~~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~~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~~CalOptima Health's SIU shall consult with qualified personnel in reviewing the Medical Records and other records. If ~~CalOptima~~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~~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~~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;

~~a.~~c. Member name;

~~b.~~d. Unique Member identification (ID) number;

~~c.~~e. Claim number;

~~d.~~f. HCPCS/CPT Code;

~~e.~~g. ICD-9 and/or ICD-10 codes;

~~f.~~h. Revenue codes;

i. Place of service;

j. Modifier;

~~g.~~k. Date(s) of service;

~~h.~~l. Number of services billed;

~~i.~~m. Number of units allowed;

~~j.~~n. Billed amount;

~~k.~~o. Allowed amount;

~~l.~~p. Paid amount;

~~m.~~q. Overpayment amount; and

~~n.~~r. ~~Denial~~ Overpayment recovery reason.

D. Resolution

1. If ~~CalOptima~~CalOptima Health's SIU investigation has identified an Overpayment, and does not contain a component of FWA, the Overpayment shall be referred to ~~CalOptima~~CalOptima Health Claims Administration Department for Overpayment set up, collection, and recoupment, as outlined in ~~CalOptima~~CalOptima Health Policy FF.2001: Claims Processing for Covered

Services for which CalOptima Health is Financially Responsible~~Rendered to CalOptima~~CalOptima Health ~~Direct- Administrative Members, CalOptima~~CalOptima Health ~~Community Network Members, or Members Enrolled in a Shared Risk Group~~.

2. 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~~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~~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~~CalOptima Health Claims Administration Department;

   e. Notify the DHCS and/or the CMS of Overpayment determinations, in accordance with ~~CalOptima~~CalOptima Health Policy HH.1107~~A~~: Fraud, Waste, and Abuse Investigation and Reporting and as required by law and state and federal regulations, but no later than sixty (60) calendar days after the date ~~CalOptima~~CalOptima Health identified the Overpayment.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. ~~CalOptima~~CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. ~~CalOptima~~CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
~~C. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect~~
~~D.~~C. ~~CalOptima~~CalOptima Health PACE Program Agreement
~~E.~~D. ~~CalOptima~~CalOptima Health Policy FF.2001: Claims Processing for Covered Services for which CalOptima is Financially Responsible~~Rendered to CalOptima~~CalOptima Health ~~Direct- Administrative Members, CalOptima~~CalOptima Health ~~Community Network Members, or Members Enrolled in a Shared Risk Group~~
~~F.~~E. ~~CalOptima~~CalOptima Health Policy HH.1107~~A~~: Fraud, Waste, and Abuse Investigation and Reporting
~~G.~~F. CMS Guidance for Reporting Medicare Advantage Organization and/or Sponsor Identified Overpayments for CMS
~~H.~~G. Department of Health Care Services (DHCS) All Plan Letter (APL) 15-026: Actions Required following Notice of a Credible Allegation of Fraud
~~I.~~H. California Health and Safety Code §1371
~~J.~~I. Social Security Act, §1128J(d)
~~K.~~J. Title 22, California Code of Regulations (C.C.R.), §§51045, 51047, 51458.1
~~L.~~K. Title 28, California Code of Regulations (C.C.R.), §1300.71
~~M.~~L. 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.~~M. Title 42, Code of Federal Regulations (C.F.R.), §§411.404, 411.406, 411.408
~~O.~~N. Title 45, Code of Federal Regulations (C.F.R.), §79
~~P.~~O. Welfare and Institutions Code, 14172, 14172.5, 14173, 14176, 14177

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	12/01/2016	HH.5000Δ	Provider Overpayment Investigation and Determination	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.5000Δ	Provider Overpayment Investigation and Determination	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.5000Δ	Provider Overpayment Investigation and Determination	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.5000Δ	Provider Overpayment Investigation and Determination	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.5000Δ	Provider Overpayment Investigation and Determination	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.5000Δ	Provider Overpayment Investigation and Determination	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	HH.5000~~Δ~~	Provider Overpayment Investigation and Determination	Medi-Cal OneCare PACE

IX. GLOSSARY

Term	Definition
Abuse	Actions that may, directly or indirectly, result in unnecessary costs to a ~~CalOptima~~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.
Delegation Oversight Committee (DOC)	A subcommittee of the Compliance Committee chaired by the Director of Audit & 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: 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~~CalOptima Health policy. OneCare ~~& OneCare Connect~~: 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: 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.~~A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Health Network, or other person or institution who furnishes Covered Services.~~ ~~OneCare Connect: A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Health Network, physician group, or other person or institution who furnishes Covered Services.~~
Schedule II Medication	Narcotic substances with a high potential for Abuse which may lead to severe psychological or physical dependence.
Waste	Overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a ~~CalOptima~~CalOptima Health Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

1

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:	12/31/2022
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. 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;
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 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 ten (10) business days

      ii. Second Request – records must be returned within four (4) business days

      iii. Final warning – records must be returned within one (1) 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. Member name;

d. Unique Member identification (ID) number;

e. Claim number;

f. HCPCS/CPT Code;

g. ICD-9 and/or ICD-10 codes;

h. Revenue codes;

i. Place of service;

j. Modifier;

k. Date(s) of service;

l. Number of services billed;

m. Number of units allowed;

n. Billed amount;

o. Allowed amount;

p. Paid amount;

q. Overpayment amount; and

r. 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. 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;

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 sixty (60) calendar days 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. CMS Guidance for Reporting Medicare Advantage Organization and/or Sponsor Identified Overpayments for CMS
G. Department of Health Care Services (DHCS) All Plan Letter (APL) 15-026: Actions Required following Notice of a Credible Allegation of Fraud
H. California Health and Safety Code §1371
I. Social Security Act, §1128J(d)
J. Title 22, California Code of Regulations (C.C.R.), §§51045, 51047, 51458.1
K. Title 28, California Code of Regulations (C.C.R.), §1300.71
L. 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
M. Title 42, Code of Federal Regulations (C.F.R.), §§411.404, 411.406, 411.408
N. Title 45, Code of Federal Regulations (C.F.R.), §79
O. Welfare and Institutions Code, 14172, 14172.5, 14173, 14176, 14177

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	12/01/2016	HH.5000Δ	Provider Overpayment Investigation and Determination	Medi-Cal OneCare OneCare Connect PACE
Revised	12/07/2017	HH.5000Δ	Provider Overpayment Investigation and Determination	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.5000Δ	Provider Overpayment Investigation and Determination	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.5000Δ	Provider Overpayment Investigation and Determination	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.5000Δ	Provider Overpayment Investigation and Determination	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.5000Δ	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

IX. GLOSSARY

Term	Definition
Abuse	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.
Delegation Oversight Committee (DOC)	A subcommittee of the Compliance Committee chaired by the Director of Audit & 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: 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. 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: 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.

Term	Definition
Schedule II Medication	Narcotic substances with a high potential for Abuse which may lead to severe psychological or physical dependence.
Waste	Overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Health Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

1

Policy:	HH.3007~~A~~
Title:	**Member Rights to Request Restrictions on Use and Disclosure of Protected Health Information**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	*/s/*
Effective Date:	04/01/2003
Revised Date:	12/31/2022
Applicable to:	☒ Medi-Cal ☒ OneCare ~~OneCare Connect~~ ☒ PACE ☐ Administrative

I. PURPOSE

This policy describes the process by which a Member may request ~~CalOptima~~CalOptima Health to restrict the Use and Disclosure of his or her Protected Health Information (PHI), and how ~~CalOptima~~CalOptima Health shall process such requests in accordance with applicable statutory, regulatory, and contractual requirements.

II. POLICY

A. ~~CalOptima~~CalOptima Health must permit a Member to request restrictions of Uses and Disclosures of PHI for Treatment, Payment, and Health Care Operations and Disclosures permitted under Title 45, Code of Federal Regulations, Section 164.510(b). A Member may request ~~CalOptima~~CalOptima Health, in writing or orally, to restrict the Use and/or Disclosure of his or her PHI.

1. ~~CalOptima~~CalOptima Health retains the right to approve or deny such request.

B. ~~CalOptima~~CalOptima Health may agree to the Member's request to restrict Disclosure of PHI about the Member if:

1. The PHI pertains solely to a health care item or service for which the Member, or person other than the health plan on behalf of the Member, has paid the covered entity in full. If the law requires the Disclosure, ~~CalOptima~~CalOptima Health does not have to agree to the Member's restriction.

C. If ~~CalOptima~~CalOptima Health approves a Member's request to restrict the Use and Disclosure of the Member's PHI, ~~CalOptima~~CalOptima Health shall not be subject to such restrictions if:

1. Disclosure is Required by Law;

2. The restricted PHI is needed:

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a. By a treating Provider;

b. For public health activities;

c. To report abuse, neglect, domestic violence, and activities related to criminal acts; or

~~c.~~d. By a coroner.

3. The Member requires Emergency Services; or

4. The Disclosure is among those defined in Title 45, Code of Federal Regulations, Sections 164.512 and 164.522.

D. ~~CalOptima~~CalOptima Health shall not Use and Disclose PHI covered by an agreed upon restriction in violation of that restriction. ~~CalOptima~~CalOptima Health cannot take back what was Used or Disclosed prior to approving the restriction request, but will limit the Use or Disclosure, in accordance with an agreed upon restriction in the future.

III. PROCEDURE

A. Requests for Restrictions on Use and Disclosure:

1. The Member or a Member's Personal Representative shall submit a written request to restrict either the Use and/or Disclosure of the Member's PHI to the ~~CalOptima~~CalOptima Health Office of Compliance. The request must include:

a. Request to Restrict Information on Use and Disclosure of Protected Health Information Form;

b. The PHI that is to be restricted;

c. Whether the Member wants to restrict the Use, Disclosure, or both; and

d. To whom the ~~limitations~~ restriction(s) apply (e.g., Disclosures to a spouse, partner, or parent);

2. ~~CalOptima~~CalOptima Health ~~shall~~ may discuss the request with a Member or a Member's Personal Representative to ensure that such restrictions are in the Member's best interest.

~~2.~~3. If the restriction request involves Use, Disclosures, or both by contracted Providers, ~~CalOptima~~CalOptima Health may ask the Member to submit a separate restriction request to the Member's Providers.

~~3.~~4. ~~CalOptima~~CalOptima Health will remind the Member that ~~CalOptima~~CalOptima Health:

a. Retains the right to approve or deny such request;

b. May release the restricted PHI in emergency situations;

c. May release the restricted PHI if Required by Law; and

d. May terminate the agreement to restrict PHI.

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~~4.~~5. ~~CalOptima~~CalOptima Health shall review a Member's request to restrict Use and Disclosure of PHI in coordination with Business Associates, as appropriate.

~~5.~~6. ~~CalOptima~~CalOptima Health will document the restriction, if any.

~~6.~~7. ~~CalOptima~~CalOptima Health shall notify the Member of the decision to approve or deny the Member's request within thirty (30) calendar days of receipt of the request, using the Response to Request for Restriction on Use and Disclosure of PHI Form.

B. Terminating a Restriction

1. ~~CalOptima~~CalOptima Health may terminate its agreement to a restriction of Use and Disclosure under the following circumstances:

   a. The Member agrees to, or requests, the termination, in writing, to ~~CalOptima~~CalOptima Health.

   b. The Member agrees verbally to the termination, and the verbal agreement is documented by ~~CalOptima~~CalOptima Health; or

   c. ~~CalOptima~~CalOptima Health notifies the Member that it shall terminate its agreement to the restriction(s), except that such termination is only effective with respect to PHI created, or received, after the individual has been notified of the termination, except as provided in Section II.B.1. of this policy.

C. The Office of Compliance shall retain copies of all requests and related notices on file for ten (10) years from the date the request is received by ~~CalOptima~~CalOptima Health or the date when the restriction was last in effect, whichever is later.

IV. ATTACHMENT(S)

A. Request for Restriction on Use and Disclosure of Protected Health Information
B. Response to Request for Restriction on Use and Disclosure of Protected Health Information
C. Termination of Restriction

V. REFERENCE(S)

A. CalOptima Health Compliance Plan
~~A.~~B. ~~CalOptima~~CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
~~B.~~C. ~~CalOptima~~CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
~~C. CalOptimaCalOptima Health Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect~~
D. ~~CalOptima~~CalOptima Health PACE Program Agreement
~~E. CalOptimaCalOptima Health Compliance Plan~~
~~F.~~E. ~~CalOptima~~CalOptima Health Privacy Program
~~G.A. Office of Civil Rights Privacy Rule Summary - Notice and Other Individual Rights~~
F. ~~CalOptima~~CalOptima Health Policy HH.3000~~A~~: Notice of Privacy Practices
~~H.~~G. Department of Managed Health Care (DMHC) APL 22-010 (OPL) Guidance Regarding AB 1184 - Confidentiality of Medical Information

H. Office of Civil Rights Privacy Rule Summary- Notice and Other Individual Rights
I. Title 45, Code of Federal Regulations, §164.512
J. Title 45, Code of Federal Regulations, §164.522

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
TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/01/2003	HH.3007	Member Right to Request Restrictions on Use and Disclosure of Protected Health Information	Medi-Cal
Effective	06/01/2005	MA.9206	Member Right to Request Restrictions on Use and Disclosure of Protected Health Information	OneCare
Revised	07/01/2007	HH.3007	Member Right to Request Restrictions on Use and Disclosure of Protected Health Information	Medi-Cal
Revised	01/01/2009	MA.9206	Member Right to Request Restrictions on Use and Disclosure of Protected Health Information	OneCare
Revised	07/01/2011	HH.3007	Member Right to Request Restrictions on Use and Disclosure of Protected Health Information	Medi-Cal
Revised	07/01/2011	MA.9206	Member Right to Request Restrictions on Use and Disclosure of Protected Health Information	OneCare
Revised	01/01/2013	HH.3007Δ	Member Right to Request Restrictions on Use and Disclosure of Protected Health Information	Medi-Cal OneCare
Revised	01/01/2014	HH.3007	Member Right to Request Restrictions on Use and Disclosure of Protected Health Information	Medi-Cal
Revised	05/01/2014	MA.9206	Member Right to Request Restrictions on Use and Disclosure of Protected Health Information	OneCare

Action	Date	Policy	Policy Title	Program(s)
Revised	11/01/2014	HH.3007	Member Right to Request Restrictions on Use and Disclosure of Protected Health Information	Medi-Cal
Revised	11/01/2014	MA.9206	Member Right to Request Restrictions on Use and Disclosure of Protected Health Information	OneCare
Revised	09/01/2015	HH.3007	Member Right to Request Restrictions on Use and Disclosure of Protected Health Information	Medi-Cal
Revised	09/01/2015	MA.9206	Member Right to Request Restrictions on Use and Disclosure of Protected Health Information	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.3007Δ	Member Right to Request Restrictions on Use and Disclosure of Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9206	Member Right to Request Restrictions on Use and Disclosure of Protected Health Information	OneCare OneCare Connect PACE
Revised	12/07/2017	HH.3007Δ	Member Right to Request Restrictions on Use and Disclosure of Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.3007Δ	Member Right to Request Restrictions on Use and Disclosure of Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.3007Δ	Member Right to Request Restrictions on Use and Disclosure of Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.3007Δ	Member Right to Request Restrictions on Use and Disclosure of Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.3007Δ	Member Right to Request Restrictions on Use and Disclosure of Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
~~Revised~~	12/31/2022	HH.3007~~A~~	Member Right to Request Restrictions on Use and Disclosure of Protected Health Information	Medi-Cal OneCare PACE

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IX. GLOSSARY

Term	Definition
Authorized 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~~CalOptima Health Policy HH.3009: Access by Member's Authorized Representative. ~~OneCare Connect: An individual either appointed by a Member or authorized under State or other applicable law to act on behalf of the Member in filing a Grievance, requesting a Prior Authorization request, or in dealing with any level of the Appeals process. Unless otherwise stated in Title 42 of the Code of Federal Regulations, Part 423, Subpart M, the representative has all of the rights and responsibilities of a Member in obtaining a Prior Authorization request or in dealing with any of the levels of the Appeals process, subject to the rules described in Part 422, Subpart M.~~
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 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.
Emergency Services	Medi-Cal: Covered inpatient and outpatient services that are furnished by a Provider qualified to furnish those health services needed to evaluate or stabilize an Emergency Medical Condition. OneCare & OneCare Connect: Those covered inpatient and outpatient services required that are: 1. Furnished by a physician qualified to furnish emergency services; and 2. Needed to evaluate or stabilize an Emergency Medical Condition.
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.
Member	A beneficiary enrolled in a ~~CalOptima~~CalOptima Health program.
Payment	Has the meaning in 42 Code of Federal Regulations Section 164.501, including: activities carried out by ~~CalOptima~~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, Utilization review activities including pre-certification, preauthorization, concurrent, or retrospective review of services.

Term	Definition
Protected Health Information (PHI)	Has the meaning in 45, Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is 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.~~A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Health Network, or other person or institution who furnishes Covered Services.~~ ~~OneCare Connect: A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Health Network, physician group, or other person or institution who furnishes Covered Services.~~
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.
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.3007
Title:	**Member Rights to Request Restrictions on Use and Disclosure of Protected Health Information**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	*/s/*
Effective Date:	04/01/2003
Revised Date:	12/31/2022
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ PACE ☐ Administrative

I. PURPOSE

This policy describes the process by which a Member may request CalOptima Health to restrict the Use and Disclosure of his or her Protected Health Information (PHI), and how CalOptima Health shall process such requests in accordance with applicable statutory, regulatory, and contractual requirements.

II. POLICY

A. CalOptima Health must permit a Member to request restrictions of Uses and Disclosures of PHI for Treatment, Payment, and Health Care Operations and Disclosures permitted under Title 45, Code of Federal Regulations, Section 164.510(b). A Member may request CalOptima Health, in writing or orally, to restrict the Use and/or Disclosure of his or her PHI.

1. CalOptima Health retains the right to approve or deny such request.

B. CalOptima Health may agree to the Member's request to restrict Disclosure of PHI about the Member if:

1. The PHI pertains solely to a health care item or service for which the Member, or person other than the health plan on behalf of the Member, has paid the covered entity in full. If the law requires the Disclosure, CalOptima Health does not have to agree to the Member's restriction.

C. If CalOptima Health approves a Member's request to restrict the Use and Disclosure of the Member's PHI, CalOptima Health shall not be subject to such restrictions if:

1. Disclosure is Required by Law;

2. The restricted PHI is needed:

   a. By a treating Provider;

   b. For public health activities;

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c. To report abuse, neglect, domestic violence, and activities related to criminal acts; or

d. By a coroner.

3. The Member requires Emergency Services; or

4. The Disclosure is among those defined in Title 45, Code of Federal Regulations, Sections 164.512 and 164.522.

D. CalOptima Health shall not Use and Disclose PHI covered by an agreed upon restriction in violation of that restriction. CalOptima Health cannot take back what was Used or Disclosed prior to approving the restriction request, but will limit the Use or Disclosure, in accordance with an agreed upon restriction in the future.

III. PROCEDURE

A. Requests for Restrictions on Use and Disclosure:

1. The Member or a Member's Personal Representative shall submit a written request to restrict either the Use and/or Disclosure of the Member's PHI to the CalOptima Health Office of Compliance. The request must include:

a. Request to Restrict Information on Use and Disclosure of Protected Health Information Form;

b. The PHI that is to be restricted;

c. Whether the Member wants to restrict the Use, Disclosure, or both; and

d. To whom the restriction(s) apply (e.g., Disclosures to a spouse, partner, or parent);

2. CalOptima Health may discuss the request with a Member or a Member's Personal Representative to ensure that such restrictions are in the Member's best interest.

3. If the restriction request involves Use, Disclosures, or both by contracted Providers, CalOptima Health may ask the Member to submit a separate restriction request to the Member's Providers.

4. CalOptima Health will remind the Member that CalOptima Health:

a. Retains the right to approve or deny such request;

b. May release the restricted PHI in emergency situations;

c. May release the restricted PHI if Required by Law; and

d. May terminate the agreement to restrict PHI.

5. CalOptima Health shall review a Member's request to restrict Use and Disclosure of PHI in coordination with Business Associates, as appropriate.

6. CalOptima Health will document the restriction, if any.

7. CalOptima Health shall notify the Member of the decision to approve or deny the Member's request within thirty (30) calendar days of receipt of the request, using the Response to Request for Restriction on Use and Disclosure of PHI Form.

B. Terminating a Restriction

1. CalOptima Health may terminate its agreement to a restriction of Use and Disclosure under the following circumstances:

   a. The Member agrees to, or requests, the termination, in writing, to CalOptima Health.

   b. The Member agrees verbally to the termination, and the verbal agreement is documented by CalOptima Health; or

   c. CalOptima Health notifies the Member that it shall terminate its agreement to the restriction(s), except that such termination is only effective with respect to PHI created, or received, after the individual has been notified of the termination, except as provided in Section II.B.1. of this policy.

C. The Office of Compliance shall retain copies of all requests and related notices on file for ten (10) years from the date the request is received by CalOptima Health or the date when the restriction was last in effect, whichever is later.

IV. ATTACHMENT(S)

A. Request for Restriction on Use and Disclosure of Protected Health Information
B. Response to Request for Restriction on Use and Disclosure of Protected Health Information
C. Termination of Restriction

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 Privacy Program
F. CalOptima Health Policy HH.3000: Notice of Privacy Practices
G. Department of Managed Health Care (DMHC) APL 22-010 (OPL) Guidance Regarding AB 1184 - Confidentiality of Medical Information
H. Office of Civil Rights Privacy Rule Summary- Notice and Other Individual Rights
I. Title 45, Code of Federal Regulations, §164.512
J. Title 45, Code of Federal Regulations, §164.522

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
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TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
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Revised	07/01/2011	HH.3007	Member Right to Request Restrictions on Use and Disclosure of Protected Health Information	Medi-Cal
Revised	07/01/2011	MA.9206	Member Right to Request Restrictions on Use and Disclosure of Protected Health Information	OneCare
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Revised	09/01/2015	MA.9206	Member Right to Request Restrictions on Use and Disclosure of Protected Health Information	OneCare OneCare Connect PACE

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Action	Date	Policy	Policy Title	Program(s)
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Retired	12/01/2016	MA.9206	Member Right to Request Restrictions on Use and Disclosure of Protected Health Information	OneCare OneCare Connect PACE
Revised	12/07/2017	HH.3007Δ	Member Right to Request Restrictions on Use and Disclosure of Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
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Revised	12/20/2021	HH.3007Δ	Member Right to Request Restrictions on Use and Disclosure of Protected Health Information	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	HH.3007	Member Right to Request Restrictions on Use and Disclosure of Protected Health Information	Medi-Cal OneCare PACE

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IX. GLOSSARY

Term	Definition
Authorized 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.
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.

Term	Definition
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.
Emergency Services	Medi-Cal: Covered inpatient and outpatient services that are furnished by a Provider qualified to furnish those health services needed to evaluate or stabilize an Emergency Medical Condition. OneCare & OneCare Connect: Those covered inpatient and outpatient services required that are: 1. Furnished by a physician qualified to furnish emergency services; and 2. Needed to evaluate or stabilize an Emergency Medical Condition.
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.
Member	A beneficiary enrolled in a CalOptima Health program.
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, 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 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.

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Term	Definition
Provider	Medi-Cal: A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, or other person or institution that furnishes Covered Services. OneCare: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B.
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.
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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Request for Restriction on Use and Disclosure of Protected Health Information (PHI)

Date of Request: _____

Member Name: _____ Date of Birth: _____

Member CIN: _____ Telephone Number: _____

I understand that CalOptima Health may use or disclose (release) my Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. CalOptima Health may also release information to someone involved in my care or the payment for my care, such as a family member or friend.

I understand that CalOptima Health does not have to agree to my request.

I request a restriction on CalOptima Health's Use and Disclosure of Protected Health Information (PHI). The information I want limited is:

_____

_____

I want to limit CalOptima Health's:

☐ Use of this Information
☐ Disclosure of this information
☐ Both the use and disclosure of this information

I want the limits to apply to the following person/entity (For example: spouse): _____

REQUIRED USES AND DISCLOSURES:

Even if CalOptima Health agrees to the restriction, the information may still be shared under the following circumstances:

- During medical emergency if the restricted information is needed to provide emergency treatment. However, if the information is disclosed during an emergency, CalOptima Health will tell the recipient not to use or disclose it for any other purpose.
- For health agency oversight activities
- For uses or disclosures otherwise required by law
- If a restriction is agreed to, the termination in writing
- I orally agree to the termination and the oral agreement is documented
- CalOptima Health informs me that it is terminating the agreement. In this case, the termination is only effective for PHI created or received by CalOptima Health after I am notified of the termination.

Continue on page 2.

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: www.caloptima.org, 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 a.m. to 5:30 p.m. Members with hearing or speech impairments can call our TDD/TTY line at 1-714-246-8523 or toll-free at **1-800-735-2929**. 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:

CalOptima Health
Customer Service Department
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: _____

[DATE]

[NAME]
[ADDRESS]
[CITY], [STATE] [ZIP]

Re: Response to Request for Restriction on Use and Disclosure of Protected Health Information (PHI)

Dear [NAME]:

CalOptima Health has received your Request for Restriction on Use and Disclosure of Protected Health Information (PHI) dated [DATE].

☐ CalOptima Health agrees to the restriction you requested
☐ CalOptima Health does not agree to the restriction you requested
☐ Other: _____

Even if CalOptima Health agrees to the restriction, the information may still be shared under the following circumstances:

- During medical emergency if the restricted information is needed to provide emergency treatment. However, if the information is disclosed during an emergency, CalOptima Health will tell the recipient not to use or disclose it for any other purpose.
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For more information about your privacy rights, please refer to your copy of the CalOptima Health Notice of Privacy Practices. It is also available on our website: www.caloptima.org, or from the Customer Service Department at CalOptima Health by calling **1-714-246-8500** or toll-free at **1-888-587-8088**, Monday through Friday from 8 a.m. to 5:30 p.m. Members with hearing or speech impairments can call our TDD/TTY line at **1-714-246-8523** or toll-free at **1-800-735-2929**. We have staff who 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:

CalOptima Health
Customer Service Department
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.

Sincerely,

Privacy Officer

Rev. 10/2022

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Termination of Restriction Form

Date: _____ Date of Birth: _____

Member Name: _____ Member CIN: _____

The member named above requested a restriction on the Use and Disclosure of Protected Health Information (PHI) dated [DATE].

☐ The member requests the restriction to be terminated.
Member Signature: _____

If Authorized Representative (please include legal documentation):

Print Name: _____ Relationship to Member: _____

☐ The member agrees to the termination of the restriction.
Member Signature: _____

If Authorized Representative (please include legal documentation):

Print Name: _____ Relationship to Member: _____

☐ CalOptima Health is informing you that the agreement is terminated. The termination is effective only with respect to Protected Health Information (PHI) created or received by us after you received this notification.

☐ The member agreed orally to the termination.
Print Name and Signature of CalOptima Representative who received the oral agreement:

_____

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: www.caloptima.org, 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 a.m. to 5:30 p.m. Members with hearing or speech impairments can call our TDD/TTY line at **1-714-246-8523** or toll-free at **1-800-735-2929**. 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:

CalOptima Health
Customer Service Department
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.

Sincerely,

Privacy Officer

Policy:	HH.3008~~A~~
Title:	**Member Right to Request Confidential Communications**
Department:	Office of Compliance
Section:	Privacy
CEO Approval:	*/s/*
Effective Date:	04/01/2003
Revised Date:	12/31/2022
Applicable to:	☒ Medi-Cal ☒ OneCare ~~OneCare Connect~~ ☒ PACE ☐ Administrative

I. PURPOSE

This policy describes the process by which a Member may request to receive Confidential Communications from ~~CalOptima~~CalOptima Health regarding Protected Health Information (PHI).

II. POLICY

A. ~~CalOptima~~CalOptima Health shall permit Members to request and shall accommodate a reasonable written request to receive communications of PHI by alternative means, ~~(when available), or to~~such as an alternative phone number or at an alternative address~~locations~~, 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~~CalOptima Health.

~~A.~~B. ~~CalOptima~~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.

~~B.~~C. ~~CalOptima~~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~~CalOptima Health's Customer Service Department, ~~or by mail~~which will be routed to:

Attention: Office of Compliance - Privacy
~~CalOptima~~CalOptima Health
505 City Parkway West
Orange, CA 92868

B. ~~CalOptima~~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~~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~~CalOptima Health information at home; and

2. Provides a valid alternate physical mailing address for written communications, and/or specified phone number for ~~outbound~~ calls and/or voicemail messages from ~~CalOptima~~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.

~~F.~~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.

~~G.~~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

~~H.~~ 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 ~~FACETS™~~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. ~~of use, such as Guiding Care.~~

I.

~~I.~~

J. ~~J.~~ All written requests shall be retained for ten (10) years and in accordance with ~~CalOptima~~CalOptima Health Policy HH.2022~~A~~: Record Retention and Access.

IV. ATTACHMENT(S)

A. Request for Restriction on Manner/Method of Confidential Communications Form

V. REFERENCE(S)

A. ~~CalOptima~~CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage

B. ~~CalOptima~~CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal

~~C. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect~~

~~D.~~C. ~~CalOptima~~CalOptima Health PACE Program Agreement

~~E.~~D. ~~CalOptima~~CalOptima Health Compliance Plan

~~F.~~E. ~~CalOptima~~CalOptima Health Privacy Program

~~G.~~F. ~~CalOptima~~CalOptima Health Policy HH.2022~~A~~: Record Retention and Access

G. ~~CalOptima~~CalOptima Health Policy HH.3000~~A~~: 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
TBD	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
Effective	06/01/2005	MA.9211	Member Right to Request Confidential Communications	OneCare
Revised	04/01/2007	HH.3008	Member Right to Request Confidential Communications	Medi-Cal
Revised	04/01/2007	MA.9211	Member Right to Request Confidential Communications	OneCare
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	02/01/2012	MA.9211	Member Right to Request Confidential Communications	OneCare
Revised	02/01/2013	HH.3008Δ	Member Right to Request Confidential Communications	Medi-Cal OneCare
Revised	02/01/2014	MA.9211	Member Right to Request Confidential Communications	OneCare
Revised	06/01/2014	MA.9211	Member Right to Request Confidential Communications	OneCare
Revised	09/01/2014	MA.9211	Member Right to Request Confidential Communications	OneCare
Revised	09/01/2015	HH.3008	Member Right to Request Confidential Communications	Medi-Cal
Revised	09/01/2015	MA.9211	Member Right to Request Confidential Communications	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.3008Δ	Member Right to Request Confidential Communications	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9211	Member Right to Request Confidential Communications	OneCare OneCare Connect PACE
Revised	12/07/2017	HH.3008Δ	Member Right to Request Confidential Communications	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.3008Δ	Member Right to Request Confidential Communications	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.3008Δ	Member Right to Request Confidential Communications	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.3008Δ	Member Right to Request Confidential Communications	Medi-Cal OneCare OneCare Connect PACE

Action	Date	Policy	Policy Title	Program(s)
Revised	12/20/2021	HH.3008Δ	Member Right to Request Confidential Communications	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	HH.3008~~A~~	Member Right to Request Confidential Communications	Medi-Cal OneCare PACE

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~~CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Member	A beneficiary enrolled in a ~~CalOptima~~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~~CalOptima Health Policy HH.3009: Access by Member's Authorized Representative. ~~OneCare Connect: An individual either appointed by a Member or authorized under State or other applicable law to act on behalf of the Member in filing a Grievance, requesting a Prior Authorization request, or in dealing with any level of the Appeals process. Unless otherwise stated in Title 42 of the Code of Federal Regulations, Part 423, Subpart M, the representative has all of the rights and responsibilities of a Member in obtaining a Prior Authorization request or in dealing with any of the levels of the Appeals process, subject to the rules described in Part 422, Subpart M.~~
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~~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. 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.~~A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Health Network, or other person or institution who furnishes Covered Services.~~ ~~OneCare Connect: A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Health Network, physician group, or other person or institution who furnishes Covered Services.~~
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:	12/31/2022
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:

Attention: 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.

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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
TBD	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
Effective	06/01/2005	MA.9211	Member Right to Request Confidential Communications	OneCare
Revised	04/01/2007	HH.3008	Member Right to Request Confidential Communications	Medi-Cal

Action	Date	Policy	Policy Title	Program(s)
Revised	04/01/2007	MA.9211	Member Right to Request Confidential Communications	OneCare
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	02/01/2012	MA.9211	Member Right to Request Confidential Communications	OneCare
Revised	02/01/2013	HH.3008Δ	Member Right to Request Confidential Communications	Medi-Cal OneCare
Revised	02/01/2014	MA.9211	Member Right to Request Confidential Communications	OneCare
Revised	06/01/2014	MA.9211	Member Right to Request Confidential Communications	OneCare
Revised	09/01/2014	MA.9211	Member Right to Request Confidential Communications	OneCare
Revised	09/01/2015	HH.3008	Member Right to Request Confidential Communications	Medi-Cal
Revised	09/01/2015	MA.9211	Member Right to Request Confidential Communications	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.3008Δ	Member Right to Request Confidential Communications	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9211	Member Right to Request Confidential Communications	OneCare OneCare Connect PACE
Revised	12/07/2017	HH.3008Δ	Member Right to Request Confidential Communications	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.3008Δ	Member Right to Request Confidential Communications	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.3008Δ	Member Right to Request Confidential Communications	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.3008Δ	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

Action	Date	Policy	Policy Title	Program(s)
Revised	12/31/2022	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. 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.
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: www.caloptima.org, 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:

CalOptima Health
Customer Service Department
505 City Parkway West
Orange, CA 92868

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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:	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:	12/31/2022
Applicable to:	☒ Medi-Cal ☒ OneCare ~~☐ OneCare Connect~~ ☐ 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~~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~~CalOptima Health shall certify data, information, and documentation submitted to DHCS.

B. ~~CalOptima~~CalOptima Health shall submit a completed and signed DHCS-approved certification statement on ~~CalOptima~~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~~CalOptima Health to DHCS.

2. The certification statement shall apply to all data, information, and documentation submitted to DHCS, as follows:

   a. Encounter data;

   b. Provider network 274 data;

   c. Other documentation and data submitted to DHCS describing ~~CalOptima~~CalOptima Health's provider network;

   d. Data submitted for the purpose of determining ~~CalOptima~~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~~CalOptima Health's Medical Loss Ratio (MLR);

f. Documentation submitted to DHCS on a monthly, quarterly, or annual basis related to ~~CalOptima~~CalOptima Health's financial status;

g. Ownership and control information, including ownership and control information for subcontractors as required under Title 42, Code of Federal Regulations (CFR) section 455.104.

h. Annual report of overpayment recoveries;

i. Monthly and quarterly template data, including but not limited to, Grievance and Appeals data and Behavioral Health Treatment data; ~~and~~

j. Monthly number of members enrolled in Dual Eligible Special Needs Plans (D-SNP); and

~~j.~~k. Any other data, information or documentation related to the performance of ~~CalOptima~~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~~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. ~~Direct~~ Submissions to DHCS not via RAC

1. In limited instances, certain ~~CalOptima~~CalOptima Health departments submit data, information, and documentation ~~directly~~ to DHCS not via the Regulatory Affairs & Compliance (RAC) Department, but instead either directly or via another ~~CalOptima~~CalOptima Health Department (e.g., Information Technology Services). Additionally, in limited instances, certain ~~CalOptima~~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~~CalOptima Health department responsible for data, information, and documentation submitted ~~directly~~ to DHCS, ~~and~~ not via the ~~Regulatory Affairs & Compliance~~RAC Department ~~(RAC)~~, shall submit an attestation to the

~~Regulatory Affairs & Compliance~~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 ("~~[REPORT NAME]~~ [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.

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~~CalOptima Health policy HH.2005~~A~~: Corrective Action Plan.

~~i.~~ii.

B. Submissions to DHCS via RAC~~the Regulatory Affairs & Compliance Department~~

1. In most instances, ~~CalOptima~~CalOptima Health departments ~~do not~~ submit data, information, and documentation ~~directly to DHCS, but rather submit information~~ to the RAC Department that~~, which~~ in turn completes the submission(s) to DHCS.

a. In these instances, a Designee from each ~~CalOptima~~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)] ~~[DEPT NAME] Direct~~ 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~~CalOptima Health policy HH.2005~~A~~: 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~~CalOptima Health Policy HH.2005~~A~~: Corrective Action Plan.

C. Based on these internal attestations, t~~T~~he 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 - ~~Direct~~ Attestation (Submissions not via RAC)
~~B.~~C. Document and Data Attestation - FAQs

V. REFERENCE(S)

A. ~~CalOptima~~CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. ~~CalOptima~~CalOptima Health Policy HH.2005~~A~~: 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.
~~D.~~E. ~~CalOptima~~CalOptima Health State Medicaid Agency Contract (SMAC) with DHCS for Dual Eligible Special Needs Plan (D-SNP)

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
TBD	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

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IX. GLOSSARY

Term	Definition
Appeal	Medi-Cal: A review by ~~CalOptima~~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 the procedures that deal with the review of an adverse initial determination made by CalOptima Health on health care services or benefits under Part C or D the Member believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the Member), or on any amounts the Member must pay for a service or drug as defined in 42 CFR §422.566(b) and §423.566(b). These procedures include reconsideration or redetermination , a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (MAC), and judicial review.
Behavioral Health Treatment	Professional services and treatment programs, including but not limited to Applied Behavior Analysis (ABA) and other evidence-based behavior intervention programs that develop and restore, to the maximum extent practicable, the functioning of an individual with Autism Spectrum Disorder. BHT is the design, implementation, and evaluation of environmental modification using behavioral stimuli and consequences to produce socially significant improvement in human behavior.
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.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Grievance	Medi-Cal: An oral or written expression of dissatisfaction about any matter other than an action that is an adverse benefit determination, as identified within the definition of an Appeal, and may include, but is not limited to: the quality of care or services provided, interpersonal relationships with a Provider or ~~CalOptima~~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~~CalOptima Health to make an authorization decision. OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken.

Term	Definition
Medical Loss Ratio (MLR)	The percentage calculated by dividing the Health Network's total medical costs paid on behalf of ~~CalOptima~~CalOptima Health Members by the total revenue received from ~~CalOptima~~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.

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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:	12/31/2022
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;

   b. Provider network 274 data;

   c. Other documentation and data submitted to DHCS describing CalOptima Health's provider network;

   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 as required under Title 42, Code of Federal Regulations (CFR) section 455.104.

h. Annual report of overpayment recoveries;

i. Monthly and quarterly template data, including but not limited to, Grievance and Appeals data and Behavioral Health Treatment data;

j. Monthly number of members enrolled in Dual Eligible Special Needs Plans (D-SNP); and

k. 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 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. Based on these internal 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. CalOptima Health State Medicaid Agency Contract (SMAC) with DHCS for Dual Eligible Special Needs Plan (D-SNP)

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
TBD	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

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 the procedures that deal with the review of an adverse initial determination made by CalOptima Health on health care services or benefits under Part C or D the Member believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the Member), or on any amounts the Member must pay for a service or drug as defined in 42 CFR §422.566(b) and §423.566(b). These procedures include reconsideration or redetermination , a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (MAC), and judicial review.
Behavioral Health Treatment	Professional services and treatment programs, including but not limited to Applied Behavior Analysis (ABA) and other evidence-based behavior intervention programs that develop and restore, to the maximum extent practicable, the functioning of an individual with Autism Spectrum Disorder. BHT is the design, implementation, and evaluation of environmental modification using behavioral stimuli and consequences to produce socially significant improvement in human behavior.
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.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Grievance	Medi-Cal: An oral or written expression of dissatisfaction about any matter other than an action that is an adverse benefit determination, as identified within the definition of an Appeal, and may include, but is not limited to: the quality of care or services provided, interpersonal relationships with a Provider or CalOptima 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. 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.

Term	Definition
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.

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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~~CalOptima Health has mirrored this process to require each department that submits data ~~directly or indirectly~~ to DHCS (via or not via the Medi-Cal Regulatory Affairs & Compliance (RAC)) to submit an attestation to Medi-Cal ~~Regulatory Affairs & Compliance (~~RAC~~)~~ Department. Based on these internal attestations, the CEO signs ~~the MCP~~CalOptima~~CalOptima Health's monthly certification statement.

Instructions ~~[*Indirect Submission to DHCS via RAC*]~~:

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 Monica Domicolo at mdomicolo@caloptima.org or (714) 796-6111.

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.)*

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

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wet signature, you will need to complete the date below and scan a copy of the attestation.

Date: _____

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Document and Data Attestation

Submissions 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 Monica Domicolo at mdomicolo@caloptima.org or (714) 796-6111.

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.)*

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.

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Date: _____

CalOptima Health Data Certification Attestation, All Plan Letter 17-005
Title 42, Code of Federal Regulations (42 CFR), Sections (§§) 438.604 and 438.606 (revised in June 2017) Rev. 10/2022

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Document and Data Attestation

Submissions not via RAC

Background:
Title 42, Code of Federal Regulations (42 CFR), Sections (§§) 438.604 and 438.606 (revised in 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~~CalOptima Health has mirrored this process to require each department that submits data ~~directly or indirectly~~ to DHCS (via or not via the Medi-Cal Regulatory Affairs & Compliance (RAC)) to submit an attestation to Medi-Cal ~~Regulatory Affairs & Compliance (~~RAC~~)~~ Department. Based on these internal attestations, the CEO signs ~~the MCP~~CalOptima~~CalOptima~~ Health's monthly certification statement.

Instructions ~~*[Direct Submissions to DHCS]*~~: 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. 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 Monica Domicolo at mdomicolo@caloptima.org or (714) 796-6111.

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. *(Please refer to the FAQ document linked above for info on who can attest.)*

Name: _____

Title: _____

Department: _____

Signature: _____

NOTE: If you are using an electronic signature, please be sure the time stamp reflects the current date. If you are using a wet signature, you will need to complete the date below and scan a copy of the attestation.

Date: _____

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Document and Data Attestation

Submissions not via RAC

Background:
Title 42, Code of Federal Regulations (42 CFR), Sections (§§) 438.604 and 438.606 (revised in 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 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. 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 Monica Domicolo at mdomicolo@caloptima.org or (714) 796-6111.

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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Date: _____

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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~~CalOptima Health delegates that I do not feel comfortable attesting to. Do I still need to attest to the information?
   Answer: ~~No.~~ 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~~the Regulatory Affairs InfoNet page~~ for Office of Compliance under "~~Documents~~Data Attestations".

   The ~~general~~ "Attestation (Submissions via RAC)" template is to be used for ~~indirect~~ submissions to DHCS via RAC. Whereas, the "~~Direct~~ Attestation (Submissions not via RAC)" template is to be used for any data that you submit ~~*directly*~~ to DHCS not via RAC, but rather directly or via another ~~CalOptima~~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 ~~*directly or indirectly* (~~via or not via RAC~~)~~ to DHCS, as outlined below.

   ~~Indirect s~~Submissions via RAC: ~~No~~Generally, each report will~~is required to~~ 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.

   ~~Direct s~~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~~CalOptima Health policy HH.2005: Corrective Action Plan.

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Policy:	HH.2002~~A~~
Title:	**Sanctions**
Department:	Office of Compliance
Section:	~~Regulatory Affairs & Compliance~~Not Applicable
CEO Approval:	*/s/*
Effective Date:	10/01/1998
Revised Date:	12/31/2022
Applicable to:	☒ Medi-Cal ☒ OneCare ~~☒ OneCare Connect~~ ☒ PACE ☐ Administrative

I. PURPOSE

This policy describes the process by which ~~CalOptima~~CalOptima Health shall impose Sanctions on a First Tier, Downstream, or Related Entity (FDR) to enforce effective correction of non-compliance with statutory, regulatory, contractual, or ~~CalOptima~~CalOptima Health policy requirements, Fraud, Waste, and Abuse, or the FDR's failure to satisfactorily implement corrective actions.

II. POLICY

A. ~~CalOptima~~CalOptima Health, through the Compliance Committee, may impose Sanctions against an FDR if it fails to comply with statutory, regulatory, contractual, ~~CalOptima~~CalOptima Health policy, and other requirements related to ~~CalOptima~~CalOptima Health programs. The Compliance Committee shall approve and oversee all Sanctions.

B. ~~CalOptima~~CalOptima Health may impose Sanctions against an FDR immediately following the FDR's failure to comply with statutory, regulatory, contractual, ~~CalOptima~~CalOptima Health policy, or other requirements related to ~~CalOptima~~CalOptima Health programs, with or without a Corrective Action Plan (CAP) requirement.

C. If required by ~~CalOptima~~CalOptima Health, an FDR must submit a CAP response to ~~CalOptima~~CalOptima Health, in accordance with ~~CalOptima~~CalOptima Health Policy HH.2005~~A~~: Corrective Action Plan. ~~CalOptima~~CalOptima Health may also impose Sanctions if an FDR fails to submit, remediate, or implement a CAP response, or take corrective action under any approved CAP in the time, or manner, required by ~~CalOptima~~CalOptima Health.

D. The extent of the Sanction shall be commensurate with the severity of the deficiency identified as it relates to the risk posed to the ~~CalOptima~~CalOptima Health Member(s), as well as other financial or accreditation exposure to ~~CalOptima~~CalOptima Health~~,~~ and designed to correct the underlying issue and prevent future recurrence.

E. Sanctions include, but are not limited to, financial penalties, suspension of membership enrollment, de-delegation, and/or termination of contract. ~~CalOptima~~CalOptima Health retains the right to take termination action in addition to, and notwithstanding, the imposition of other Sanctions under this Policy.

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F. In the event an FDR fails to remediate its non-compliance in the time or manner required by ~~CalOptima~~CalOptima Health, ~~CalOptima~~CalOptima Health may impose additional and/or more severe Sanctions.

III. PROCEDURE

A. Basis for Sanctions

1. ~~CalOptima~~CalOptima Health may impose Sanctions or take any other action against an FDR based on the identification of deficient performance or non-compliance of an FDR. Non-compliance may be established through and may include, but is not limited to:

~~a. Findings from performance reviews and/or delegation oversight activities, in accordance with CalOptima~~CalOptima Health ~~Policy GG.1619: Delegation Oversight;~~

~~b. Findings from regulatory reviews; including but not limited to the Department of Health Care Services (DHCS), the Department of Managed Health Care (DMHC), and the Centers for Medicare & Medicaid Services (CMS) audits;~~

a. Findings from performance reviews and/or delegation oversight activities, in accordance with CalOptima Health Policy GG.1619: Delegation Oversight;

~~c.~~ Findings from regulatory reviews; including but not limited to the Department of Health Care Services (DHCS), the Department of Managed Health Care (DMHC), and the Centers for Medicare & Medicaid Services (CMS) audits;

b.

~~d.~~c. Findings from Provider and Member complaints and surveys;

~~e.~~d. Engaging in Fraud, Waste, or Abuse as specified in ~~CalOptima~~CalOptima Health Policy HH.1105~~A~~: Fraud, Waste, and Abuse Detection;

~~f.~~e. Failing to report data, or other information, in the time or manner required by ~~CalOptima~~CalOptima Health including, but not limited to, Encounter data;

~~g.~~f. Engaging in any prohibited Marketing Activities, as outlined in ~~CalOptima~~CalOptima Health Policy MA.2001: Marketing Materials Standards;

~~h.~~g. Failing to have the required amounts and types of financial reserves, or to meet financial solvency requirements;

~~i.~~h. Failing to comply with the ~~CalOptima~~CalOptima Health Compliance Program and investigations including, but not limited to, ~~CalOptima~~CalOptima Health's Code of Conduct and policies;

~~j.~~i. Breaching any covenant, condition, or term of the contract or agreement including, but not limited to, failing to perform contracted duties and responsibilities in the time or manner required by ~~CalOptima~~CalOptima Health;

~~k.~~j. Failing to submit, remediate, or implement a CAP response, or take corrective action under any approved CAP response in the time or manner required by ~~CalOptima~~CalOptima Health; and

~~l.~~k. Failing to comply with any other review of statutory, regulatory, contractual, ~~CalOptima~~CalOptima Health policy and other requirements related to a ~~CalOptima~~CalOptima Health policy.

A. Determining Sanction

1. ~~CalOptima~~CalOptima Health's Compliance Committee shall review findings of an FDR's deficient performance or non-compliance as provided by ~~CalOptima~~CalOptima Health's ~~Audit~~ Delegation~~&~~ Oversight Committee (D~~A~~OC) and in accordance with ~~CalOptima~~CalOptima Health Policy GG.1619: Delegation Oversight.

2. The ~~CalOptima~~CalOptima Health Compliance Committee has the authority to authorize and implement all Sanctions~~,~~ and shall oversee and monitor all Sanctions imposed.

3. The Compliance Committee shall determine the severity of the Sanction based upon findings of deficient performance or non-compliance with applicable state and federal laws and regulations. Sanctions will vary in severity based on the extent and type of finding, including, but not limited to, findings in audits, investigations, contractual obligations, quality improvement system monitoring, routine monitoring, corrective action plan requirements, encounter and provider data submissions, grievances and appeals, network adequacy reviews, assessments of timely access requirements, reviews of utilization data, complaints from Members and other stakeholders, whistleblowers, and self-disclosures. Actions that are determined to endanger a Member or prevent access to Covered Services will be reviewed and acted upon immediately by the Office of Compliance. Sanctions shall be designed to correct the underlying issue and prevent future occurrence. Sanctions imposed may include, but not be limited to, termination of the contract between the FDR and ~~CalOptima~~CalOptima Health.

4. The Compliance Committee shall consult with ~~the L~~legal counsel~~Affairs Department~~ on the imposition of Sanctions including, but not limited to, contract terminations, as necessary and appropriate.

B. Types of Sanctions

1. ~~CalOptima~~CalOptima Health may impose any one or a combination of the following Sanctions ~~may include any of the following~~:

   a. Financial penalties defined in the contract;

   b. Enrollment freeze - Auto Assignment, Member selection, or both;

   c. De-delegation of delegated function(s);

   d. The requirement to engage and pay for an external auditor, or other consultant, acceptable to and approved by ~~CalOptima~~CalOptima Health, in order to correct the identified deficiency(ies), non-compliance, or FWA to ~~CalOptima~~CalOptima Health's satisfaction;

   e. Termination of the contract, or agreement, with the non-compliant organization;

   f. Forfeiture of FDR financial security;

   g. Capitation deduction; and/or

h. Any other action ~~CalOptima~~CalOptima Health deems appropriate and reasonable.

2. Monetary Sanctions

a. Monetary Sanctions are imposed independently and are in addition to any other sums owed to ~~CalOptima~~CalOptima Health, such as refunding of Overpayments. Monetary Sanctions will be assessed and determined independently using the following guidelines:

i. Monetary Sanctions may be separately and independently assessed and may also be assessed for each day the FDR fails to correct an identified deficiency.

ii.
For deficiencies that impact Members, each impacted Member may constitute a separate violation. For example, ~~CalOptima~~CalOptima Health may calculate a violation, which directly impacts a Member's access to Covered Services, in the following terms:

1) A limit of $25,000 per Member in which the FDR failed to provide Medically Necessary services that the FDR is required to provide, under law, or under its ~~C~~contract.

2) Per Member penalties may be assessed when there is adverse impact to the ~~m~~Member for the following situations:

a) Inappropriate delay/denial of covered medical services/ drugs, and/or ~~a~~Appeal rights;

b) Incorrect premiums charged, or unnecessary out-of-pockets costs incurred; or

c) Inaccurate or untimely plan benefit information (e.g., wrong denial notices) provided.

b. Monetary Sanctions may also be applied in aggregate based on capitation on a per determination basis. For example, Monetary Sanctions can be calculated in the following terms:

~~i.~~ 1% off the monthly capitation amount for a first violation.
i.

~~ii.~~ 2% off the monthly capitation amount for a second violation.
ii.

~~iii.~~ 3% off the monthly capitation amount for each subsequent violation.
iii.

iv. If ~~CalOptima~~CalOptima Health does not have the ~~m~~Member-specific data or the per Member impact cannot be clearly analyzed, it may calculate the penalty under the per determination basis. Please note that ~~CalOptima~~CalOptima Health may choose to impose a per determination penalty for a violation when the FDR has provided ~~CalOptima~~CalOptima Health with an ~~I~~impact ~~A~~analysis and ~~CalOptima~~CalOptima Health determines that ~~m~~Members were adversely affected by the violation.

~~a.~~c. Parties with pending monetary Sanctions are responsible for paying monetary Sanctions in the time and manner required by ~~CalOptima~~CalOptima Health. Failure to render payments in the time and manner outlined by ~~CalOptima~~CalOptima Health may result in capitation deduction or payment withhold.

~~B.~~C. Notification of Sanction

1. ~~CalOptima~~CalOptima Health shall notify an FDR, in writing. Such notice shall:

   a. Detail the findings of non-compliance;

   b. Reference the applicable statutory, regulatory, contractual, ~~CalOptima~~CalOptima Health policies, or other requirements that are the basis of the findings;

   c. Provide detailed information describing the Sanction, including the effective date, duration of, and reason for each sanction proposed;

   d. Identify time frames by which the FDR shall be required to achieve compliance, as applicable;

   e. Inform the FDR that ~~CalOptima~~CalOptima Health may impose additional Sanctions if compliance is not achieved in the manner and time frame specified; and

   f. Provide notice of the FDR's right to file a Complaint ~~Complaint~~, in accordance with ~~CalOptima~~CalOptima Health policy.

2. In the event that ~~CalOptima~~CalOptima Health imposes a financial Sanction on an FDR as a direct consequence of an Immediate Corrective Action Plan (ICAP) and with respect to the ~~CalOptima~~CalOptima Health Medi-Cal Program, the Regulatory Affairs & Compliance Department shall report the issue to ~~CalOptima~~CalOptima Health's DHCS Contract Manager for Medi-Cal within three (3) business days of imposition.

D. Provider Complaint Process

~~C.~~ 1. If an FDR disagrees with the Sanction, the FDR may file a complaint with ~~CalOptima~~CalOptima Health's Grievance and Appeals Resolution Services (GARS) department, as per ~~policy~~CalOptima Health Policies MA.9006: Provider Complaint Process, or HH.1101: ~~CalOptima~~CalOptima Health Provider Complaint.

~~D.~~E. The Compliance Committee shall oversee and monitor the FDR's response to the Sanctions letter.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. ~~CalOptima~~CalOptima Health Code of Conduct
B. ~~CalOptima~~CalOptima Health Compliance Plan

C. ~~CalOptima~~CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage

D. ~~CalOptima~~CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal

~~E. CalOptima Three-Way Contract with the Centers for Medicare and Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect~~

~~F.~~E. ~~CalOptima~~CalOptima Health, Health Network Service Agreement

~~G.~~F. ~~CalOptima~~CalOptima Health PACE Program Agreement

G. ~~CalOptima~~CalOptima Health Policy GG.1619: Delegation Oversight

H. ~~CalOptima~~CalOptima Health Policy HH.1101: ~~CalOptima~~CalOptima Health Provider Complaint

~~H.~~I. ~~CalOptima~~CalOptima Health Policy HH.1105~~A~~: Fraud and Abuse Detection

J. ~~CalOptima~~CalOptima Health Policy HH.2005~~A~~: Corrective Action Plan

K. ~~CalOptima~~CalOptima Health Policy MA.9006: Provider Complaint Process

L. CMS Civil Monetary Penalty Calculation Methodology

~~I.~~

~~J.~~M. Department of Health Care Services (DHCS) All Plan Letter (APL) 17-004: Subcontractual Relationships and Delegation

~~K.~~N. Medicare Managed Care Manual, Chapter 21

~~L.~~O. Medicare Prescription Drug Benefit Manual, Chapter 9

~~M.~~P. Title 22, California Code of Regulations (CCR), §51301 et. seq.

~~N.~~Q. Title 42, Code of Federal Regulations (CFR), §455.2

~~O.~~R. Title 18, United States Code (USC), §1347

S. Welfare and Institutions Code, §14043.1(a)

~~CalOptima Policy HH.1101: CalOptima Provider Complaint~~

~~CalOptima Policy MA.9006: Provider Complaint Process~~

~~P. CMS Civil Monetary Penalty Calculation Methodology~~

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
12/11/2013	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/01/1998	HH.2002	Health Network Sanctions	Medi-Cal
Revised	10/01/2002	HH.2002	Health Network Sanctions	Medi-Cal
Revised	07/01/2004	HH.2002	Health Network Sanctions	Medi-Cal
Effective	08/01/2005	MA.9105	Contracted Provider Sanctions	OneCare
Revised	01/01/2008	HH.2002	Health Network Sanction	Medi-Cal
Revised	08/01/2008	MA.9105	Contracted Provider Sanctions	OneCare
Revised	04/01/2013	HH.2002	Health Network Sanction	Medi-Cal OneCare
Revised	04/01/2014	MA.9105	Sanctions	OneCare
Revised	09/01/2015	HH.2002	Sanctions	Medi-Cal
Revised	09/01/2015	MA.9105	Sanctions	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.2002Δ	Sanctions	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2015	MA.9105	Sanctions	OneCare OneCare Connect PACE
Revised	12/07/2017	HH.2002Δ	Sanctions	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.2002Δ	Sanctions	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.2002Δ	Sanctions	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.2002Δ	Sanctions	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.2002Δ	Sanctions	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	HH.2002~~Δ~~	Sanctions	Medi-Cal OneCare PACE

IX. GLOSSARY

Term	Definition
Abuse	Actions that may, directly or indirectly, result in unnecessary costs to a ~~CalOptima~~CalOptima Health Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.
~~Audit & Oversight Committee (AOC)~~	~~A subcommittee of the Compliance Committee chaired by the Director(s) of Audit and Oversight to oversee CalOptima~~CalOptima Health~~'s delegated functions. The composition of the AOC includes representatives from CalOptima~~CalOptima Health~~'s departments as provided for in in CalOptima~~CalOptima Health~~ Policy HH.4001: Audit & Oversight Committee.~~
Centers for Medicare & Medicaid Services (CMS)	The federal agency within the United States Department of Health and Human Services (DHHS) that administers that Federal Medicare program and works in partnership with state governments to administer Medicaid programs.
Compliance Committee	The CalOptima Health committee that consists of executive officers, managers of key operating divisions, and legal counsel that oversees implementation of CalOptima Health's Compliance Program.~~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; Executive Director of Compliance; and Executive Director of Human Resources.~~
Compliance Program	The program (including, without limitation, this Compliance Plan, Code of Conduct and Policies and Procedures) developed and adopted by ~~CalOptima~~CalOptima Health to promote, monitor and ensure that ~~CalOptima~~CalOptima Health's operations and practices and the practices of its Board Member, Employees and FDRs comply with applicable law and ethical standards.
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~~CalOptima Health, the Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services, or designated representatives. FDRs and/or ~~CalOptima~~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~~CalOptima Health and its regulators.

Term	Definition
Delegation Oversight Committee (DOC)	A subcommittee of the Compliance Committee chaired by the Director of Audit and Oversight to oversee CalOptima Health's delegated functions. The composition of the DOC includes representatives from CalOptima Health's departments as provided for in in CalOptima Health Policy HH.4001: Delegation Oversight Committee.
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.
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*.
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a ~~CalOptima~~CalOptima Health Program benefit, below the level of the arrangement between ~~CalOptima~~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.
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 ~~& OneCare Connect~~: 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~~CalOptima Health should not include denied, adjusted, or duplicate claims.
First Tier, Downstream, and Related Entities (FDRs)	~~Means~~ First Tier, Downstream or Related Entity, as separately defined herein.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with ~~CalOptima~~CalOptima Health to provide administrative services or health care services to a Member under a ~~CalOptima~~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 Section 1347).
Member	A beneficiary enrolled in a ~~CalOptima~~CalOptima Health Program.

Term	Definition
Related Entity	Any entity that is related to ~~CalOptima~~CalOptima Health by common ownership or control and that: performs some of ~~CalOptima~~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~~CalOptima Health at a cost of more than $2,500 during a contract period.
Sanction	An action taken by ~~CalOptima~~CalOptima Health, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on an FDR's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to ~~CalOptima~~CalOptima Health Programs.
Waste	Medi-Cal: The overutilization or inappropriate utilization of services and misuse of resources, and typically is not a criminal or intentional act, as stated in CMS' Fraud, Waste, and Abuse Toolkit. OneCare: The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a ~~CalOptima~~CalOptima Health Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Policy:	HH.2002
Title:	**Sanctions**
Department:	Office of Compliance
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	10/01/1998
Revised Date:	12/31/2022
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ PACE ☐ Administrative

I. PURPOSE

This policy describes the process by which CalOptima Health shall impose Sanctions on a First Tier, Downstream, or Related Entity (FDR) to enforce effective correction of non-compliance with statutory, regulatory, contractual, or CalOptima Health policy requirements, Fraud, Waste, and Abuse, or the FDR's failure to satisfactorily implement corrective actions.

II. POLICY

A. CalOptima Health, through the Compliance Committee, may impose Sanctions against an FDR if it fails to comply with statutory, regulatory, contractual, CalOptima Health policy, and other requirements related to CalOptima Health programs. The Compliance Committee shall approve and oversee all Sanctions.

B. CalOptima Health may impose Sanctions against an FDR immediately following the FDR's failure to comply with statutory, regulatory, contractual, CalOptima Health policy, or other requirements related to CalOptima Health programs, with or without a Corrective Action Plan (CAP) requirement.

C. If required by CalOptima Health, an FDR must submit a CAP response to CalOptima Health, in accordance with CalOptima Health Policy HH.2005: Corrective Action Plan. CalOptima Health may also impose Sanctions if an FDR fails to submit, remediate, or implement a CAP response, or take corrective action under any approved CAP in the time, or manner, required by CalOptima Health.

D. The extent of the Sanction shall be commensurate with the severity of the deficiency identified as it relates to the risk posed to the CalOptima Health Member(s), as well as other financial or accreditation exposure to CalOptima Health and designed to correct the underlying issue and prevent future recurrence.

E. Sanctions include, but are not limited to, financial penalties, suspension of membership enrollment, de-delegation, and/or termination of contract. CalOptima Health retains the right to take termination action in addition to, and notwithstanding, the imposition of other Sanctions under this Policy.

F. In the event an FDR fails to remediate its non-compliance in the time or manner required by CalOptima Health, CalOptima Health may impose additional and/or more severe Sanctions.

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III. PROCEDURE

A. Basis for Sanctions

1. CalOptima Health may impose Sanctions or take any other action against an FDR based on the identification of deficient performance or non-compliance of an FDR. Non-compliance may be established through and may include, but is not limited to:

   a. Findings from performance reviews and/or delegation oversight activities, in accordance with CalOptima Health Policy GG.1619: Delegation Oversight;

   b. Findings from regulatory reviews; including but not limited to the Department of Health Care Services (DHCS), the Department of Managed Health Care (DMHC), and the Centers for Medicare & Medicaid Services (CMS) audits;

   c. Findings from Provider and Member complaints and surveys;

   d. Engaging in Fraud, Waste, or Abuse as specified in CalOptima Health Policy HH.1105: Fraud, Waste, and Abuse Detection;

   e. Failing to report data, or other information, in the time or manner required by CalOptima Health including, but not limited to, Encounter data;

   f. Engaging in any prohibited Marketing Activities, as outlined in CalOptima Health Policy MA.2001: Marketing Materials Standards;

   g. Failing to have the required amounts and types of financial reserves, or to meet financial solvency requirements;

   h. Failing to comply with the CalOptima Health Compliance Program and investigations including, but not limited to, CalOptima Health's Code of Conduct and policies;

   i. Breaching any covenant, condition, or term of the contract or agreement including, but not limited to, failing to perform contracted duties and responsibilities in the time or manner required by CalOptima Health;

   j. Failing to submit, remediate, or implement a CAP response, or take corrective action under any approved CAP response in the time or manner required by CalOptima Health; and

   k. Failing to comply with any other review of statutory, regulatory, contractual, CalOptima Health policy and other requirements related to a CalOptima Health policy.

A. Determining Sanction

1. CalOptima Health's Compliance Committee shall review findings of an FDR's deficient performance or non-compliance as provided by CalOptima Health's Delegation Oversight Committee (DOC) and in accordance with CalOptima Health Policy GG.1619: Delegation Oversight.

2. The CalOptima Health Compliance Committee has the authority to authorize and implement all Sanctions and shall oversee and monitor all Sanctions imposed.

3. The Compliance Committee shall determine the severity of the Sanction based upon findings of deficient performance or non-compliance with applicable state and federal laws and regulations. Sanctions will vary in severity based on the extent and type of finding, including, but not limited to, findings in audits, investigations, contractual obligations, quality improvement system monitoring, routine monitoring, corrective action plan requirements, encounter and provider data submissions, grievances and appeals, network adequacy reviews, assessments of timely access requirements, reviews of utilization data, complaints from Members and other stakeholders, whistleblowers, and self-disclosures. Actions that are determined to endanger a Member or prevent access to Covered Services will be reviewed and acted upon immediately by the Office of Compliance. Sanctions shall be designed to correct the underlying issue and prevent future occurrence. Sanctions imposed may include, but not be limited to, termination of the contract between the FDR and CalOptima Health.

4. The Compliance Committee shall consult with legal counsel on the imposition of Sanctions including, but not limited to, contract terminations, as necessary and appropriate.

B. Types of Sanctions

1. CalOptima Health may impose any one or a combination of the following Sanctions:

   a. Financial penalties defined in the contract;

   b. Enrollment freeze - Auto Assignment, Member selection, or both;

   c. De-delegation of delegated function(s);

   d. The requirement to engage and pay for an external auditor, or other consultant, acceptable to and approved by CalOptima Health, in order to correct the identified deficiency(ies), non-compliance, or FWA to CalOptima Health's satisfaction;

   e. Termination of the contract, or agreement, with the non-compliant organization;

   f. Forfeiture of FDR financial security;

   g. Capitation deduction; and/or

   h. Any other action CalOptima Health deems appropriate and reasonable.

2. Monetary Sanctions

   a. Monetary Sanctions are imposed independently and are in addition to any other sums owed to CalOptima Health, such as refunding of Overpayments. Monetary Sanctions will be assessed and determined independently using the following guidelines:

      i. Monetary Sanctions may be separately and independently assessed and may also be assessed for each day the FDR fails to correct an identified deficiency.

      ii. For deficiencies that impact Members, each impacted Member may constitute a separate violation. For example, CalOptima Health may calculate a violation, which directly impacts a Member's access to Covered Services, in the following terms:

1) A limit of $25,000 per Member in which the FDR failed to provide Medically Necessary services that the FDR is required to provide, under law, or under its contract.

2) Per Member penalties may be assessed when there is adverse impact to the Member for the following situations:

a) Inappropriate delay/denial of covered medical services/ drugs, and/or Appeal rights;

b) Incorrect premiums charged, or unnecessary out-of-pockets costs incurred; or

c) Inaccurate or untimely plan benefit information (e.g., wrong denial notices) provided.

b. Monetary Sanctions may also be applied in aggregate based on capitation on a per determination basis. For example, Monetary Sanctions can be calculated in the following terms:

i. 1% off the monthly capitation amount for a first violation.

ii. 2% off the monthly capitation amount for a second violation.

iii. 3% off the monthly capitation amount for each subsequent violation.

iv. If CalOptima Health does not have the Member-specific data or the per Member impact cannot be clearly analyzed, it may calculate the penalty under the per determination basis. Please note that CalOptima Health may choose to impose a per determination penalty for a violation when the FDR has provided CalOptima Health with an impact analysis and CalOptima Health determines that Members were adversely affected by the violation.

c. Parties with pending monetary Sanctions are responsible for paying monetary Sanctions in the time and manner required by CalOptima Health. Failure to render payments in the time and manner outlined by CalOptima Health may result in capitation deduction or payment withhold.

C. Notification of Sanction

1. CalOptima Health shall notify an FDR, in writing. Such notice shall:

a. Detail the findings of non-compliance;

b. Reference the applicable statutory, regulatory, contractual, CalOptima Health policies, or other requirements that are the basis of the findings;

c. Provide detailed information describing the Sanction, including the effective date, duration of, and reason for each sanction proposed;

d. Identify time frames by which the FDR shall be required to achieve compliance, as applicable;

e. Inform the FDR that CalOptima Health may impose additional Sanctions if compliance is not achieved in the manner and time frame specified; and

f. Provide notice of the FDR's right to file a Complaint, in accordance with CalOptima Health policy.

2. In the event that CalOptima Health imposes a financial Sanction on an FDR as a direct consequence of an Immediate Corrective Action Plan (ICAP) and with respect to the CalOptima Health Medi-Cal Program, the Regulatory Affairs & Compliance Department shall report the issue to CalOptima Health's DHCS Contract Manager for Medi-Cal within three (3) business days of imposition.

D. Provider Complaint Process

1. If an FDR disagrees with the Sanction, the FDR may file a complaint with CalOptima Health's Grievance and Appeals Resolution Services (GARS) department, as per CalOptima Health Policies MA.9006: Provider Complaint Process, or HH.1101: CalOptima Health Provider Complaint.

E. The Compliance Committee shall oversee and monitor the FDR's response to the Sanctions letter.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Code of Conduct
B. CalOptima Health Compliance Plan
C. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
E. CalOptima Health, Health Network Service Agreement
F. CalOptima Health PACE Program Agreement
G. CalOptima Health Policy GG.1619: Delegation Oversight
H. CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint
I. CalOptima Health Policy HH.1105: Fraud and Abuse Detection
J. CalOptima Health Policy HH.2005: Corrective Action Plan
K. CalOptima Health Policy MA.9006: Provider Complaint Process
L. CMS Civil Monetary Penalty Calculation Methodology
M. Department of Health Care Services (DHCS) All Plan Letter (APL) 17-004: Subcontractual Relationships and Delegation
N. Medicare Managed Care Manual, Chapter 21
O. Medicare Prescription Drug Benefit Manual, Chapter 9
P. Title 22, California Code of Regulations (CCR), §51301 et. seq.
Q. Title 42, Code of Federal Regulations (CFR), §455.2
R. Title 18, United States Code (USC), §1347
S. Welfare and Institutions Code, §14043.1(a)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
12/11/2013	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/01/1998	HH.2002	Health Network Sanctions	Medi-Cal
Revised	10/01/2002	HH.2002	Health Network Sanctions	Medi-Cal
Revised	07/01/2004	HH.2002	Health Network Sanctions	Medi-Cal
Effective	08/01/2005	MA.9105	Contracted Provider Sanctions	OneCare
Revised	01/01/2008	HH.2002	Health Network Sanction	Medi-Cal
Revised	08/01/2008	MA.9105	Contracted Provider Sanctions	OneCare
Revised	04/01/2013	HH.2002	Health Network Sanction	Medi-Cal OneCare
Revised	04/01/2014	MA.9105	Sanctions	OneCare
Revised	09/01/2015	HH.2002	Sanctions	Medi-Cal
Revised	09/01/2015	MA.9105	Sanctions	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.2002Δ	Sanctions	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2015	MA.9105	Sanctions	OneCare OneCare Connect PACE
Revised	12/07/2017	HH.2002Δ	Sanctions	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.2002Δ	Sanctions	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.2002Δ	Sanctions	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.2002Δ	Sanctions	Medi-Cal OneCare OneCare Connect PACE

Action	Date	Policy	Policy Title	Program(s)
Revised	12/20/2021	HH.2002Δ	Sanctions	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	HH.2002	Sanctions	Medi-Cal OneCare PACE

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IX. GLOSSARY

Term	Definition
Abuse	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.
Centers for Medicare & Medicaid Services (CMS)	The federal agency within the United States Department of Health and Human Services (DHHS) that administers that Federal Medicare program and works in partnership with state governments to administer Medicaid programs.
Compliance Committee	The CalOptima Health committee that consists of executive officers, managers of key operating divisions, and legal counsel that oversees implementation of CalOptima Health's Compliance Program.
Compliance Program	The program (including, without limitation, this Compliance Plan, Code of Conduct and 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 Member, Employees and FDRs comply with applicable law and ethical standards.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima Health, the Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services, or designated representatives. FDRs and/or CalOptima Health departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima Health and its regulators.
Delegation Oversight Committee (DOC)	A subcommittee of the Compliance Committee chaired by the Director of Audit and Oversight to oversee CalOptima Health's delegated functions. The composition of the DOC includes representatives from CalOptima Health's departments as provided for in in CalOptima Health Policy HH.4001: Delegation Oversight Committee.
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.
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*.

Term	Definition
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Health Program benefit, below the level of the arrangement between CalOptima Health and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
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 (FDRs)	First Tier, Downstream or Related Entity, as separately defined herein.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima Health to provide administrative services or health care services to a Member under a CalOptima Health Program.
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).
Member	A beneficiary enrolled in a CalOptima Health Program.
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.
Sanction	An action taken by CalOptima Health, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on an FDR's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima Health Programs.

Term	Definition
Waste	Medi-Cal: The overutilization or inappropriate utilization of services and misuse of resources, and typically is not a criminal or intentional act, as stated in CMS' Fraud, Waste, and Abuse Toolkit. OneCare: The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Health Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

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Policy:	HH.2005~~A~~
Title:	**Corrective Action Plan**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance~~Not Applicable~~
CEO Approval:	*/s/*
Effective Date:	11/01/1998
Revised Date:	12/31/2022
Applicable to:	☒ Medi-Cal ☒ OneCare ~~☒ OneCare Connect~~ ☒ PACE ☐ Administrative

I. PURPOSE

This policy defines the requirements for ~~CalOptima~~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~~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 its FDRs from performing ~~its~~ their own routine monitoring, investigation and corrective action process. As an example, refer to CalOptima Health Policy GG.1615:~~A~~ Corrective Action Plan for Practitioners.

II. POLICY

A. ~~CalOptima~~CalOptima Health's Office of Compliance shall conduct Auditing, operational Monitoring, and investigations of internal ~~CalOptima~~CalOptima Health departments and its FDRs to ensure compliance with statutory, regulatory, contractual, ~~CalOptima~~CalOptima Health policy, and other requirements related to ~~CalOptima~~CalOptima Health programs.

B. ~~CalOptima~~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~~CalOptima Health's Office of Compliance shall require ~~CalOptima~~CalOptima Health internal departments and FDRs to bring their operations into full compliance with statutory, regulatory, contractual, ~~CalOptima~~CalOptima Health policy, and other requirements, which ~~CalOptima~~CalOptima Health or its regulators have identified as non-compliant, within time frames established by ~~CalOptima~~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~~CalOptima Health's Office of Compliance.

1. Failure by the internal department to respond accurately, timely, and in compliance with statutory, regulatory, contractual, ~~CalOptima~~CalOptima Health policy, or other requirements to ~~CalOptima~~CalOptima Health's Office of Compliance's ICAP or CAP request may lead to further action.

2. Failure by an FDR to respond accurately, timely, and in compliance with statutory, regulatory, contractual, ~~CalOptima~~CalOptima Health policy, or other requirements to ~~CalOptima~~CalOptima Health's Office of Compliance's ICAP, or CAP, request may lead to further action. ~~CalOptima~~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~~CalOptima Health Policy HH.2002~~A~~: Sanctions.

III. PROCEDURE

A. Basis for an ICAP or CAP

1. ~~CalOptima~~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~~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~~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~~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~~CalOptima Health's Office of Compliance determines an internal department, or FDR, has failed to comply with statutory, regulatory, contractual, ~~CalOptima~~CalOptima Health policy, or other requirements, the Office of Compliance may issue an ICAP, or CAP request, to address the problem. ~~CalOptima~~CalOptima Health's Office of Compliance shall coordinate its efforts with ~~CalOptima~~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~~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~~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~~CalOptima Health's Office of Compliance, the internal department or FDR is required to cease non-compliant activities within two (2) business days of receiving the ICAP request.

b. The internal department or FDR shall provide a written response within three (3) 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~~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 fourteen (14) calendar days. ~~CalOptima~~CalOptima Health's 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~~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 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~~CalOptima Health's Office of Compliance shall issue a written notice to the internal department or ~~to~~ 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~~CalOptima Health's 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~~CalOptima Health's Compliance Officer or Designee.

e. Explain the possible consequences, specific to the nature of the issue and degree of completeness in accordance with ~~CalOptima~~CalOptima Health Policy HH.2002~~A~~: Sanctions;

f. ~~Escalating~~Possibility of escalating to the department's Chief, or the FDR's Chief Executive Officer (CEO) or their Designee; and

g. ~~Notice~~Possibility of referral to the ~~Audit &~~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~~CalOptima Health's Compliance Officer or Designee, ~~CalOptima~~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~~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~~CalOptima Health's Compliance Officer or Designee, ~~CalOptima~~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~~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~~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~~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~~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~~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~~CalOptima Health's Office of Compliance.

3. ~~CalOptima~~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~~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~~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 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~~CalOptima Health's Office of Compliance shall track all CAP and ICAP requests issued utilizing a standardized tool.

2. ~~CalOptima~~CalOptima Health's Office of Compliance shall report the status of all CAP/ICAP requests to the ~~Audit & Oversight Committee~~DOC and the Compliance Committee.

3. In the event that ~~CalOptima~~CalOptima Health's Office of Compliance makes a determination to self-disclose the ICAP or significant incident of noncompliance with respect to the ~~CalOptima~~CalOptima Health Medi-Cal or Medicare Program, the Regulatory Affairs &

Compliance Department shall report the issue to ~~CalOptima~~CalOptima Health's DHCS Contract Manager and/or CMS Account Manager.

a. The Office of Compliance will submit the Self-Disclosure report to the 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 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~~CalOptima Health's internal department, or FDR, has repeat deficiencies, the issue(s) shall be reported to the ~~Audit & Oversight Committee~~DOC and the Compliance Committee by the Office of Compliance for further action.

IV. ATTACHMENT(S)

A. ICAP/CAP Request Template

V. REFERENCE(S)

A. ~~CalOptima~~CalOptima Health Compliance Plan
B. ~~CalOptima~~CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. ~~CalOptima~~CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
~~D. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect~~
~~E.~~D. ~~CalOptima~~CalOptima Health PACE Program Agreement
E. ~~CalOptima~~CalOptima Health Policy GG.1615~~A~~: Corrective Action Plan for Practitioners
F. ~~CalOptima~~CalOptima Health Policy HH.2002~~A~~: Sanctions
~~G. CalOptima Policy MA.9124: CMS Self-Disclosure~~
~~H.~~G. Department of Health Care Services (DHCS) All Plan Letter 17-004: Subcontractual Relationships and Delegation
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

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
TBD	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
Effective	08/01/2005	MA.9104	Corrective Action Plan	OneCare
Revised	06/01/2007	HH.2005	Health Network Corrective Action Plan	Medi-Cal
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Revised	04/01/2013	HH.2005	Corrective Action Plan	Medi-Cal OneCare
Revised	04/01/2014	MA.9104	Corrective Action Plan	OneCare
Revised	12/01/2014	MA.9104	Corrective Action Plan	Cal MediConnect OneCare PACE
Revised	09/01/2015	HH.2005	Corrective Action Plan	Medi-Cal
Revised	09/01/2015	MA.9104	Corrective Action Plan	OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9104	Corrective Action Plan	OneCare OneCare Connect PACE
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Revised	12/07/2017	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
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Action	Date	Policy	Policy Title	Program(s)
Revised	12/05/2019	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised	05/05/2022	HH.2005Δ	Corrective Action Plan	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	HH.2005~~A~~	Corrective Action Plan	Medi-Cal OneCare ~~OneCare Connect~~ 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.
~~Audit & Oversight Committee (AOC)~~	~~A subcommittee of the Compliance Committee chaired by the Director(s) of Audit & Oversight to oversee CalOptimaCalOptima Health's delegated functions. The composition of the AOC includes representatives from CalOptimaCalOptima Health's departments as provided for in CalOptimaCalOptima Health Policy HH.4001A: Audit & Oversight Committee.~~
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~~CalOptima Health, the Centers for Medicare & Medicaid Services (CMS), or designated representatives. First Tier Entities and/or ~~CalOptima~~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~~CalOptima Health and its regulators.
Delegation Oversight Committee (DOC)	A subcommittee of the Compliance Committee chaired by the Director of Audit & 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.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a ~~CalOptima~~CalOptima Health Program benefit, below the level of the arrangement between ~~CalOptima~~CalOptima Health and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
Employee	For purposes of this policy, any and all employees of ~~CalOptima~~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.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with ~~CalOptima~~CalOptima Health to provide administrative services or health care services to a Member under a ~~CalOptima~~CalOptima Health Program.

Term	Definition
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~~CalOptima Health Program.
Monitoring	Regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective
Related Entity	Any entity that is related to ~~CalOptima~~CalOptima Health by common ownership or control and that: performs some of ~~CalOptima~~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~~CalOptima Health at a cost of more than $2,500 during a contract period.
Sanction	An action taken by ~~CalOptima~~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~~CalOptima Health Programs.

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:	12/31/2022
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 its 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.

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.

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1. Failure by the internal department to respond accurately, timely, and in compliance with statutory, regulatory, contractual, CalOptima Health policy, or other requirements to CalOptima Health's Office of Compliance's ICAP or CAP request may lead to further action.

2. Failure by an FDR to respond accurately, timely, and in compliance with statutory, regulatory, contractual, CalOptima Health policy, or other requirements to CalOptima Health's 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 is required to cease non-compliant activities within two (2) business days of receiving the ICAP request.

   b. The internal department or FDR shall provide a written response within three (3) 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 fourteen (14) calendar days. CalOptima Health's 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 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 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 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 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 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 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 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 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 repeat deficiencies, the issue(s) shall be reported to the DOC and the Compliance Committee by the Office of Compliance for further action.

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
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E. CalOptima Health Policy GG.1615: Corrective Action Plan for Practitioners
F. CalOptima Health Policy HH.2002: Sanctions
G. Department of Health Care Services (DHCS) All Plan Letter 17-004: Subcontractual Relationships and Delegation
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

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
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12/20/2021	Special Meeting of the CalOptima Board of Directors
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TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

1

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Revised	12/31/2022	HH.2005	Corrective Action Plan	Medi-Cal OneCare PACE

1

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.
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Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
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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.
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.
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.

Term	Definition
Member	A beneficiary who is enrolled in a CalOptima Health Program.
Monitoring	Regular reviews directed by management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective
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.
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.

1

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**	

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.

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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 (eg 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)	Name, Title	Signature	Date
Approved by: (CalOptima Health Office of Compliance)	Name, Title	Signature	Date

Policy:	HH.2020~~A~~
Title:	**Conducting Compliance Investigations**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	*/s/*
Effective Date:	12/01/2012
Revised Date:	12/31/2022
Applicable to:	☒ Medi-Cal ☒ OneCare ~~☒ OneCare Connect~~ ☒ PACE ☐ Administrative

I. PURPOSE

This policy outlines the process for conducting and overseeing compliance investigations, or inquiries into allegations, of violations of the ~~CalOptima~~CalOptima Health Code of Conduct, any statute, regulation, or guideline applicable to federal and/or state health care programs, or of ~~CalOptima~~CalOptima Health's policies and procedures.

II. POLICY

A. ~~CalOptima~~CalOptima Health's Employees, Governing Body, and First Tier, Downstream and Related Entities (FDRs), have affirmative obligations under ~~CalOptima~~CalOptima Health's Compliance Program to report all violations and suspected violations of law, regulations, and/or policies and procedures (hereafter, "policies"), the ~~CalOptima~~CalOptima Health Code of Conduct, and/or other compliance issues. ~~CalOptima~~CalOptima Health maintains various disclosure and reporting mechanisms (i.e., Compliance and Ethics Hotline) which allow such individuals to fulfill these obligations.

1. ~~CalOptima~~CalOptima Health's Employees, Governing Body, and FDRs shall commence such preliminary investigations within the time frame identified in Section III.B.1.

B. ~~CalOptima~~CalOptima Health has a non-Retaliation policy regarding the reporting and investigating of incidents of non-compliance with applicable laws, regulations, the ~~CalOptima~~CalOptima Health Code of Conduct, and/or policies, or other compliance issues, as outlined in ~~CalOptima~~CalOptima Health Policy HH.3012~~A~~: Non-Retaliation for Reporting Violations.

C. The Compliance Officer or Designee is responsible for investigating potential non-compliance with applicable laws, regulations, the ~~CalOptima~~CalOptima Health Code of Conduct, and/or policies, or other compliance issues involving ~~CalOptima~~CalOptima Health, including its officers and Employees, and refer matters to the Compliance Committee, as appropriate. Potential non-compliance with applicable laws, regulations, and/or policies, or other compliance issues, may be discovered through, for example, reports to ~~CalOptima~~CalOptima Health's Compliance and Ethics Hotline, complaints, routine Monitoring, or regulatory audits.

D. The Compliance Officer or Designee shall promptly conduct a preliminary review of potential incidents of non-compliance with applicable laws, regulations, the ~~CalOptima~~CalOptima Health Code of Conduct, and/or policies, or other compliance issues, to determine whether there is sufficient credible information and basis to warrant to a full compliance investigation of the matter. In conducting such preliminary review, the Compliance Officer or Designee may refer the matter to another appropriate ~~CalOptima~~CalOptima Health department, including referrals to the Chief Human Resources Officer, who is responsible for investigations related to Employee harassment and discrimination and related matters.

E. The Privacy Officer or Designee in collaboration with the Security Officer or Designee, shall be responsible for investigations of potential violations of Protected Health Information (PHI) under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, as amended, including implementing regulations, the Health Information Technology for Economic and Clinical Health (HITECH) Act, and applicable state privacy, security, and confidentiality laws.

F. Whenever there is credible evidence that suggests violation of criminal, civil, or administrative laws, the Compliance Officer, or Designee may consult with ~~CalOptima~~CalOptima Health's legal counsel for further guidance regarding reports to law enforcement agencies or state or federal regulators, or other appropriate actions.

G. Whenever there is credible evidence that suggests Fraud, Waste, or Abuse, the Compliance Officer, or Designee, shall evaluate, investigate, and report the matter as appropriate, in accordance with ~~CalOptima~~CalOptima Health Policies HH.1105~~A~~: Fraud, Waste, and Abuse Detection and HH.1107~~A~~: Fraud, Waste, and Abuse Investigation and Reporting.

H. In conducting internal investigations, ~~CalOptima~~CalOptima Health shall respect the rights of all persons involved in the investigation, including those persons accused of non-compliance, in accordance with ~~CalOptima~~CalOptima Health Policy HH.3012~~A~~: Non-Retaliation for Reporting Violations. ~~CalOptima~~CalOptima Health strictly prohibits Retaliation against Employees for reporting compliance concerns, and/or participating in internal investigations.

III. PROCEDURE

A. Preliminary Investigation

1. The Compliance Officer or Designee shall:

a. Evaluate all incidents of potential non-compliance with applicable laws, regulations, and/or policies, the ~~CalOptima~~CalOptima Health Code of Conduct, or other compliance issues regardless of source;

~~b.~~ Determine whether there is sufficient information and basis to proceed with a full investigation of the incident/matter, or whether additional information is necessary;

b.

Determine the appropriate approach to be taken as a result of the information provided, such as, but not limited to a Corrective Action Plan (CAP), an educational letter (Reminder of Contractual Obligations), a Warning letter, or other actions as deemed appropriate;~~.~~

c.

~~c.~~d. Determine whether the incident/matter is an inquiry, or is otherwise appropriate for referral to another ~~CalOptima~~CalOptima Health department, or whether it is a non-issue that warrants closure of the compliance matter;

~~d.~~e. Determine whether the incident, if verified to be true, would necessitate a referral or report to one (1) or more of ~~CalOptima~~CalOptima Health's regulatory agencies or such agency's designated contractor.

~~e.~~f. If applicable, report the incident to Centers for Medicare & Medicaid Services (CMS) and/or the Department of Health Care Services (DHCS) in accordance with ~~CalOptima~~CalOptima Health Policy MA.9124: CMS Self-Disclosure.

2. If the Compliance Officer or Designee determines that a full investigation of the incident is appropriate, he or she shall review whether ~~CalOptima~~CalOptima Health needs to take any preventive or corrective actions prior to the completion of the full investigation, including, without limitation, preliminary reports to regulatory agencies, placement of Employees on administrative leave, etc. The Compliance Officer or Designee may recommend the temporary or permanent cessation of internal activities that may be the cause of, or contribute to, the alleged non-compliance, as appropriate. The Compliance Officer or Designee may consult with ~~CalOptima~~CalOptima Health's legal counsel on such actions, as needed.

3. The Compliance Officer or Designee shall determine if an investigation is warranted. The Compliance Officer or Designee shall establish the scope of the investigation based on the following factors, to include, but not be limited to:

   a. The availability of individuals who may be involved;

   b. The time frame of the alleged violations;

   c. Whether the alleged violations appear to be an isolated incident, or pattern of improper conduct;

   d. Whether the alleged violations indicate a systemic, or procedural, deficiency in a department's operation; and

   e. The time requirements for conducting the investigation, including, any regulatory obligations for commencement and completion of the investigation.

4. Prior to initiating the investigation, the Compliance Officer or Designee shall fully explore and understand all the allegations and related issues raised in a complaint.

5. Based on the scope of the investigation, the Compliance Officer or Designee shall develop an investigative plan. The Compliance Officer may delegate investigative activities~~,~~ but retains ultimate supervision and responsibility for compliance investigations.

6. The Compliance Officer shall assume responsibility for carrying out the investigation~~,~~ or shall assign a qualified person to carry out the investigation, who is organizationally removed from any of the parties directly involved in the investigation.

B. Investigation

1. The Compliance Officer or Designee shall initiate the investigation ~~(including gathering all documents, conducting interviews, and obtaining other relevant evidence)~~ promptly and

generally no later than fourteen (14) calendar days after the potential non-compliance ~~was~~ is ~~identified~~ reported (and earlier if the regulatory requirement dictates such and/or if the matter requires more immediate resolution).

2. All communications, evidence, and reports shall be saved, logged, and sequentially numbered upon receipt by the Compliance Officer or Designee and maintained in the investigation case file.

3. All information gathered by the Compliance Officer or Designee during the investigation shall be held in confidence, in accordance with applicable state and federal law, except as specifically authorized by ~~CalOptima~~CalOptima Health policies and procedures, and applicable law.

4. The Compliance Officer or Designee shall:

   a. Conduct interviews, in person and in private, with one (1) interviewee at a time;

   ~~a.~~ Follow professional interview principles and techniques; and
   b.

   ~~b.~~c. Ensure circumstance and content of the interview are supported by a witness for sensitive interviews.

5. The Compliance Officer or Designee shall have a full understanding of the relevant laws, regulations, and government guidance pertinent to the investigation before conducting the investigation~~,~~ and may consult with ~~CalOptima~~CalOptima Health's legal counsel for guidance on the subject matter at issue.

6. Investigations shall be completed within a reasonable time period, and as expeditiously as possible, based on the circumstances, including but not limited to, consideration of relevant statutory and/or regulatory requirements (e.g., overpayment disclosure and refunding requirements); the potential that the matter involves Fraud or Abuse; and/or the potential for ongoing financial or other harm to ~~CalOptima~~CalOptima Health, any federal or state health care program, and/or any individual while the investigation is conducted.

7. The Compliance Officer or Designee shall review whether there are sufficient internal resources, or whether ~~external~~ resources are needed to conduct the investigation. If ~~external~~ resources are necessary, the Compliance Officer, or Designee, may consult with ~~CalOptima~~CalOptima Health's legal counsel to determine the best course of action.

C. Involvement of Legal Representation

1. Any member of a ~~CalOptima~~CalOptima Health Governing Body, Employee, or FDR who is the subject of an investigation is free to retain independent counsel. If a member of a ~~CalOptima~~CalOptima Health Governing Body, Employee, or FDR is already represented by counsel, the Compliance Officer or Designee shall discuss ramifications with ~~CalOptima~~CalOptima Health's legal counsel before proceeding.

2. If a member of a ~~CalOptima~~CalOptima Health Governing Body, Employee, or FDR is being interviewed, and requests the presence of an attorney, the interview shall be stopped, and the Compliance Officer or Designee shall notify ~~CalOptima~~CalOptima Health's legal counsel.

3. If the interview is with a member of a ~~CalOptima~~CalOptima Health Governing Body, Employee, or FDR who is suspected of serious misconduct, ~~CalOptima~~CalOptima Health's

legal counsel shall advise the member of a ~~CalOptima~~CalOptima Health Governing Body, Employee, or FDR of the seriousness of the matter and ~~CalOptima~~CalOptima Health's policy to disclose the result of its investigation to other government agencies, including appropriate state and/or federal law enforcement agencies.

D. Documenting and reporting findings of the investigation

1. For every interview, the Compliance Officer or Designee shall prepare a written interview report covering all the key points derived from that contact.

2. The Compliance Officer or Designee shall:

   a. Write the investigation report;

   b. File with the original written communication; and

   c. Include a summary of the individual's complaint, a chronology of events, the investigator's findings/conclusions, and, as appropriate, recommended actions with specific responsibilities assigned to managers to ensure implementation.

3. The Compliance Officer or Designee shall review root cause analyses, corrective action plans, remediation plans, and future monitoring/auditing plans, as appropriate, to address verified incidents of non-compliance or deficiencies to ensure they do not recur in the future. The Compliance Officer or Designee may consult with the ~~CalOptima~~CalOptima Health Compliance Committee, legal counsel, Human Resources Department, or other parties, as necessary and appropriate, to develop these plans.

4. The Compliance Officer or Designee shall report the findings to the Compliance Committee, as appropriate, along with recommendations for final corrective action, in order to confirm completion of the investigative tasks. The Compliance Committee can determine if additional steps are necessary to complete the investigation.

5. The Compliance Officer or Designee shall distribute and report complete investigations to the Compliance Committee. No copies shall be provided to other parties, unless requested to do so and approved by the Compliance Officer, or Designee.

6. If potential legal issues exist, the report shall be provided to ~~CalOptima~~CalOptima Health's legal counsel for appropriate action.

7. If the investigation and report have been requested or directed by ~~CalOptima~~CalOptima Health's legal counsel, the report should be marked "Attorney-Client Privilege" or "Attorney Work Product," as requested by ~~CalOptima~~CalOptima Health's legal counsel, and furnished only to ~~CalOptima~~CalOptima Health's legal counsel. Under those circumstances, it shall be the responsibility of ~~CalOptima~~CalOptima Health's legal counsel to report and advise management about the facts, circumstances, and alternative courses of action.

8. Upon review of the report by the Compliance Committee, the Compliance Officer or Designee shall act upon the findings and recommendations for corrective action measures and determine whether adverse actions should be taken against any parties, and if so, determine the Sanction itself. The Compliance Officer, or Designee, as appropriate, may consult with ~~CalOptima~~CalOptima Health's legal counsel in making the necessary decisions.

9. Before taking action on the results of an investigation, the Compliance Officer or Designee shall ensure that the complainant (if known) has received general feedback on the results of the investigation, but not the details of the investigation, or any specific action or decisions relating to any individual.

10. The Compliance Officer or Designee shall report the results of an investigation to the ~~CalOptima~~CalOptima Health Board of Directors and the Chief Executive Officer, as appropriate.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. ~~CalOptima~~CalOptima Health Compliance Plan
B. ~~CalOptima~~CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. ~~CalOptima~~CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. ~~CalOptima~~CalOptima Health PACE Program Agreement
E. ~~CalOptima~~CalOptima Health Policy HH.1105~~A~~: Fraud, Waste, and Abuse Detection
F. ~~CalOptima~~CalOptima Health Policy HH.1107~~A~~: Fraud, Waste, and Abuse Investigation and Reporting
G. ~~CalOptima~~CalOptima Health Policy HH.3012~~A~~: Non-Retaliation for Reporting Violations
~~H. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect~~
~~I.~~H. Health Information Technology for Economic and Clinical Health (HITECH) Act
~~J.~~I. Health Insurance Portability and Accountability Act (HIPAA) of 1996, including implementing regulations
~~K.~~J. Medicare Managed Care Manual, Chapter 21
~~L.~~K. Medicare Prescription Drug Benefit Manual, Chapter 9
~~M.~~L. Title 42, Code of Federal Regulations (C.F.R.), §455.15
~~N.~~M. Title 42, Code of Federal Regulations (C.F.R.), §455.2
~~O.~~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
TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	12/01/2012	HH.2020	Conducting Internal Investigations	Medi-Cal
Revised	04/01/2014	HH.2020	Conducting Internal Investigations	Medi-Cal
Effective	11/01/2014	MA.9125	Conducting Internal Investigations	OneCare
Revised	09/01/2015	HH.2020	Conducting Internal Investigations	Medi-Cal
Revised	09/01/2015	MA.9125	Conducting Compliance Investigations	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.2020Δ	Conducting Compliance Investigations	Medi-Cal OneCare OneCare Connect PACE
Retired	12/01/2016	MA.9125	Conducting Compliance Investigations	OneCare OneCare Connect PACE
Revised	12/07/2017	HH.2020Δ	Conducting Compliance Investigations	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.2020Δ	Conducting Compliance Investigations	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.2020Δ	Conducting Compliance Investigations	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.2020Δ	Conducting Compliance Investigations	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.2020Δ	Conducting Compliance Investigations	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	HH.2020~~Δ~~	Conducting Compliance Investigations	Medi-Cal OneCare PACE

IX. GLOSSARY

Term	Definition
Abuse	Actions that may, directly or indirectly, result in: unnecessary costs to a ~~CalOptima~~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.
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.
Code of Conduct	The statement setting forth the principles and standards governing ~~CalOptima~~CalOptima Health's activities to which Board Members, Employees, FDRs, and agents of ~~CalOptima~~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; Compliance Officer; and Chief Human Resources Officer.
Compliance Program	The program (including, without limitation, this Compliance Plan, Code of Conduct and Policies and Procedures and Procedures) developed and adopted by ~~CalOptima~~CalOptima Health to promote, monitor and ensure that ~~CalOptima~~CalOptima Health's operations and practices and the practices of its Board Member, Employees and FDRs comply with applicable law and ethical standards.
Confidential	Entrusted with private or personal information that is confined to a person or group as opposed to the public.
Designee	A person selected or designated to carry out a duty or role. The assigned Designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a ~~CalOptima~~CalOptima Health Program benefit, below the level of arrangement between ~~CalOptima~~CalOptima Health and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
Employee	For purposes of this policy, any and all employees of ~~CalOptima~~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 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~~CalOptima Health to provide administrative services or health care services to a Member under a ~~CalOptima~~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 Section 1347).
Governing Body	The Board of Directors of ~~CalOptima~~CalOptima Health.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, enacted on August 21, 1996. Sections 261 through 264 if HIPAA require the Secretary of the U.S. Department of Health and Human Services to publicize standards for the electronic exchange, privacy and security of health information, as amended.
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~~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~~CalOptima Health by common ownership or control and that: performs some of ~~CalOptima~~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~~CalOptima Health at a cost of more than $2,500 during a contract period.
Retaliation	Includes, but not limited to, coercion, threats, intimidation, discrimination, and other forms of retaliatory action against individuals.
Sanction	An action taken by ~~CalOptima~~CalOptima Health, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on an FDR's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to ~~CalOptima~~CalOptima Health Programs.
Waste	The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a ~~CalOptima~~CalOptima Health Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

1

Policy:	HH.2020
Title:	**Conducting Compliance Investigations**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	*/s/*
Effective Date:	12/01/2012
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C. The Compliance Officer or Designee is responsible for investigating potential non-compliance with applicable laws, regulations, the CalOptima Health Code of Conduct, and/or policies, or other compliance issues involving CalOptima Health, including its officers and Employees, and refer matters to the Compliance Committee, as appropriate. Potential non-compliance with applicable laws, regulations, and/or policies, or other compliance issues, may be discovered through, for example, reports to CalOptima Health's Compliance and Ethics Hotline, complaints, routine Monitoring, or regulatory audits.

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conducting such preliminary review, the Compliance Officer or Designee may refer the matter to another appropriate CalOptima Health department, including referrals to the Chief Human Resources Officer, who is responsible for investigations related to Employee harassment and discrimination and related matters.

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F. Whenever there is credible evidence that suggests violation of criminal, civil, or administrative laws, the Compliance Officer, or Designee may consult with CalOptima Health's legal counsel for further guidance regarding reports to law enforcement agencies or state or federal regulators, or other appropriate actions.

G. Whenever there is credible evidence that suggests Fraud, Waste, or Abuse, the Compliance Officer, or Designee, shall evaluate, investigate, and report the matter as appropriate, in accordance with CalOptima Health Policies HH.1105: Fraud, Waste, and Abuse Detection and HH.1107: Fraud, Waste, and Abuse Investigation and Reporting.

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1. The Compliance Officer or Designee shall:

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   d. Determine whether the incident/matter is an inquiry, or is otherwise appropriate for referral to another CalOptima Health department, or whether it is a non-issue that warrants closure of the compliance matter;

   e. Determine whether the incident, if verified to be true, would necessitate a referral or report to one (1) or more of CalOptima Health's regulatory agencies or such agency's designated contractor.

f. If applicable, report the incident to Centers for Medicare & Medicaid Services (CMS) and/or the Department of Health Care Services (DHCS) in accordance with CalOptima Health Policy MA.9124: CMS Self-Disclosure.

2. If the Compliance Officer or Designee determines that a full investigation of the incident is appropriate, he or she shall review whether CalOptima Health needs to take any preventive or corrective actions prior to the completion of the full investigation, including, without limitation, preliminary reports to regulatory agencies, placement of Employees on administrative leave, etc. The Compliance Officer or Designee may recommend the temporary or permanent cessation of internal activities that may be the cause of, or contribute to, the alleged non-compliance, as appropriate. The Compliance Officer or Designee may consult with CalOptima Health's legal counsel on such actions, as needed.

3. The Compliance Officer or Designee shall determine if an investigation is warranted. The Compliance Officer or Designee shall establish the scope of the investigation based on the following factors, to include, but not be limited to:

   a. The availability of individuals who may be involved;

   b. The time frame of the alleged violations;

   c. Whether the alleged violations appear to be an isolated incident, or pattern of improper conduct;

   d. Whether the alleged violations indicate a systemic, or procedural, deficiency in a department's operation; and

   e. The time requirements for conducting the investigation, including, any regulatory obligations for commencement and completion of the investigation.

4. Prior to initiating the investigation, the Compliance Officer or Designee shall fully explore and understand all the allegations and related issues raised in a complaint.

5. Based on the scope of the investigation, the Compliance Officer or Designee shall develop an investigative plan. The Compliance Officer may delegate investigative activities but retains ultimate supervision and responsibility for compliance investigations.

6. The Compliance Officer shall assume responsibility for carrying out the investigation or shall assign a qualified person to carry out the investigation, who is organizationally removed from any of the parties directly involved in the investigation.

B. Investigation

1. The Compliance Officer or Designee shall initiate the investigation promptly and generally no later than fourteen (14) calendar days after the potential non-compliance is reported (and earlier if the regulatory requirement dictates such and/or if the matter requires more immediate resolution).

2. All communications, evidence, and reports shall be saved, logged, and sequentially numbered upon receipt by the Compliance Officer or Designee and maintained in the investigation case file.

3. All information gathered by the Compliance Officer or Designee during the investigation shall be held in confidence, in accordance with applicable state and federal law, except as specifically authorized by CalOptima Health policies and procedures, and applicable law.

4. The Compliance Officer or Designee shall:

   a. Conduct interviews, in person and in private, with one (1) interviewee at a time;

   b. Follow professional interview principles and techniques; and

   c. Ensure circumstance and content of the interview are supported by a witness for sensitive interviews.

5. The Compliance Officer or Designee shall have a full understanding of the relevant laws, regulations, and government guidance pertinent to the investigation before conducting the investigation and may consult with CalOptima Health's legal counsel for guidance on the subject matter at issue.

6. Investigations shall be completed within a reasonable time period, and as expeditiously as possible, based on the circumstances, including but not limited to, consideration of relevant statutory and/or regulatory requirements (e.g., overpayment disclosure and refunding requirements); the potential that the matter involves Fraud or Abuse; and/or the potential for ongoing financial or other harm to CalOptima Health, any federal or state health care program, and/or any individual while the investigation is conducted.

7. The Compliance Officer or Designee shall review whether there are sufficient internal resources, or whether resources are needed to conduct the investigation. If resources are necessary, the Compliance Officer, or Designee, may consult with CalOptima Health's legal counsel to determine the best course of action.

C. Involvement of Legal Representation

1. Any member of a CalOptima Health Governing Body, Employee, or FDR who is the subject of an investigation is free to retain independent counsel. If a member of a CalOptima Health Governing Body, Employee, or FDR is already represented by counsel, the Compliance Officer or Designee shall discuss ramifications with CalOptima Health's legal counsel before proceeding.

2. If a member of a CalOptima Health Governing Body, Employee, or FDR is being interviewed, and requests the presence of an attorney, the interview shall be stopped, and the Compliance Officer or Designee shall notify CalOptima Health's legal counsel.

3. If the interview is with a member of a CalOptima Health Governing Body, Employee, or FDR who is suspected of serious misconduct, CalOptima Health's legal counsel shall advise the member of a CalOptima Health Governing Body, Employee, or FDR of the seriousness of the matter and CalOptima Health's policy to disclose the result of its investigation to other government agencies, including appropriate state and/or federal law enforcement agencies.

D. Documenting and reporting findings of the investigation

1. For every interview, the Compliance Officer or Designee shall prepare a written interview report covering all the key points derived from that contact.

2. The Compliance Officer or Designee shall:

   a. Write the investigation report;

   b. File with the original written communication; and

   c. Include a summary of the individual's complaint, a chronology of events, the investigator's findings/conclusions, and, as appropriate, recommended actions with specific responsibilities assigned to managers to ensure implementation.

3. The Compliance Officer or Designee shall review root cause analyses, corrective action plans, remediation plans, and future monitoring/auditing plans, as appropriate, to address verified incidents of non-compliance or deficiencies to ensure they do not recur in the future. The Compliance Officer or Designee may consult with the CalOptima Health Compliance Committee, legal counsel, Human Resources Department, or other parties, as necessary and appropriate, to develop these plans.

4. The Compliance Officer or Designee shall report the findings to the Compliance Committee, as appropriate, along with recommendations for final corrective action, in order to confirm completion of the investigative tasks. The Compliance Committee can determine if additional steps are necessary to complete the investigation.

5. The Compliance Officer or Designee shall distribute and report complete investigations to the Compliance Committee. No copies shall be provided to other parties, unless requested to do so and approved by the Compliance Officer, or Designee.

6. If potential legal issues exist, the report shall be provided to CalOptima Health's legal counsel for appropriate action.

7. If the investigation and report have been requested or directed by CalOptima Health's legal counsel, the report should be marked "Attorney-Client Privilege" or "Attorney Work Product," as requested by CalOptima Health's legal counsel, and furnished only to CalOptima Health's legal counsel. Under those circumstances, it shall be the responsibility of CalOptima Health's legal counsel to report and advise management about the facts, circumstances, and alternative courses of action.

8. Upon review of the report by the Compliance Committee, the Compliance Officer or Designee shall act upon the findings and recommendations for corrective action measures and determine whether adverse actions should be taken against any parties, and if so, determine the Sanction itself. The Compliance Officer, or Designee, as appropriate, may consult with CalOptima Health's legal counsel in making the necessary decisions.

9. Before taking action on the results of an investigation, the Compliance Officer or Designee shall ensure that the complainant (if known) has received general feedback on the results of the investigation, but not the details of the investigation, or any specific action or decisions relating to any individual.

10. The Compliance Officer or Designee shall report the results of an investigation to the CalOptima Health Board of Directors and the Chief Executive Officer, as appropriate.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Compliance Plan
B. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Health PACE Program Agreement
E. CalOptima Health Policy HH.1105: Fraud, Waste, and Abuse Detection
F. CalOptima Health Policy HH.1107: Fraud, Waste, and Abuse Investigation and Reporting
G. CalOptima Health Policy HH.3012: Non-Retaliation for Reporting Violations
H. Health Information Technology for Economic and Clinical Health (HITECH) Act
I. Health Insurance Portability and Accountability Act (HIPAA) of 1996, including implementing regulations
J. Medicare Managed Care Manual, Chapter 21
K. Medicare Prescription Drug Benefit Manual, Chapter 9
L. Title 42, Code of Federal Regulations (C.F.R.), §455.15
M. Title 42, Code of Federal Regulations (C.F.R.), §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
TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	12/01/2012	HH.2020	Conducting Internal Investigations	Medi-Cal
Revised	04/01/2014	HH.2020	Conducting Internal Investigations	Medi-Cal
Effective	11/01/2014	MA.9125	Conducting Internal Investigations	OneCare
Revised	09/01/2015	HH.2020	Conducting Internal Investigations	Medi-Cal
Revised	09/01/2015	MA.9125	Conducting Compliance Investigations	OneCare OneCare Connect PACE
Revised	12/01/2016	HH.2020Δ	Conducting Compliance Investigations	Medi-Cal OneCare OneCare Connect PACE

Action	Date	Policy	Policy Title	Program(s)
Retired	12/01/2016	MA.9125	Conducting Compliance Investigations	OneCare OneCare Connect PACE
Revised	12/07/2017	HH.2020Δ	Conducting Compliance Investigations	Medi-Cal OneCare OneCare Connect PACE
Revised	12/06/2018	HH.2020Δ	Conducting Compliance Investigations	Medi-Cal OneCare OneCare Connect PACE
Revised	12/05/2019	HH.2020Δ	Conducting Compliance Investigations	Medi-Cal OneCare OneCare Connect PACE
Revised	12/03/2020	HH.2020Δ	Conducting Compliance Investigations	Medi-Cal OneCare OneCare Connect PACE
Revised	12/20/2021	HH.2020Δ	Conducting Compliance Investigations	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	HH.2020	Conducting Compliance Investigations	Medi-Cal OneCare PACE

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IX. GLOSSARY

Term	Definition
Abuse	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.
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.
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; Compliance Officer; and Chief Human Resources Officer.
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.
Confidential	Entrusted with private or personal information that is confined to a person or group as opposed to the public.
Designee	A person selected or designated to carry out a duty or role. The assigned Designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Health Program benefit, below the level of arrangement between CalOptima Health and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
Employee	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 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 Section 1347).
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, enacted on August 21, 1996. Sections 261 through 264 if HIPAA require the Secretary of the U.S. Department of Health and Human Services to publicize standards for the electronic exchange, privacy and security of health information, as amended.
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.
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.
Retaliation	Includes, but not limited to, coercion, threats, intimidation, discrimination, and other forms of retaliatory action against individuals.
Sanction	An action taken by CalOptima Health, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on an FDR's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima Health Programs.
Waste	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:	MA.9124
Title:	**CMS Self-Disclosure**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	/s/
Effective Date:	08/01/2014
Revised Date:	12/31/2022
Applicable to:	☐ Medi-Cal ☒ OneCare ~~☒ OneCare Connect~~ ☒ PACE ☐ Administrative

I. PURPOSE

This policy establishes a process for self-disclosing incidences of significant Medicare program non-compliance to ~~CalOptima's~~CalOptima Health's Centers for Medicare & Medicaid Services (CMS) Regional Account Manager and/or the Department of Health Care Services (DHCS) Contract Manager. This self-disclosing process ensures that corrective actions are taken timely when non-compliance incidents are identified.

II. POLICY

A. CalOptima Health follows the guidelines and regulations set forth by CMS regarding compliance to the Medicare Program and monitoring process for Part C and Part D programs.

B. The Office of Compliance oversees and implements an effective Compliance Program to prevent, detect, and correct Part C and Part D programs' non-compliance.

C. This policy encourages internal and external business units to voluntarily identify, disclose, and correct non-compliance incidents to meet the Medicare program guidelines and regulations set forth by CMS.

D. Self–reported non-compliance incidents reported to the Office of Compliance are investigated and Corrective Action Plans (CAPs) issued and responded to, as promptly as the severity level assigned to the non-compliance incident allows, and as described in CalOptima Health Policy HH.2005~~A~~: Corrective Action Plan.

III. PROCEDURE

A. Submitting a Self-Disclosure

1. The department Director, Manager, or delegate liaison has twenty-four hours (24) hours (once an incident is identified) to Self-Disclose a non-compliance incident to the Office of Compliance. In severe non-compliance incidents impacting and threatening a Member's state of health, the non-compliance Self-Disclosure report must be completed as soon as it is identified.

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2. The department Director, Manager, or delegate liaison must document the non-compliance incident and submit the Self-Disclosure to the Office of Compliance. The department Director, Manager, or delegate liaison may use the attached Non-Compliance Self-Disclosure Form (SDF) to disclose the non-compliance issue to the Office of Compliance.

3. The Self-Disclosure must be submitted electronically.

4. Depending on the severity of the incident being reported, the Office of Compliance will review the submission and respond back within three to five (3-5) business days to the submitting party either accepting, or rejecting, the disclosure.

B. Required Information Related to the Self-Disclosing Incident

1. To Self-Disclose a non-compliance incident to the Office of Compliance, the submitting party must provide the following information in the Self-Disclosure report:

   a. Contact information:

      i. Submitter contact name, phone number, email, and address (for external submitters), and area of non-compliance (For example: Enrollment, Pharmacy, Customer Service, Sales, etc.).

   b. A brief description/summary of the identified non-compliance incident, including specific time frames during which the internal or external party might have been out of compliance. Any applicable supporting documentation should be included.

   c. A brief description of why the internal or external party believes they are out of compliance with the identified area.

   d. Circumstances under which the non-compliance was discovered (For example: Grievance, complaint, Audits, or through a business data analysis), and actions taken, if any, to correct the non-compliance upon discovery of the incident.

   e. A root cause analysis and the impact on risks to health, safety, or quality of care posed by the incident disclosed with sufficient information to allow the Office of Compliance to assess the severity of the non-compliance incident or risk, and steps that should be taken to meet compliance.

   f. If applicable, the dates, or range of dates, whereby the non-compliance was cured and if any claims or services were, or have been, impacted.

   g. Remediating measures taken to prevent future non-compliance of that nature from reoccurring, Monitoring steps and implementation time frames, including proof of remediation. (For example: employee training, enhancing internal control procedures, increased internal Auditing efforts, increased oversight by management, etc.)

   h. A description of appropriate Member/Provider notices, if applicable, provided with disclosure of the non-compliance incident.

C. Office of Compliance Investigation & Corrective Action Plan (CAP)

1. Upon receipt of a Self-Disclosure submission, the Office of Compliance will begin its investigation of the disclosed information. The extent of the investigation will depend upon the severity of the incident and evidence, or documentation provided in the Self-Disclosure report.

2. If additional non-compliance incidents are discovered during the investigation process, that incident will be treated as a new non-compliance incident and the self-disclosing party will be required to complete a new Self-Disclosure report for that incident.

3. To facilitate the investigation process, the Office of Compliance will review and request additional information and conduct interviews, if necessary, with the applicable parties/departments. If additional information is requested based on the severity of the incident, the self-disclosing applicable parties/departments shall submit the requested information to the Office of Compliance, in accordance with CalOptima Health Policy HH.2005~~A~~: Corrective Action Plan.

4. The Office of Compliance shall complete its initial investigation, upon which the self-disclosing department will be provided with initial findings and a request for CAP which must be completed and responded to by the self-disclosing business unit, in accordance with CalOptima Health Policy HH.2005~~A~~: Corrective Action Plan.

5. If the non-compliance is a result of a Grievance filing, the Office of Compliance will provide the Grievance & Appeals Director with the final resolution for insertion into the Member Grievance file.

D. Findings Report

1. Upon completion of the investigation, the Office of Compliance will submit the Self-Disclosure findings report to the Medicare Compliance Officer (MCO) and Chief Compliance Officer (CCO) for review and sign off.

2. The MCO will review the details of the issue and relay a recommendation to the CCO as to whether the non-compliance is of a level of significance that warrants reporting the issue to the relevant regulators.

3. If the recommendation is made that the issue is to be disclosed to the pertinent regulators, the MCO will report the details of the issue to the appropriate CalOptima Health senior management. The CCO will report the issue to the CEO and the Board of Directors.

~~2.~~4. Once the above ~~step has~~steps have been completed, and an accepted CAP (if applicable) has been submitted, the ~~Compliance Officer~~MCO, or Designee, will submit the non-compliance incident to ~~CalOptima's~~CalOptima Health's CMS Regional Account Manager and/or the Department of Health Care Services (DHCS) Contract Manager including any steps taken to correct the non-compliance, immediately, but no later than ten (10) calendar days.

~~3.~~5. CalOptima Health shall report the incident to CMS as soon as possible after its discovery and sufficient details have been obtained.

~~4.~~6. The ~~Compliance Officer~~MCO, or Designee, may also submit the final, signed Non-Compliance Self-Disclosure Form outlining the course of actions that included the accepted CAP, and

continued monitoring efforts to the CCO or Executive Director, and Director of the business unit and applicable Committees.

IV. ATTACHMENT(S)

A. Non-Compliance Self-Disclosure Form

V. REFERENCE(S)

A. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
~~B. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect~~
~~C.~~B. ~~CalOptima~~ Health PACE Program Agreement
~~D.~~C. CalOptima Health Compliance Plan
~~E.~~D. CalOptima Health Policy HH.2005~~A~~: Corrective Action Plan
~~F.~~E. "CMS Consideration of Self-Disclosure by Plan Sponsors of Non-Compliance Conduct in the Determination of Compliance Actions," Health Plan Management System, Issued 02/27/2013.
~~G.~~F. Medicare Managed Care Manual, Chapter 21
~~H.~~G. Medicare Prescription Drug Benefit Manual, Chapter 9
~~I.~~H. Title 42, Code of Federal Regulations **(**C.F.R.), §§422.503(b)(4)(vi)(G)
~~J.~~I. Title 42, Code of Federal Regulations (C.F.R.), §§423.504(b)(~~4~~)(vi)(G)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	08/01/2014	MA.9124	CMS Self Disclosure	OneCare
Revised	12/01/2014	MA.9124	CMS Self Disclosure	OneCare
Revised	09/01/2015	MA.9124	CMS Self Disclosure	OneCare OneCare Connect
Revised	12/01/2016	MA.9124	CMS Self Disclosure	OneCare OneCare Connect
Revised	12/07/2017	MA.9124	CMS Self-Disclosure	OneCare OneCare Connect

Action	Date	Policy	Policy Title	Program(s)
Revised	12/06/2018	MA.9124	CMS Self-Disclosure	OneCare OneCare Connect PACE
Revised	12/05/2019	MA.9124	CMS Self-Disclosure	OneCare OneCare Connect PACE
Revised	12/03/2020	MA.9124	CMS Self-Disclosure	OneCare OneCare Connect PACE
Revised	12/20/2021	MA.9124	CMS Self-Disclosure	OneCare OneCare Connect PACE
Revised	12/31/2022	MA.9124	CMS Self-Disclosure	OneCare PACE

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IX. GLOSSARY

Term	Definition
Audit	A formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being Audited and normally performed by individuals with one of several acknowledged certifications
Centers for Medicare & Medicaid Services (CMS)	The federal agency within the United States Department of Health and Human Services (DHHS) that administers that Federal Medicare program and works in partnership with state governments to administer Medicaid programs.
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's~~CalOptima Health's operations and practices and the practices of its Board Member, Employees and FDRs comply with applicable law and ethical standards.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal Audits or monitoring activities by CalOptima Health, the Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services, or designated representatives. FDRs and/or CalOptima Health departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima Health and its regulators.
Department of Health Care Services (DHCS)	The California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as 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.
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. ~~OneCare Connect: Any complaint or dispute, other than one that constitutes an organization determination under 42 C.F.R. § 422.566 or other than an Adverse Benefit Determination under 42 C.F.R. § 438.400, expressing dissatisfaction with any aspect of the CalOptima's or Provider's operations, activities, or behavior, regardless of whether remedial action is requested pursuant to 42 C.F.R. § 422.561. (Possible subjects for Grievances include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the Member's rights). Also called a "Complaint."~~

Term	Definition
	PACE: A complaint, either written or oral, expressing dissatisfaction with service delivery or the quality of care furnished, as defined by the federal PACE regulation 42 CFR Section 460.120.
Member	A beneficiary enrolled in a CalOptima Health Program.
Provider	~~OneCare: A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Health Network, or other person or institution who furnishes Covered Services.~~ ~~OneCare Connect: A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Health Network, physician group, or other person or institution who furnishes Covered Services.~~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.
Self-Disclosure	The act of voluntarily notifying the compliance governing body of a non-compliance incident.

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Policy:	MA.9124
Title:	**CMS Self-Disclosure**
Department:	Office of Compliance
Section:	Regulatory Affairs & Compliance
CEO Approval:	*/s/*
Effective Date:	08/01/2014
Revised Date:	12/31/2022
Applicable to:	☐ Medi-Cal ☒ OneCare ☒ PACE ☐ Administrative

I. PURPOSE

This policy establishes a process for self-disclosing incidences of significant Medicare program non-compliance to CalOptima Health's Centers for Medicare & Medicaid Services (CMS) Regional Account Manager and/or the Department of Health Care Services (DHCS) Contract Manager. This self-disclosing process ensures that corrective actions are taken timely when non-compliance incidents are identified.

II. POLICY

A. CalOptima Health follows the guidelines and regulations set forth by CMS regarding compliance to the Medicare Program and monitoring process for Part C and Part D programs.

B. The Office of Compliance oversees and implements an effective Compliance Program to prevent, detect, and correct Part C and Part D programs' non-compliance.

C. This policy encourages internal and external business units to voluntarily identify, disclose, and correct non-compliance incidents to meet the Medicare program guidelines and regulations set forth by CMS.

D. Self–reported non-compliance incidents reported to the Office of Compliance are investigated and Corrective Action Plans (CAPs) issued and responded to, as promptly as the severity level assigned to the non-compliance incident allows, and as described in CalOptima Health Policy HH.2005: Corrective Action Plan.

III. PROCEDURE

A. Submitting a Self-Disclosure

1. The department Director, Manager, or delegate liaison has twenty-four hours (24) hours (once an incident is identified) to Self-Disclose a non-compliance incident to the Office of Compliance. In severe non-compliance incidents impacting and threatening a Member's state of health, the non-compliance Self-Disclosure report must be completed as soon as it is identified.

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2. The department Director, Manager, or delegate liaison must document the non-compliance incident and submit the Self-Disclosure to the Office of Compliance. The department Director, Manager, or delegate liaison may use the attached Non-Compliance Self-Disclosure Form (SDF) to disclose the non-compliance issue to the Office of Compliance.

3. The Self-Disclosure must be submitted electronically.

4. Depending on the severity of the incident being reported, the Office of Compliance will review the submission and respond back within three to five (3-5) business days to the submitting party either accepting, or rejecting, the disclosure.

B. Required Information Related to the Self-Disclosing Incident

1. To Self-Disclose a non-compliance incident to the Office of Compliance, the submitting party must provide the following information in the Self-Disclosure report:

   a. Contact information:

      i. Submitter contact name, phone number, email, and address (for external submitters), and area of non-compliance (For example: Enrollment, Pharmacy, Customer Service, Sales, etc.).

   b. A brief description/summary of the identified non-compliance incident, including specific time frames during which the internal or external party might have been out of compliance. Any applicable supporting documentation should be included.

   c. A brief description of why the internal or external party believes they are out of compliance with the identified area.

   d. Circumstances under which the non-compliance was discovered (For example: Grievance, complaint, Audits, or through a business data analysis), and actions taken, if any, to correct the non-compliance upon discovery of the incident.

   e. A root cause analysis and the impact on risks to health, safety, or quality of care posed by the incident disclosed with sufficient information to allow the Office of Compliance to assess the severity of the non-compliance incident or risk, and steps that should be taken to meet compliance.

   f. If applicable, the dates, or range of dates, whereby the non-compliance was cured and if any claims or services were, or have been, impacted.

   g. Remediating measures taken to prevent future non-compliance of that nature from reoccurring, Monitoring steps and implementation time frames, including proof of remediation. (For example: employee training, enhancing internal control procedures, increased internal Auditing efforts, increased oversight by management, etc.)

   h. A description of appropriate Member/Provider notices, if applicable, provided with disclosure of the non-compliance incident.

C. Office of Compliance Investigation & Corrective Action Plan (CAP)

1. Upon receipt of a Self-Disclosure submission, the Office of Compliance will begin its investigation of the disclosed information. The extent of the investigation will depend upon the severity of the incident and evidence, or documentation provided in the Self-Disclosure report.

2. If additional non-compliance incidents are discovered during the investigation process, that incident will be treated as a new non-compliance incident and the self-disclosing party will be required to complete a new Self-Disclosure report for that incident.

3. To facilitate the investigation process, the Office of Compliance will review and request additional information and conduct interviews, if necessary, with the applicable parties/departments. If additional information is requested based on the severity of the incident, the self-disclosing applicable parties/departments shall submit the requested information to the Office of Compliance, in accordance with CalOptima Health Policy HH.2005: Corrective Action Plan.

4. The Office of Compliance shall complete its initial investigation, upon which the self-disclosing department will be provided with initial findings and a request for CAP which must be completed and responded to by the self-disclosing business unit, in accordance with CalOptima Health Policy HH.2005: Corrective Action Plan.

5. If the non-compliance is a result of a Grievance filing, the Office of Compliance will provide the Grievance & Appeals Director with the final resolution for insertion into the Member Grievance file.

D. Findings Report

1. Upon completion of the investigation, the Office of Compliance will submit the Self-Disclosure findings report to the Medicare Compliance Officer (MCO) and Chief Compliance Officer (CCO) for review and sign off.

2. The MCO will review the details of the issue and relay a recommendation to the CCO as to whether the non-compliance is of a level of significance that warrants reporting the issue to the relevant regulators.

3. If the recommendation is made that the issue is to be disclosed to the pertinent regulators, the MCO will report the details of the issue to the appropriate CalOptima Health senior management. The CCO will report the issue to the CEO and the Board of Directors.

4. Once the above steps have been completed, and an accepted CAP (if applicable) has been submitted, the MCO, or Designee, will submit the non-compliance incident to CalOptima Health's CMS Regional Account Manager and/or the Department of Health Care Services (DHCS) Contract Manager including any steps taken to correct the non-compliance, immediately, but no later than ten (10) calendar days.

5. CalOptima Health shall report the incident to CMS as soon as possible after its discovery and sufficient details have been obtained.

6. The MCO, or Designee, may also submit the final, signed Non-Compliance Self-Disclosure Form outlining the course of actions that included the accepted CAP, and continued monitoring efforts to the CCO or Executive Director, and Director of the business unit and applicable Committees.

IV. ATTACHMENT(S)

A. Non-Compliance Self-Disclosure Form

V. REFERENCE(S)

A. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Health PACE Program Agreement
C. CalOptima Health Compliance Plan
D. CalOptima Health Policy HH.2005: Corrective Action Plan
E. "CMS Consideration of Self-Disclosure by Plan Sponsors of Non-Compliance Conduct in the Determination of Compliance Actions," Health Plan Management System, Issued 02/27/2013.
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.), §§422.503(b)(4)(vi)(G)
I. Title 42, Code of Federal Regulations (C.F.R.), §§423.504(b)(4)(vi)(G)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
12/07/2017	Regular Meeting of the CalOptima Board of Directors
12/06/2018	Regular Meeting of the CalOptima Board of Directors
12/05/2019	Regular Meeting of the CalOptima Board of Directors
12/03/2020	Regular Meeting of the CalOptima Board of Directors
12/20/2021	Special Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	08/01/2014	MA.9124	CMS Self Disclosure	OneCare
Revised	12/01/2014	MA.9124	CMS Self Disclosure	OneCare
Revised	09/01/2015	MA.9124	CMS Self Disclosure	OneCare OneCare Connect
Revised	12/01/2016	MA.9124	CMS Self Disclosure	OneCare OneCare Connect
Revised	12/07/2017	MA.9124	CMS Self-Disclosure	OneCare OneCare Connect

Action	Date	Policy	Policy Title	Program(s)
Revised	12/06/2018	MA.9124	CMS Self-Disclosure	OneCare OneCare Connect PACE
Revised	12/05/2019	MA.9124	CMS Self-Disclosure	OneCare OneCare Connect PACE
Revised	12/03/2020	MA.9124	CMS Self-Disclosure	OneCare OneCare Connect PACE
Revised	12/20/2021	MA.9124	CMS Self-Disclosure	OneCare OneCare Connect PACE
Revised	12/31/2022	MA.9124	CMS Self-Disclosure	OneCare PACE

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IX. GLOSSARY

Term	Definition
Audit	A formal, systematic, and disciplined approach designed to review, evaluate, and improve the effectiveness of processes and related controls using a particular set of standards (e.g., policies and procedures, laws and regulations) used as base measures. Auditing is governed by professional standards and completed by individuals independent of the process being Audited and normally performed by individuals with one of several acknowledged certifications
Centers for Medicare & Medicaid Services (CMS)	The federal agency within the United States Department of Health and Human Services (DHHS) that administers that Federal Medicare program and works in partnership with state governments to administer Medicaid programs.
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.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal Audits or monitoring activities by CalOptima Health, the Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services, or designated representatives. FDRs and/or CalOptima Health departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima Health and its regulators.
Department of Health Care Services (DHCS)	The California Department of Health Care Services, the State agency that oversees California's Medicaid program, known as 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.
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. PACE: A complaint, either written or oral, expressing dissatisfaction with service delivery or the quality of care furnished, as defined by the federal PACE regulation 42 CFR Section 460.120.
Member	A beneficiary enrolled in a CalOptima Health Program.
Provider	Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members.

Term	Definition
	Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B.
Self-Disclosure	The act of voluntarily notifying the compliance governing body of a non-compliance incident.

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NON-COMPLIANCE SELF-DISCLOSURE FORM

Person Submitting Form

Department Name or Organization (Vendor):	**Department (Vendor) Contact Name and Phone Number (Vendor Address, if applicable):**
Date Non-Compliance Allegation Received:	**Date of Non-Compliance:**
Summary of Issue:	
Root Cause:	
Member Impact (If applicable, how many and which members?)	

Non-Compliance Information

Who Caused the Issue?	**Who was Affected by the Issue?**
Remediation Taken (Step by Step of Who, What, When, and Where):	
Proof of Remediation:	
How will Dept./Vendor prevent this from happening again?	

For Office of Compliance Use Only

☐ Corrective Action Plan (CAP)	☐ Retrain	☐ No Action Required	☐ Other
Compliance Findings:			

Compliance Officer Signature:	**Date:**

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 1, 2022
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar
18. Approve Modifications to CalOptima Health Policy GA.3400: Annual Investments

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

Recommended Action
Approve modifications to CalOptima Health Policy GA.3400: Annual Investments.

Background
At the February 27, 1996, meeting, the CalOptima Health Board of Directors (Board) approved the Annual Investment Policy (AIP) covering investments made between March 1, 1996, and February 28, 1997. In September 1996, the Board authorized the creation of the Investment Advisory Committee (IAC). The IAC reviews the AIP annually and recommends policy revisions, if necessary, to the Finance and Audit Committee (FAC) and the Board for their respective approvals.

At the December 20, 2021, special meeting, the Board approved changes to CalOptima Health Policy GA.3400: Annual Investments for Calendar Year (CY) 2022. The policy was revised to extend the fixed maturity limit to three (3) years for certain permitted investments in the Operating Funds Portfolio, allow for 144a securities to conform to the California Government Code, and increase the maximum percentage of the portfolio from 30% to 40% that can be state and local California agency obligations.

Discussion
Payden & Rygel and MetLife, CalOptima Health's investment managers, and Meketa Investment Group, Inc., CalOptima Health's investment adviser, submitted proposed revisions to CalOptima Health Policy GA.3400: Annual Investments for CY 2023. Staff has reviewed the proposed revisions and recommends approval of the following modifications.

Below is a list of substantive changes to the policy, which are reflected in the attached redline. 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 Section	Proposed Change	Rationale	Impact
Page 11, Section III.D.2.L.i.a	Replace "traditional money market" with "comparable fixed rate"	To clarify that floating rate securities should be comparable to fixed rate securities	None
Page 12, Section III.E.3	Add (Code 40%) to Commercial Paper and detailed footnote	Provide clarification on Maximum Term allowed per the Code; no change to the current policy	None

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Policy Section	Proposed Change	Rationale	Impact
		maximum percent of allocation which is at 25%	

Fiscal Impact
There is no immediate fiscal impact.

Rationale for Recommendation
The proposed changes to CalOptima Health Policy GA.3400: Annual Investments reflect the recommendations of CalOptima Health's investment managers, Payden & Rygel and MetLife, with concurrence from CalOptima Health's investment adviser, Meketa Investment Group, Inc. These recommended changes continue to support CalOptima Health's goals to maintain safety of principal and achieve a market rate of return while maintaining necessary liquidity during periods of uncertainty. Per the review conducted by Meketa Investment Group, Inc., there were no changes in the California Government Code affecting local agencies noted for CY 2023.

Concurrence
Meketa Investment Group, Inc.
Troy R. Szabo, Outside General Counsel, Kennaday Leavitt
Investment Advisory Committee
Finance and Audit Committee

Attachments
1. Policy GA.3400: Annual Investment Policy – redline and clean versions

/s/ Michael Hunn *11/23/2022*
Authorized Signature **Date**

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Policy:	GA.3400
Title:	**Annual Investments**
Department:	CalOptima Health Administrative
Section:	Finance
CEO Approval:	*/s/*
Effective Date:	01/01/2018
Revised Date:	01/01/2023
Applicable to:	☐ Medi-Cal ☐ OneCare ~~☐ OneCare Connect~~ ☐ PACE ☒ Administrative

I. PURPOSE

This policy sets forth the investment guidelines for all Operating Funds and Board-Designated Reserve Funds of CalOptima Health invested on or after January 10, 2006, to ensure ~~CalOptima's~~CalOptima Health's funds are prudently invested according to the Board of Directors' objectives and the California Government Code to preserve Capital, provide necessary Liquidity, and achieve a market-average Rate of Return through Economic Cycles. Each annual review takes effect upon its adoption by the Board of Directors.

II. POLICY

A. CalOptima Health investments may only be made as authorized by this Policy.

1. This Policy shall conform to California Government Code, Section 53600 et seq. (hereinafter, the Code) as well as customary standards of prudent investment management. Should the provisions of the Code be, or become, more restrictive than those contained herein, such provisions shall be considered immediately incorporated into this Policy and adhered to.

2. Safety of Principal: Safety of Principal is the primary objective of CalOptima Health and, as such, each investment transaction shall seek to ensure that large Capital losses are avoided from securities or Broker-Dealer default.

   a. CalOptima Health shall seek to ensure that Capital losses are minimized from the erosion of market value and preserve principal by mitigating the two (2) types of Risk: Credit Risk and Market Risk.

      i. Credit Risk shall be mitigated by investing in only permitted investments and by diversifying the Investment Portfolio, in accordance with this Policy.

      ii. Market Risk shall be mitigated by matching Maturity Dates, to the extent possible, with ~~CalOptima's~~CalOptima Health's expected cash flow needs and other factors.

   b. It is explicitly recognized herein, however, that in a diversified portfolio, occasional losses are inevitable and must be considered within the context of the overall investment return.

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3. Liquidity: Liquidity is the second most important objective of CalOptima Health. It is important that each portfolio contain investments for which there is a secondary market, and which offer the flexibility to be easily sold at any time with minimal Risk of loss of either the principal or interest based upon then prevailing rates.

4. Total Return: ~~CalOptima's~~CalOptima Health's Investment Portfolios shall be designed to attain a market-average Rate of Return through Economic Cycles given an acceptable level of Risk, established by the Board of Directors' and the CalOptima Health Treasurer's objectives.

   a. The performance Benchmark for each Investment Portfolio shall be based upon published Market Indices as primary Benchmark, and Custom Peer Group Reports, as necessary, for short-term investments of comparable Risk and duration.

      i. These performance Benchmarks shall be reviewed monthly by CalOptima Health staff, and quarterly by ~~CalOptima's~~CalOptima Health's Treasurer and the Investment Advisory Committee members and shall be reported to the Board of Directors.

B. The investments purchased by an Investment Manager shall be held by the Custodian Bank acting as the agent of CalOptima Health under the terms of a custody agreement in compliance with California Government Code, Section 53608.

C. Investment Managers must certify that they will purchase securities from Broker-Dealers (other than themselves) or financial institutions in compliance with California Government Code, Section 53601.5 and this Policy.

D. The Board of Directors, or persons authorized to make investment decisions on behalf of CalOptima Health (e.g., Chief Officers), are trustees and fiduciaries subject to the Prudent Person Standard, as defined in the Code, which shall be applied in the context of managing an overall portfolio.

E. ~~CalOptima's~~CalOptima Health's Officers, employees, Board members, and Investment Advisory Committee members involved in the investment process shall refrain from personal and professional business activities that could conflict with the proper execution of the investment program, or which could impair their ability to fulfill their roles in the investment process.

   1. ~~CalOptima's~~CalOptima Health's Officers and employees involved in the investment process are not permitted to have any material financial interests in financial institutions, including state or federal credit unions, that conduct business with CalOptima Health, and are not permitted to have any personal financial, or investment holdings, that could be materially related to the performance of ~~CalOptima's~~CalOptima Health's investments.

F. On an annual basis, ~~CalOptima's~~CalOptima Health's Treasurer shall provide the Board of Directors with this Policy for review and adoption by the Board, to ensure that all investments made are following this Policy.

   1. This Policy shall be reviewed annually by the Board of Directors at a public meeting pursuant to California Government Code, Section 53646, Subdivision (a).

   2. This policy may only be changed by the Board of Directors.

III. PROCEDURE

A. Delegation of Authority

1. Authority to manage ~~CalOptima's~~CalOptima Health's investment program is derived from an order of the Board of Directors.

    a. Management responsibility for the investment program shall be delegated to ~~CalOptima's~~CalOptima Health's Treasurer, as appointed by the Board of Directors, for a one (1)-year period following the approval of this Policy.

        i. The Board of Directors may renew the delegation of authority annually.

    b. No person may engage in investment transactions except as provided under the terms of this Policy and the procedures established by ~~CalOptima's~~CalOptima Health's Treasurer.

B. CalOptima Health Treasurer Responsibilities

1. The Treasurer shall be responsible for:

    a. All actions undertaken and shall establish a system of controls to regulate the activities of subordinate officials and Board-approved Investment Managers;

    b. The oversight of ~~CalOptima's~~CalOptima Health's Investment Portfolio;

    c. Directing ~~CalOptima's~~CalOptima Health's investment program and for compliance with this Policy pursuant to the delegation of authority to invest funds or to sell or exchange securities; and

    d. Providing a quarterly report to the Board of Directors in accordance with California Government Code, Section 53646, Subdivision (b).

2. The Treasurer shall also be responsible for ensuring that:

    a. The Operating Funds and Board-Designated Reserve Funds targeted average maturities are established and reviewed monthly.

    b. All Investment Managers are provided a copy of this Policy, which shall be appended to an Investment Manager's investment contract.

        i. Any investments made by an Investment Manager outside this Policy may subject the Investment Manager to termination for cause or other appropriate remedies or sanctions, as determined by the Board of Directors.

    c. Investment diversification and portfolio performance is reviewed monthly to ensure that Risk levels and returns are reasonable and that investments are diversified in accordance with this Policy.

    d. All Investment Managers are selected and evaluated for review by the Chief Executive Officer and the Board of Directors.

C. Investment Advisory Committee

1. The Investment Advisory Committee shall not make, or direct, CalOptima Health staff to make any particular investment, purchase any particular investment product, or conduct business with any particular investment companies, or brokers.

a. It shall not be the purpose of the Investment Advisory Committee to advise on particular investment decisions of CalOptima Health.

2. The Investment Advisory Committee shall be responsible for the following functions:

a. Annual review of this Policy before its consideration by the Board of Directors and revision recommendations, as necessary, to the Finance and Audit Committee of the Board of Directors.

b. Quarterly review of ~~CalOptima's~~CalOptima Health's Investment Portfolio for conformance with this Policy's diversification and maturity guidelines, and recommendations to the Finance and Audit Committee of the Board of Directors, as appropriate.

c. Provision of comments to ~~CalOptima's~~CalOptima Health's staff regarding potential investments and potential investment strategies.

d. Performance of such additional duties and responsibilities pertaining to ~~CalOptima's~~CalOptima Health's investment program as may be required from time to time by specific action and direction of the Board of Directors.

D. Permitted Investments

1. CalOptima Health shall invest only in Instruments as permitted by the Code, subject to the limitations of this Policy.

a. Permitted investments under the Operating Funds, unless otherwise specified, are subject to a maximum stated term of three (3) years. Note that the Code allows for up to five (5) years.

b. Permitted investments under the Board-Designated Reserve Funds, unless otherwise specified, are subject to a maximum stated term of five (5) years. Note that the Code allows for up to five (5) years.

c. The Board of Directors must grant express written authority to make an investment, or to establish an investment program, of a longer term.

2. Permitted investments shall include:

a. U.S. Treasuries

i. These investments are direct obligations of the United States of America and securities which are fully and unconditionally guaranteed as to the timely payment of principal and interest by the full faith and credit of the United States of America.

ii. U.S. Government securities include:

a) Treasury Bills: U.S. Government securities issued and traded at a discount;

b) Treasury Notes and Bonds: Interest bearing debt obligations of the U.S. Government which guarantees interest and principal payments;

c) Treasury Separate Trading of Registered Interest and Principal Securities (STRIPS): U.S. Treasury securities that have been separated into their component

parts of principal and interest payments and recorded as such in the Federal Reserve book-entry record-keeping system;

d) Treasury Inflation Protected (TIPs) securities: Special U.S. Treasury notes, or Bonds, that offer protection from Inflation. Coupon payments and underlying principal are automatically increased to compensate for Inflation, as measured by the Consumer Price Index (CPI); and

e) Treasury Floating Rate Notes (FRNs): U.S. Treasury Bonds issued with a variable coupon.

iii. U.S. Treasury coupon and principal STRIPS, as well as TIPs, are not considered to be derivatives for the purposes of this Policy and are, therefore, permitted investments pursuant to this Policy.

iv. Maximum Term:

Fund Type	**Term Assigned**	**Term Allowed by the Code**
Operating Funds	3 years	5 years
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 5 years 5 years	 5 years 5 years

b. Federal Agencies and U.S. Government Sponsored Enterprises

i. These investments represent obligations, participations, or other Instruments of, or issued by, a federal agency or a U.S. government sponsored enterprise, including those issued by, or fully guaranteed as to principal and interest by, the issuers.

ii. These are U.S. Government related organizations, the largest of which are government financial intermediaries assisting specific credit markets (e.g., housing, agriculture). Often simply referred to as "Agencies," the following are specifically allowed:

a) Federal Home Loan Banks (FHLB);

b) Federal Home Loan Mortgage Corporation (FHLMC);

c) Federal National Mortgage Association (FNMA);

d) Federal Farm Credit Banks (FFCB);

e) Government National Mortgage Association (GNMA);

f) Small Business Administration (SBA);

g) Export-Import Bank of the United States;

h) U.S. Maritime Administration;

i) Washington Metro Area Transit Authority (WMATA);

j) U.S. Department of Housing & Urban Development;

k) Tennessee Valley Authority;

l) Federal Agricultural Mortgage Company (FAMC);

m) Federal Deposit Insurance Corporation (FDIC)-backed Structured Sale Guaranteed Notes (SSGNs); and

n) National Credit Union Administration (NCUA) securities.

iii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	3 years	5 years
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 5 years 5 years	 5 years 5 years

iv. Any Federal Agency and U.S. Government Sponsored Enterprise security not specifically mentioned above is not a permitted investment.

c. State and California Local Agency Obligations

i. Such obligations must be issued by an entity whose general obligation debt is rated P-1 by Moody's, or A-1 by Standard & Poor's, or Rated F1 by Fitch, or equivalent or better for short-term obligations, or an "A-" rating or its equivalent or better by a Nationally Recognized Statistical Rating Organization (NRSRO) for long-term obligations. Public agency Bonds issued for private purposes (e.g., industrial development Bonds) are specifically excluded as permitted investments.

ii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	3 years	5 years
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 5 years 5 years	 5 years 5 years

d. Banker's Acceptances

i. Time drafts which a bank "accepts" as its financial responsibility as part of a trade finance process. These short-term notes are sold at a discount, and are obligations of the drawer (i.e., the bank's trade finance client) as well as the bank. Once accepted, the bank is irrevocably obligated to pay the Banker's Acceptance (BA) upon maturity, if the drawer does not. Eligible banker's acceptances:

a) Are eligible for purchase by the Federal Reserve System~~,~~ and are drawn on and accepted by a bank rated F1, or better, by Fitch Ratings Service, or are rated A-l for short-term deposits by Standard & Poor's, or P-1 for short-term deposits by Moody's, or are comparably rated by a nationally recognized rating agency.

ii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	180 days	180 days
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 180 days 180 days	 180 days 180 days

e. Commercial Paper (CP)

i. CP is negotiable (i.e., marketable or transferable), although it is typically held to maturity. The maximum maturity is two hundred seventy (270) days, with most CP issued for terms of less than thirty (30) days. CP must meet the following criteria:

a) CP of "prime" quality, rated F1, or better, by Fitch Ratings Service, or are rated A-l for short-term deposits by Standard & Poor's, or P-1 for short-term by Moody's, or are comparably rated by a nationally recognized statistical rating organization (NRSRO);

b) The entity that issues the CP shall meet all of the following conditions in either paragraph (1) or (2):

(1) The entity meets the following criteria:

(A) Is organized and operating in the United States as a general corporation.

(B) Has total assets in excess of five hundred million dollars ($500,000,000).

(C) Has debt other than commercial paper, if any, that is rated in a Rating Category of "A" or its equivalent or higher by an NRSRO.

(2) The entity meets the following criteria:

(A) Is organized within the United States as a special purpose corporation, trust, or limited liability company.

(B) Has program wide credit enhancements including, but not limited to, overcollateralization, letters of credit, or a surety bond.

(C) Has commercial paper that is rated "A-1" or higher, or the equivalent, by an NRSRO; and

c) May not represent more than ten percent (10%) of the outstanding CP of the issuing corporation.

ii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	270 days	270 days
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 270 days 270 days	 270 days 270 days

f. Negotiable Certificates of Deposit

i. Negotiable Certificates of Deposit must be issued by a Nationally- or state-chartered bank, or state or federal association or by a state licensed branch of a foreign bank, which have been rated F1 or better, by Fitch Ratings Service, or are rated A-l for short-term deposits by Standard & Poor's and P-1 for short-term deposits by Moody's or are comparably rated by a nationally recognized rating agency.

ii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	1 year	5 years
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 1 year 1 year	 5 years 5 years

g. Repurchase Agreements

i. U.S. Treasury and U.S. Agency Repurchase Agreements collateralized by the U.S. Government may be purchased through any registered primary Broker-Dealer subject to the Securities Investors Protection Act, or any commercial bank insured by the Federal Deposit Insurance Corporation so long as at the time of the investment, such primary dealer (or its parent) has an uninsured, unsecured, and unguaranteed obligation rated P-1 short-term, or A-2 long-term, or better, by Moody's, and A-1 short-term, or A long-term, or better, by Standard & Poor's, and F1 short-term, or A long-term or better by Fitch Ratings Service provided:

a) A Broker-Dealer master repurchase agreement signed by the Investment Manager (acting as "Agent") and approved by CalOptima Health;

b) The securities are held free and clear of any Lien by ~~CalOptima's~~CalOptima Health's custodian or an independent third party acting as agent ("Agent") for the custodian, and such third party is (i) a Federal Reserve Bank, or (ii) a bank which is a member of the Federal Deposit Insurance Corporation and which has combined Capital, Surplus and undivided profits of not less than fifty million dollars ($50,000,000) and the custodian receives written confirmation from such third party that it holds such securities, free and clear of any Lien, as agent for ~~CalOptima's~~CalOptima Health's custodian;

c) A perfected first security interest under the Uniform Commercial Code, or book entry procedures prescribed at Title 31, Code of Federal Regulations, Section 306.1 et seq., and such securities are created for the benefit of ~~CalOptima's~~CalOptima Health's custodian and CalOptima Health; and

d) The Agent will notify ~~CalOptima's~~CalOptima Health's custodian and CalOptima Health if the Valuation of the Collateral Securities falls outside of policy. Upon direction by the CalOptima Health Treasurer, the Agent will liquidate the Collateral Securities if any deficiency in the required one hundred and two percent (102%) collateral percentage is not restored within one (1) business day of such Valuation.

ii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	30 days	1 year
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 30 days 30 days	 1 year 1 year

iii. Reverse Repurchase Agreements are not allowed.

h. Corporate Securities

i. For the purpose of this Policy, permissible Corporate Securities shall be rated in a Rating Category of "A" or its equivalent or better by an NRSRO and:

a) Be issued by corporations organized and operating within the U.S. or by depository institutions licensed by the U.S. or any state and operating within the U.S. and have total assets in excess of five hundred million dollars ($500,000,000), and

b) May not represent more than ten percent (10%) of the issue in the case of a specific public offering. This limitation does not apply to debt that is "continuously offered" in a mode similar to CP, i.e., Medium Term Notes (MTNs).

ii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	3 years	5 years
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 5 years 5 years	 5 years 5 years

i. Money Market Funds

i. Shares of beneficial interest issued by diversified management companies (i.e., money market funds):

a) Which are rated AAA (or equivalent highest ranking) by two (2) of the three (3) largest nationally recognized rating services; and

b) Such investment may not represent more than ten percent (10%) of the money market fund's assets.

j. Joint Powers Authority Pool

i. A joint powers authority formed pursuant to California Government Code; Section 6509.7 may issue shares of beneficial interest to participating public agencies. The joint powers authority issuing the shares shall have retained an Investment Advisor that meets all of the following criteria:

a) Registered or exempt from registration with the Securities and Exchange Commission;

b) No less than five (5) years of experience investing in the securities and obligations authorized in the Code; and

c) Assets under management in excess of five hundred million dollars ($500,000,000).

ii. A Joint Powers Authority Pool shall be rated AAA (or equivalent highest ranking) by two (2) of the three (3) largest nationally recognized rating services.

iii. Such investment may not represent more than ten percent (10%) of the Joint Powers Authority Pool's assets.

iv. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	Not Applicable	Not Applicable
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 Not Applicable Not Applicable	 Not Applicable Not Applicable

k. Mortgage or Asset-backed Securities

i. Pass-through securities are Instruments by which the cash flow from the mortgages, receivables, or other assets underlying the security, is passed-through as principal and interest payments to the investor.

ii. Though these securities may contain a third-party guarantee, they are a package of assets being sold by a trust, not a debt obligation of the sponsor. Other types of "backed" debt Instruments have assets (e.g., leases or consumer receivables) pledged to support the debt service.

iii. Any mortgage pass-through security, collateralized mortgage obligations, mortgage-backed or other pay-through bond, equipment lease-backed certificate, consumer receivable pass-through certificate, or consumer receivable-backed bond which:

a) Are rated AA or its equivalent or better by an NRSRO.

iv. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	3 years	5 years
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 5 years stated final maturity 5 years stated final maturity	 5 years 5 years

l. Variable and Floating Rate Securities

i. Variable and floating rate securities are appropriate investments when used to enhance yield and reduce Risk.

a) They should have the same stability, Liquidity, and quality as ~~traditional money market~~ comparable fixed rate securities.

b) A variable rate security provides for the automatic establishment of a new interest rate on pre-determined reset dates.

c) For the purposes of this Policy, a variable rate security and floating rate security shall be deemed to have a maturity equal to the period remaining to that pre-determined interest rate reset date, so long as no investment shall be made in a security that at the time of the investment has a term remaining to a stated final maturity in excess of five (5) years.

ii. Variable and floating rate securities, which are restricted to investments in permitted Federal Agencies and U.S. Government Sponsored Enterprises securities, Corporate Securities, Mortgage or Asset-backed Securities, Negotiable Certificates of Deposit, and Municipal Bonds (State and California Local Agency Obligations) must utilize a single, market-determined short-term index rate, such as U. S. Treasury bills, federal funds, CP, London Interbank Offered Rate (LIBOR), the Secured Overnight Financing Rate (SOFR), or Securities Industry and Financial Markets Association (SIFMA) that is pre-determined at the time of issuance of the security.

a) Permitted variable and floating rate securities that have an embedded unconditional put option must have a stated final maturity of the security no greater than five (5) years from the date of purchase.

b) Investments in floating rate securities whose reset is calculated using more than one (1) of the above indices are not permitted, i.e., dual index notes.

c) Ratings for variable and floating rate securities shall be limited to the same minimum ratings as applied to the appropriate asset security class outlined elsewhere in this Policy.

iii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	3 years	5 years
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 5 years 5 years	 5 years 5 years

m. Supranational Obligations

i. The three (3) Supranational Institutions that issue, or unconditionally guarantee, obligations that are eligible investments are:

a) International Bank for Reconstruction and Development (IBRD);

b) International Finance Corporation (IFC); and

c) Inter-American Development Bank (IADB).

ii. Supranational obligations shall be rated in a Rating Category of "AA" or its equivalent or better by a Nationally Statistical Rating Organization (NRSRO).

iii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	3 years	5 years
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 5 years 5 years	 5 years 5 years

n. Pooled Investments

i. Pooled investments include deposits, or investments pooled with those of other local agencies consistent with the requirements of California Government Code, Section 53635 et seq. Such pools may contain a variety of investments but are limited to those permissible under the Code.

E. Diversification Guidelines

1. Diversification guidelines ensure the portfolio is not unduly concentrated in the securities of one (1) type, industry, or entity, thereby assuring adequate portfolio Liquidity should one (1) sector or company experience difficulties.

2. ~~CalOptima's~~CalOptima Health's Investment Managers must review the respective portfolios they manage to ensure compliance with ~~CalOptima's~~CalOptima Health's diversification guidelines on a continuous basis.

3. *Table 1: Maximum Percentage (%) of Investment Portfolio, by Instrument Type*

INSTRUMENTS	MAXIMUM % OF PORTFOLIO AT TIME OF PURCHASE
A. U.S. Treasuries (including U.S. Treasury Coupon and principal STRIPS as well as TIPs)	100% (Code)
B. Federal Agencies and U.S. Government Sponsored Enterprises	100% (Code)
C. State and California Local Agency Obligations	40% (Code 100%)
D. Bankers Acceptances	30% (Code 40%)
E. Commercial Paper	25% (Code 40%[1])
F. Negotiable Certificates of Deposit	30% (Code)
G. Repurchase Agreements	100% (Code)
H. Corporate Securities	30% (Code)
I. Money Market Funds	20% (Code)
J. Joint Powers Authority Pool	100% (Code)
K. Mortgage or Asset-backed Securities	20% (Code)
L. Variable and Floating Rate Securities	30% (Code)
M. Supranational Obligations	30% (Code)

[1] The Code allows up to 40% for Pooled Funds and Non-Pooled Funds with a minimum $100,000,000 of investments. The Maximum Allocation is limited to 25% for Non-Pooled Funds with under $100,000,000 of investments.

4. Issuer or Counterparty Diversification Guidelines: The percentages specified below shall be adhered to on the basis of the entire portfolio:

   a. Any one (1) Federal Agency or Government Sponsored Enterprise: None

   b. Any one (1) repurchase agreement counterparty name:

      If maturity/term is ⩽ 7 days: 50%
      If maturity/term is > 7 days: 25%

5. Issuer or Counterparty Diversification Guidelines for all other permitted investments described in Section III.D.2.a-n. of this Policy.

   a. Any one (1) corporation, bank, local agency, or other corporate name for one (1) or more series of securities, and specifically with respect to special purpose vehicles issuers for mortgage or asset-backed securities, the maximum issuer limits apply at the deal level with each securitized trust being considered a unique "issuer."

   b. Except for U.S. Government or Agency securities, no more than five percent (5%) of the Portfolio's market value will be invested in securities of a single issuer.

6. Each Investment Manager shall adhere to the diversification limits discussed in this subsection.

   a. If an Investment Manager exceeds the aforementioned diversification limits, the Investment Manager shall inform ~~CalOptima's~~CalOptima Health's Treasurer and Investment Advisory consultant (if any) by close of business on the day of the occurrence.

   b. Within the parameters authorized by the Code, the Investment Advisory Committee recognizes the practicalities of portfolio management, securities maturing and changing status, and market volatility, and, as such, will consider breaches in the context of.

      i. The amount in relation to the total portfolio concentration;

      ii. Market and security specific conditions contributing to a breach of this Policy; and

      iii. The Investment Managers' actions to enforce the spirit of this Policy and decisions made in the best interest of the portfolio.

F. Maximum Stated Term

1. Maximum stated terms for permitted investments shall be determined based on the settlement date (not the trade date) upon purchase of the security and the stated final maturity of the security.

G. Rating Downgrades

1. CalOptima Health may from time to time be invested in a security whose rating is downgraded below the quality criteria permitted by this Policy.

2. If the rating of any security held as an investment falls below the investment guidelines, the Investment Manager shall notify ~~CalOptima's~~CalOptima Health's Treasurer, or Designee, within two (2) business days of the downgrade.

a. A decision to retain a downgraded security shall be approved by ~~CalOptima's~~CalOptima Health's Treasurer, or Designee, within five (5) business days of the downgrade.

H. Investment Restrictions

1. Investment securities shall not be lent to an Investment Manager, or Broker-Dealer.

2. The Investment Portfolio or Investment Portfolios, managed by an Investment Manager, shall not be used as collateral to obtain additional investable funds.

3. Any investment not specifically referred to herein shall be considered a prohibited investment.

4. CalOptima Health reserves the right to prohibit its Investment Managers from making investments in organizations which have a line of business that conflicts with the interests of public health, as determined by the Board of Directors.

5. CalOptima Health reserves the right to prohibit investments in organizations with which it has a business relationship through contracting, purchasing, or other arrangements.

6. Except as expressly permitted by this Policy, investments in derivative securities shall not be allowed.

7. A list of prohibited investments does not currently exist, however, the Board of Directors shall provide ~~CalOptima's~~CalOptima Health's Treasurer, Investment Managers, Investment Advisory consultant, and Investment Advisory Committee with a list, should such a list be adopted by CalOptima Health in the future, of organizations that do not comply with this Policy and shall immediately notify ~~CalOptima's~~CalOptima Health's Treasurer, Investment Managers, Investment Advisory consultant and Investment Advisory Committee of any changes.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. California Government Code, §6509.7
B. California Government Code, §53600 et seq.
C. California Government Code, §53601(h), (k), (q)
D. California Government Code, §53635 et seq.
E. California Government Code. §53646, Subdivision (a) and Subdivision (b)
F. Title 31, Code of Federal Regulations (C.F.R.), §306.1 et seq.

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
10/30/2017	Special Meeting of the CalOptima Investment Advisory Committee
11/16/2017	Regular Meeting of the CalOptima Finance and Audit Committee
12/07/2017	Regular Meeting of the CalOptima Board of Directors

Date	Meeting
11/05/2018	Special Meeting of the CalOptima Investment Advisory Committee
11/15/2018	Regular Meeting of the CalOptima Finance and Audit Committee
12/06/2018	Regular Meeting of the CalOptima Board of Directors
10/21/2019	Regular Meeting of the CalOptima Investment Advisory Committee
11/15/2019	Regular Meeting of the CalOptima Finance and Audit Committee
12/05/2019	Regular Meeting of the CalOptima Board of Directors
06/04/2020	Regular Meeting of the CalOptima Board of Directors
10/19/2020	Regular Meeting of the CalOptima Investment Advisory Committee
11/19/2020	Regular Meeting of the CalOptima Finance and Audit Committee
12/03/2020	Regular Meeting of the CalOptima Board of Directors
10/25/2021	Regular Meeting of the CalOptima Investment Advisory Committee
11/18/2021	Regular Meeting of the CalOptima Finance and Audit Committee
12/20/2021	Special Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Health Investment Advisory Committee
TBD	Regular Meeting of the CalOptima Health Finance and Audit Committee
TBD	Special Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2018	GA.3400	Annual Investments	Administrative
Revised	01/01/2019	GA.3400	Annual Investments	Administrative
Revised	01/01/2020	GA.3400	Annual Investments	Administrative
Revised	06/04/2020	GA.3400	Annual Investments	Administrative
Revised	01/01/2021	GA.3400	Annual Investments	Administrative
Revised	01/01/2022	GA.3400	Annual Investments	Administrative
Revised	01/01/2023	GA.3400	Annual Investments	Administrative

IX. GLOSSARY

Term	Definition
Banker's Acceptance (BA)	Time drafts which a bank "accepts" as its financial responsibility as part of a trade finance process. These short-term notes are sold at a discount, and are obligations of the drawer (i.e., the bank's trade finance client) as well as the bank. Once accepted, the bank is irrevocably obligated to pay the banker's acceptance (BA) upon maturity, if the drawer does not. Eligible banker's acceptances: • Are eligible for purchase by the Federal Reserve System, and are drawn on and accepted by a bank rated F1, or better, by Fitch Ratings Service, or are rated A-l for short-term deposits by Standard & Poor's, or P-1 for short-term deposits by Moody's, or are comparably rated by a nationally recognized rating agency; and • May not exceed the five percent (5%) limit of any one (1) commercial bank and may not exceed the five percent (5%) limit for any security of any bank.
Benchmark	Benchmarks are usually constructed using unmanaged indices, exchange-traded Funds or mutual fund categories to represent each asset class. Benchmarks are often used as a tool to assess the allocation, Risk and return of a portfolio.
Board-Designated Reserve Funds	Funds established to address unexpected agency needs and not intended for use in the normal course of business. The amount of Board-Designated Reserve Funds should be offset by any working Capital or net current asset deficits. The desired level for these funds is a minimum of 1.4 and maximum of 2.0 months of capitation revenues as specified by CalOptima Health Policy GA.3001: Board-Designated Reserve Funds. The Board-Designated Reserve Funds shall be managed and invested as follows: 1. Tier One a. Used for the benefit and protection of ~~CalOptima's~~CalOptima Health's long-term financial viability; b. Used to cover "Special Purposes" as defined in CalOptima Health Policy GA.3001: Board-Designated Reserve Funds; or c. May be used for operational cash flow needs in lieu of a bank line of credit in the event of disruption of monthly capitation revenue receipts from the State, subject to the Board-Designated Reserve Funds having a "floor" equal to Tier Two requirements. 2. Tier Two a. Used to meet ~~CalOptima's~~CalOptima Health's regulatory compliance requirements; or b. Currently defined as ~~CalOptima's~~CalOptima Health's tangible net equity requirements as defined by Subdivision (e) of Section 1300.76 of Title 28 of the California Code of Regulations.
Bonds	A debt security, under which the issuer owes the holders a debt and, depending on the terms of the bond, is obliged to pay them interest (the coupon) and/or to repay the principal at a later date, termed the maturity date.

Term	Definition
Broker-Dealer	In financial services, a Broker-Dealer is a natural person, a company or other organization that engages in the business of trading securities for its own account or on behalf of its customers.
CalOptima Health Treasurer	Appointed by ~~CalOptima's~~CalOptima Health's Board of Directors, the treasurer is a person responsible for overseeing ~~CalOptima's~~CalOptima Health's investment funds.
Capital	Capital refers to financial assets or the financial value of assets, in the form of money or other assets owned by an organization.
Cash Flow Draws	Amount of cash needs to support CalOptima Health business operation.
Chief Officers	For the purposes of this policy, may include, but is not limited to, the Chief Executive Officer (CEO), Chief Financial Officer (CFO), and/or Chief Counsel.
Collateral Securities	A security given in addition to the direct security, and subordinate to it, intended to guarantee its validity or convertibility or insure its performance; so that, if the direct security fails, the creditor may fall back upon the collateral security.
Commercial Paper (CP)	Unsecured promissory notes issued by companies and government entities at a discount.
Consumer Price Index (CPI)	The Consumer Price Indexes (CPI) program produces monthly data on changes in the prices paid by urban consumers for a representative basket of goods and services.
Corporate Securities	Notes issued by corporations organized and operating within the U.S. or by depository institutions licensed by the U.S. or any state, and operating within the U.S.
Credit Risk	The Risk of loss due to failure of the issuer of a security.
Custodian Bank	A specialized financial institution responsible for safeguarding a firm's or individual's financial assets and is not engaged in "traditional" commercial or consumer/retail banking such as mortgage or personal lending, branch banking, personal accounts, automated teller machines (ATMs) and so forth.
Custom Peer Group Report	Developed based on a small peer universe with similar investment guidelines. The Purpose of the report is to provide more accurate performance comparison.
Designee	For purposes of this policy, a person who has been designated to act on behalf of the CalOptima Health Treasurer.
Economic Cycles	The natural fluctuation of the economy between periods of expansion (growth) and contraction (recession).
Finance and Audit Committee (FAC)	A standing committee of the CalOptima Health Board of Directors with oversight responsibilities for all financial matters of CalOptima Health including but not limited to: budget development and approval, financial reporting, investment practices and policies, purchasing and procurement practices and policies, insurance issues, and capitation and claims. The Committee serves as the primary level of Board review for any finance-related issues or policies affecting the CalOptima Health program.
Inflation	Inflation is the rate at which the general level of prices for goods and services is rising and, consequently, the purchasing power of currency is falling.
Instrument	Refers to a financial Instrument or asset that can be traded. These assets can be cash, Bonds, or shares in a company
Investment Advisor(s)	Registered or non-registered person or group that makes investment recommendations or conducts securities analysis in return for a fee.

Term	Definition
Investment Advisory Committee (IAC)	A standing committee of the CalOptima Health Board of Directors who provide advice and recommendations regarding ~~CalOptima's~~CalOptima Health's Investment Policies, Procedures and Practices.
Investment Manager(s)	A person or organization that makes investments in portfolios of securities on behalf of clients, in accordance with the investment objectives and parameters defined by these clients.
Investment Portfolio	A grouping of financial assets such as stocks, Bonds and cash equivalents, as well as their funds counterparts, including mutual, exchange-traded and closed funds. Portfolios are held directly by investors and/or managed by financial professionals.
Joint Powers Authority Pool	Shares of beneficial interest issued by a joint powers authority organized pursuant to California Government Code, Section 6509.7; each share represents an equal proportional interest in the Underlying Pool of Securities owned by the joint powers authority.
Lien	A legal right granted by the owner of property, by a law or otherwise acquired by a creditor
Liquidity	Liquidity describes the degree to which an asset or security can be quickly bought or sold in the market without affecting the asset's price.
Market Indices	Measurements of the value of a section of the stock market. It is computed from the prices of selected stocks (typically a weighted average).
Market Risk	The Risk of market value fluctuations due to overall changes in the general level of interest rates.
Maturity Dates	The date on which the principal amount of a note, draft, acceptance bond or another debt Instrument becomes due and is repaid to the investor and interest payments stop. It is also the termination or due date on which an installment loan must be paid in full.
Medium Term Notes (MTN)	A debt note that usually matures (is paid back) in five (5) – ten (10) years, but the term may be less than one (1) year or as long as one hundred (100) years. They can be issued on a fixed or floating coupon basis.
Nationally Recognized Statistical Ratings Organization (NRSRO)	A credit rating agency that the Securities and Exchange Commission in the United States registers and uses for regulatory purposes. Current NRSROs listed at www.sec.gov/ocr/ocr-current-nrsros.html.
Negotiable Certificates of Deposit	A negotiable (i.e., marketable or transferable) receipt for a time deposit at a bank or other financial institution, for a fixed time and interest rate.
Operating Funds	Funds intended to serve as a money market account for CalOptima Health to meet daily operating requirements. Deposits to this fund are comprised of State warrants that represent ~~CalOptima's~~CalOptima Health's monthly capitation revenues from its State contracts. Disbursements from this fund to ~~CalOptima's~~CalOptima Health's operating cash accounts are intended to meet operating expenses, payments to providers and other payments required in day-to-day operations.
Prudent Person Standard	When investing, reinvesting, purchasing, acquiring, exchanging, selling, or managing public funds, a trustee shall act with care, skill, prudence, and diligence under the circumstances then prevailing, including but not limited to, the general economic conditions and the anticipated needs of the agency, that a prudent person acting in a like capacity and familiarity with those matters would use in the conduct of funds of a like character and with like aims, to safeguard the principal and maintain the Liquidity needs of the agency (California Government Code, Section 53600.3)

Term	Definition
Rate of Return	The gain or loss on an investment over a specified time period, expressed as a percentage of the investment's cost. Gains on investments are defined as income received plus any Capital gains realized on the sale of the investment.
Rating Category	With respect to any long-term category, all ratings designated by a particular letter or combination of letters, without regard to any numerical modifier, plus or minus sign or other modifier.
Repurchase Agreements	A purchase of securities under a simultaneous agreement to sell these securities back at a fixed price on some future date.
Risk	Investment Risk can be defined as the probability or likelihood of occurrence of losses relative to the expected return on any particular investment. Description: Stating simply, it is a measure of the level of uncertainty of achieving the returns as per the expectations of the investor.
State and California Local Agency Obligations	Registered warrants, notes or Bonds of any of the fifty (50) U.S. states, including Bonds payable solely out of the revenues from a revenue-producing property owned, controlled, or operated by a state or by a department, board, agency, or authority of any of the fifty (50) U.S. states. Additionally, Bonds, notes, warrants, or other evidences of indebtedness of any local agency within the State of California, including Bonds payable solely out of revenues from a revenue producing property owned, controlled, or operated by the state or local agency, or by a department, board, agency or authority of the State or local agency.
Supranational Institutions	International institutions formed by two (2) or more governments that transcend boundaries to pursue mutually beneficial economic or social goals.
Surplus	Assets beyond liabilities.
Underlying Pool of Securities	Those securities and obligations that are eligible for direct investment by local public agencies.
Valuation	An estimation of the worth of a financial Instrument or asset. ~~CalOptima's~~CalOptima Health's asset managers provide CalOptima Health with reporting that shows the Valuation of each financial Instrument that they own on behalf of CalOptima Health. Each asset manager uses a variety of market sources to determine individual Valuations.

Policy:	GA.3400
Title:	**Annual Investments**
Department:	CalOptima Health Administrative
Section:	Finance
CEO Approval:	*/s/*
Effective Date:	01/01/2018
Revised Date:	01/01/2023
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ PACE ☒ Administrative

I. PURPOSE

This policy sets forth the investment guidelines for all Operating Funds and Board-Designated Reserve Funds of CalOptima Health invested on or after January 10, 2006, to ensure CalOptima Health's funds are prudently invested according to the Board of Directors' objectives and the California Government Code to preserve Capital, provide necessary Liquidity, and achieve a market-average Rate of Return through Economic Cycles. Each annual review takes effect upon its adoption by the Board of Directors.

II. POLICY

A. CalOptima Health investments may only be made as authorized by this Policy.

1. This Policy shall conform to California Government Code, Section 53600 et seq. (hereinafter, the Code) as well as customary standards of prudent investment management. Should the provisions of the Code be, or become, more restrictive than those contained herein, such provisions shall be considered immediately incorporated into this Policy and adhered to.

2. Safety of Principal: Safety of Principal is the primary objective of CalOptima Health and, as such, each investment transaction shall seek to ensure that large Capital losses are avoided from securities or Broker-Dealer default.

   a. CalOptima Health shall seek to ensure that Capital losses are minimized from the erosion of market value and preserve principal by mitigating the two (2) types of Risk: Credit Risk and Market Risk.

      i. Credit Risk shall be mitigated by investing in only permitted investments and by diversifying the Investment Portfolio, in accordance with this Policy.

      ii. Market Risk shall be mitigated by matching Maturity Dates, to the extent possible, with CalOptima Health's expected cash flow needs and other factors.

   b. It is explicitly recognized herein, however, that in a diversified portfolio, occasional losses are inevitable and must be considered within the context of the overall investment return.

3. Liquidity: Liquidity is the second most important objective of CalOptima Health. It is important that each portfolio contain investments for which there is a secondary market, and

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which offer the flexibility to be easily sold at any time with minimal Risk of loss of either the principal or interest based upon then prevailing rates.

4. Total Return: CalOptima Health's Investment Portfolios shall be designed to attain a market-average Rate of Return through Economic Cycles given an acceptable level of Risk, established by the Board of Directors' and the CalOptima Health Treasurer's objectives.

   a. The performance Benchmark for each Investment Portfolio shall be based upon published Market Indices as primary Benchmark, and Custom Peer Group Reports, as necessary, for short-term investments of comparable Risk and duration.

      i. These performance Benchmarks shall be reviewed monthly by CalOptima Health staff, and quarterly by CalOptima Health's Treasurer and the Investment Advisory Committee members and shall be reported to the Board of Directors.

B. The investments purchased by an Investment Manager shall be held by the Custodian Bank acting as the agent of CalOptima Health under the terms of a custody agreement in compliance with California Government Code, Section 53608.

C. Investment Managers must certify that they will purchase securities from Broker-Dealers (other than themselves) or financial institutions in compliance with California Government Code, Section 53601.5 and this Policy.

D. The Board of Directors, or persons authorized to make investment decisions on behalf of CalOptima Health (e.g., Chief Officers), are trustees and fiduciaries subject to the Prudent Person Standard, as defined in the Code, which shall be applied in the context of managing an overall portfolio.

E. CalOptima Health's Officers, employees, Board members, and Investment Advisory Committee members involved in the investment process shall refrain from personal and professional business activities that could conflict with the proper execution of the investment program, or which could impair their ability to fulfill their roles in the investment process.

   1. CalOptima Health's Officers and employees involved in the investment process are not permitted to have any material financial interests in financial institutions, including state or federal credit unions, that conduct business with CalOptima Health, and are not permitted to have any personal financial, or investment holdings, that could be materially related to the performance of CalOptima Health's investments.

F. On an annual basis, CalOptima Health's Treasurer shall provide the Board of Directors with this Policy for review and adoption by the Board, to ensure that all investments made are following this Policy.

   1. This Policy shall be reviewed annually by the Board of Directors at a public meeting pursuant to California Government Code, Section 53646, Subdivision (a).

   2. This policy may only be changed by the Board of Directors.

III. PROCEDURE

A. Delegation of Authority

   1. Authority to manage CalOptima Health's investment program is derived from an order of the Board of Directors.

a. Management responsibility for the investment program shall be delegated to CalOptima Health's Treasurer, as appointed by the Board of Directors, for a one (1)-year period following the approval of this Policy.

i. The Board of Directors may renew the delegation of authority annually.

b. No person may engage in investment transactions except as provided under the terms of this Policy and the procedures established by CalOptima Health's Treasurer.

B. CalOptima Health Treasurer Responsibilities

1. The Treasurer shall be responsible for:

a. All actions undertaken and shall establish a system of controls to regulate the activities of subordinate officials and Board-approved Investment Managers;

b. The oversight of CalOptima Health's Investment Portfolio;

c. Directing CalOptima Health's investment program and for compliance with this Policy pursuant to the delegation of authority to invest funds or to sell or exchange securities; and

d. Providing a quarterly report to the Board of Directors in accordance with California Government Code, Section 53646, Subdivision (b).

2. The Treasurer shall also be responsible for ensuring that:

a. The Operating Funds and Board-Designated Reserve Funds targeted average maturities are established and reviewed monthly.

b. All Investment Managers are provided a copy of this Policy, which shall be appended to an Investment Manager's investment contract.

i. Any investments made by an Investment Manager outside this Policy may subject the Investment Manager to termination for cause or other appropriate remedies or sanctions, as determined by the Board of Directors.

c. Investment diversification and portfolio performance is reviewed monthly to ensure that Risk levels and returns are reasonable and that investments are diversified in accordance with this Policy.

d. All Investment Managers are selected and evaluated for review by the Chief Executive Officer and the Board of Directors.

C. Investment Advisory Committee

1. The Investment Advisory Committee shall not make, or direct, CalOptima Health staff to make any particular investment, purchase any particular investment product, or conduct business with any particular investment companies, or brokers.

a. It shall not be the purpose of the Investment Advisory Committee to advise on particular investment decisions of CalOptima Health.

2. The Investment Advisory Committee shall be responsible for the following functions:

   a. Annual review of this Policy before its consideration by the Board of Directors and revision recommendations, as necessary, to the Finance and Audit Committee of the Board of Directors.

   b. Quarterly review of CalOptima Health's Investment Portfolio for conformance with this Policy's diversification and maturity guidelines, and recommendations to the Finance and Audit Committee of the Board of Directors, as appropriate.

   c. Provision of comments to CalOptima Health's staff regarding potential investments and potential investment strategies.

   d. Performance of such additional duties and responsibilities pertaining to CalOptima Health's investment program as may be required from time to time by specific action and direction of the Board of Directors.

D. Permitted Investments

1. CalOptima Health shall invest only in Instruments as permitted by the Code, subject to the limitations of this Policy.

   a. Permitted investments under the Operating Funds, unless otherwise specified, are subject to a maximum stated term of three (3) years. Note that the Code allows for up to five (5) years.

   b. Permitted investments under the Board-Designated Reserve Funds, unless otherwise specified, are subject to a maximum stated term of five (5) years. Note that the Code allows for up to five (5) years.

   c. The Board of Directors must grant express written authority to make an investment, or to establish an investment program, of a longer term.

2. Permitted investments shall include:

   a. U.S. Treasuries

      i. These investments are direct obligations of the United States of America and securities which are fully and unconditionally guaranteed as to the timely payment of principal and interest by the full faith and credit of the United States of America.

      ii. U.S. Government securities include:

         a) Treasury Bills: U.S. Government securities issued and traded at a discount;

         b) Treasury Notes and Bonds: Interest bearing debt obligations of the U.S. Government which guarantees interest and principal payments;

         c) Treasury Separate Trading of Registered Interest and Principal Securities (STRIPS): U.S. Treasury securities that have been separated into their component parts of principal and interest payments and recorded as such in the Federal Reserve book-entry record-keeping system;

d) Treasury Inflation Protected (TIPs) securities: Special U.S. Treasury notes, or Bonds, that offer protection from Inflation. Coupon payments and underlying principal are automatically increased to compensate for Inflation, as measured by the Consumer Price Index (CPI); and

e) Treasury Floating Rate Notes (FRNs): U.S. Treasury Bonds issued with a variable coupon.

iii. U.S. Treasury coupon and principal STRIPS, as well as TIPs, are not considered to be derivatives for the purposes of this Policy and are, therefore, permitted investments pursuant to this Policy.

iv. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	3 years	5 years
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 5 years 5 years	 5 years 5 years

b. Federal Agencies and U.S. Government Sponsored Enterprises

i. These investments represent obligations, participations, or other Instruments of, or issued by, a federal agency or a U.S. government sponsored enterprise, including those issued by, or fully guaranteed as to principal and interest by, the issuers.

ii. These are U.S. Government related organizations, the largest of which are government financial intermediaries assisting specific credit markets (e.g., housing, agriculture). Often simply referred to as "Agencies," the following are specifically allowed:

a) Federal Home Loan Banks (FHLB);

b) Federal Home Loan Mortgage Corporation (FHLMC);

c) Federal National Mortgage Association (FNMA);

d) Federal Farm Credit Banks (FFCB);

e) Government National Mortgage Association (GNMA);

f) Small Business Administration (SBA);

g) Export-Import Bank of the United States;

h) U.S. Maritime Administration;

i) Washington Metro Area Transit Authority (WMATA);

j) U.S. Department of Housing & Urban Development;

k) Tennessee Valley Authority;

l) Federal Agricultural Mortgage Company (FAMC);

m) Federal Deposit Insurance Corporation (FDIC)-backed Structured Sale Guaranteed Notes (SSGNs); and

n) National Credit Union Administration (NCUA) securities.

iii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	3 years	5 years
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 5 years 5 years	 5 years 5 years

iv. Any Federal Agency and U.S. Government Sponsored Enterprise security not specifically mentioned above is not a permitted investment.

c. State and California Local Agency Obligations

i. Such obligations must be issued by an entity whose general obligation debt is rated P-1 by Moody's, or A-1 by Standard & Poor's, or Rated F1 by Fitch, or equivalent or better for short-term obligations, or an "A-" rating or its equivalent or better by a Nationally Recognized Statistical Rating Organization (NRSRO) for long-term obligations. Public agency Bonds issued for private purposes (e.g., industrial development Bonds) are specifically excluded as permitted investments.

ii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	3 years	5 years
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 5 years 5 years	 5 years 5 years

d. Banker's Acceptances

i. Time drafts which a bank "accepts" as its financial responsibility as part of a trade finance process. These short-term notes are sold at a discount, and are obligations of the drawer (i.e., the bank's trade finance client) as well as the bank. Once accepted, the bank is irrevocably obligated to pay the Banker's Acceptance (BA) upon maturity, if the drawer does not. Eligible banker's acceptances:

a) Are eligible for purchase by the Federal Reserve System and are drawn on and accepted by a bank rated F1, or better, by Fitch Ratings Service, or are rated A-l for short-term deposits by Standard & Poor's, or P-1 for short-term deposits by Moody's, or are comparably rated by a nationally recognized rating agency.

ii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	180 days	180 days

Fund Type	Term Assigned	Term Allowed by the Code
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 180 days 180 days	 180 days 180 days

e. Commercial Paper (CP)

i. CP is negotiable (i.e., marketable or transferable), although it is typically held to maturity. The maximum maturity is two hundred seventy (270) days, with most CP issued for terms of less than thirty (30) days. CP must meet the following criteria:

a) CP of "prime" quality, rated F1, or better, by Fitch Ratings Service, or are rated A-l for short-term deposits by Standard & Poor's, or P-1 for short-term by Moody's, or are comparably rated by a nationally recognized statistical rating organization (NRSRO);

b) The entity that issues the CP shall meet all of the following conditions in either paragraph (1) or (2):

(1) The entity meets the following criteria:

(A) Is organized and operating in the United States as a general corporation.

(B) Has total assets in excess of five hundred million dollars ($500,000,000).

(C) Has debt other than commercial paper, if any, that is rated in a Rating Category of "A" or its equivalent or higher by an NRSRO.

(2) The entity meets the following criteria:

(A) Is organized within the United States as a special purpose corporation, trust, or limited liability company.

(B) Has program wide credit enhancements including, but not limited to, overcollateralization, letters of credit, or a surety bond.

(C) Has commercial paper that is rated "A-1" or higher, or the equivalent, by an NRSRO; and

c) May not represent more than ten percent (10%) of the outstanding CP of the issuing corporation.

ii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	270 days	270 days
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 270 days 270 days	 270 days 270 days

f. Negotiable Certificates of Deposit

i. Negotiable Certificates of Deposit must be issued by a Nationally- or state-chartered bank, or state or federal association or by a state licensed branch of a foreign bank, which have been rated F1 or better, by Fitch Ratings Service, or are rated A-l for short-term deposits by Standard & Poor's and P-1 for short-term deposits by Moody's or are comparably rated by a nationally recognized rating agency.

ii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	1 year	5 years
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 1 year 1 year	 5 years 5 years

g. Repurchase Agreements

i. U.S. Treasury and U.S. Agency Repurchase Agreements collateralized by the U.S. Government may be purchased through any registered primary Broker-Dealer subject to the Securities Investors Protection Act, or any commercial bank insured by the Federal Deposit Insurance Corporation so long as at the time of the investment, such primary dealer (or its parent) has an uninsured, unsecured, and unguaranteed obligation rated P-1 short-term, or A-2 long-term, or better, by Moody's, and A-1 short-term, or A long-term, or better, by Standard & Poor's, and F1 short-term, or A long-term or better by Fitch Ratings Service provided:

a) A Broker-Dealer master repurchase agreement signed by the Investment Manager (acting as “Agent”) and approved by CalOptima Health;

b) The securities are held free and clear of any Lien by CalOptima Health's custodian or an independent third party acting as agent ("Agent") for the custodian, and such third party is (i) a Federal Reserve Bank, or (ii) a bank which is a member of the Federal Deposit Insurance Corporation and which has combined Capital, Surplus and undivided profits of not less than fifty million dollars ($50,000,000) and the custodian receives written confirmation from such third party that it holds such securities, free and clear of any Lien, as agent for CalOptima Health's custodian;

c) A perfected first security interest under the Uniform Commercial Code, or book entry procedures prescribed at Title 31, Code of Federal Regulations, Section 306.1 et seq., and such securities are created for the benefit of CalOptima Health's custodian and CalOptima Health; and

d) The Agent will notify CalOptima Health's custodian and CalOptima Health if the Valuation of the Collateral Securities falls outside of policy. Upon direction by the CalOptima Health Treasurer, the Agent will liquidate the Collateral Securities if any deficiency in the required one hundred and two percent (102%) collateral percentage is not restored within one (1) business day of such Valuation.

ii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	30 days	1 year
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 30 days 30 days	 1 year 1 year

iii. Reverse Repurchase Agreements are not allowed.

h. Corporate Securities

i. For the purpose of this Policy, permissible Corporate Securities shall be rated in a Rating Category of "A" or its equivalent or better by an NRSRO and:

a) Be issued by corporations organized and operating within the U.S. or by depository institutions licensed by the U.S. or any state and operating within the U.S. and have total assets in excess of five hundred million dollars ($500,000,000), and

b) May not represent more than ten percent (10%) of the issue in the case of a specific public offering. This limitation does not apply to debt that is "continuously offered" in a mode similar to CP, i.e., Medium Term Notes (MTNs).

ii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	3 years	5 years
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 5 years 5 years	 5 years 5 years

i. Money Market Funds

i. Shares of beneficial interest issued by diversified management companies (i.e., money market funds):

a) Which are rated AAA (or equivalent highest ranking) by two (2) of the three (3) largest nationally recognized rating services; and

b) Such investment may not represent more than ten percent (10%) of the money market fund's assets.

j. Joint Powers Authority Pool

i. A joint powers authority formed pursuant to California Government Code; Section 6509.7 may issue shares of beneficial interest to participating public agencies. The joint powers authority issuing the shares shall have retained an Investment Advisor that meets all of the following criteria:

a) Registered or exempt from registration with the Securities and Exchange Commission;

b) No less than five (5) years of experience investing in the securities and obligations authorized in the Code; and

c) Assets under management in excess of five hundred million dollars ($500,000,000).

ii. A Joint Powers Authority Pool shall be rated AAA (or equivalent highest ranking) by two (2) of the three (3) largest nationally recognized rating services.

iii. Such investment may not represent more than ten percent (10%) of the Joint Powers Authority Pool's assets.

iv. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	Not Applicable	Not Applicable
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 Not Applicable Not Applicable	 Not Applicable Not Applicable

k. Mortgage or Asset-backed Securities

i. Pass-through securities are Instruments by which the cash flow from the mortgages, receivables, or other assets underlying the security, is passed-through as principal and interest payments to the investor.

ii. Though these securities may contain a third-party guarantee, they are a package of assets being sold by a trust, not a debt obligation of the sponsor. Other types of "backed" debt Instruments have assets (e.g., leases or consumer receivables) pledged to support the debt service.

iii. Any mortgage pass-through security, collateralized mortgage obligations, mortgage-backed or other pay-through bond, equipment lease-backed certificate, consumer receivable pass-through certificate, or consumer receivable-backed bond which:

a) Are rated AA or its equivalent or better by an NRSRO.

iv. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	3 years	5 years
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 5 years stated final maturity 5 years stated final maturity	 5 years 5 years

l. Variable and Floating Rate Securities

i. Variable and floating rate securities are appropriate investments when used to enhance yield and reduce Risk.

a) They should have the same stability, Liquidity, and quality as comparable fixed rate securities.

b) A variable rate security provides for the automatic establishment of a new interest rate on pre-determined reset dates.

c) For the purposes of this Policy, a variable rate security and floating rate security shall be deemed to have a maturity equal to the period remaining to that pre-determined interest rate reset date, so long as no investment shall be made in a security that at the time of the investment has a term remaining to a stated final maturity in excess of five (5) years.

ii. Variable and floating rate securities, which are restricted to investments in permitted Federal Agencies and U.S. Government Sponsored Enterprises securities, Corporate Securities, Mortgage or Asset-backed Securities, Negotiable Certificates of Deposit, and Municipal Bonds (State and California Local Agency Obligations) must utilize a single, market-determined short-term index rate, such as U. S. Treasury bills, federal funds, CP, London Interbank Offered Rate (LIBOR), the Secured Overnight Financing Rate (SOFR), or Securities Industry and Financial Markets Association (SIFMA) that is pre-determined at the time of issuance of the security.

a) Permitted variable and floating rate securities that have an embedded unconditional put option must have a stated final maturity of the security no greater than five (5) years from the date of purchase.

b) Investments in floating rate securities whose reset is calculated using more than one (1) of the above indices are not permitted, i.e., dual index notes.

c) Ratings for variable and floating rate securities shall be limited to the same minimum ratings as applied to the appropriate asset security class outlined elsewhere in this Policy.

iii. Maximum Term:

Fund Type	**Term Assigned**	**Term Allowed by the Code**
Operating Funds	3 years	5 years
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 5 years 5 years	 5 years 5 years

m. Supranational Obligations

i. The three (3) Supranational Institutions that issue, or unconditionally guarantee, obligations that are eligible investments are:

a) International Bank for Reconstruction and Development (IBRD);

b) International Finance Corporation (IFC); and

c) Inter-American Development Bank (IADB).

ii. Supranational obligations shall be rated in a Rating Category of "AA" or its equivalent or better by a Nationally Statistical Rating Organization (NRSRO).

iii. Maximum Term:

Fund Type	Term Assigned	Term Allowed by the Code
Operating Funds	3 years	5 years
Board-Designated Reserve Funds ▪ Tier One (1) ▪ Tier Two (2)	 5 years 5 years	 5 years 5 years

n. Pooled Investments

i. Pooled investments include deposits, or investments pooled with those of other local agencies consistent with the requirements of California Government Code, Section 53635 et seq. Such pools may contain a variety of investments but are limited to those permissible under the Code.

E. Diversification Guidelines

1. Diversification guidelines ensure the portfolio is not unduly concentrated in the securities of one (1) type, industry, or entity, thereby assuring adequate portfolio Liquidity should one (1) sector or company experience difficulties.

2. CalOptima Health's Investment Managers must review the respective portfolios they manage to ensure compliance with CalOptima Health's diversification guidelines on a continuous basis.

3. *Table 1: Maximum Percentage (%) of Investment Portfolio, by Instrument Type*

INSTRUMENTS	MAXIMUM % OF PORTFOLIO AT TIME OF PURCHASE
A. U.S. Treasuries (including U.S. Treasury Coupon and principal STRIPS as well as TIPs)	100% (Code)
B. Federal Agencies and U.S. Government Sponsored Enterprises	100% (Code)
C. State and California Local Agency Obligations	40% (Code 100%)
D. Bankers Acceptances	30% (Code 40%)
E. Commercial Paper	25% (Code 40%[1])
F. Negotiable Certificates of Deposit	30% (Code)
G. Repurchase Agreements	100% (Code)
H. Corporate Securities	30% (Code)
I. Money Market Funds	20% (Code)
J. Joint Powers Authority Pool	100% (Code)
K. Mortgage or Asset-backed Securities	20% (Code)
L. Variable and Floating Rate Securities	30% (Code)
M. Supranational Obligations	30% (Code)

4. Issuer or Counterparty Diversification Guidelines: The percentages specified below shall be adhered to on the basis of the entire portfolio:

[1] The Code allows up to 40% for Pooled Funds and Non-Pooled Funds with a minimum $100,000,000 of investments. The Maximum Allocation is limited to 25% for Non-Pooled Funds with under $100,000,000 of investments.

a. Any one (1) Federal Agency or Government Sponsored Enterprise: None

b. Any one (1) repurchase agreement counterparty name:

If maturity/term is ⩽ 7 days: 50%
If maturity/term is > 7 days: 25%

5. Issuer or Counterparty Diversification Guidelines for all other permitted investments described in Section III.D.2.a-n. of this Policy.

a. Any one (1) corporation, bank, local agency, or other corporate name for one (1) or more series of securities, and specifically with respect to special purpose vehicles issuers for mortgage or asset-backed securities, the maximum issuer limits apply at the deal level with each securitized trust being considered a unique "issuer."

b. Except for U.S. Government or Agency securities, no more than five percent (5%) of the Portfolio's market value will be invested in securities of a single issuer.

6. Each Investment Manager shall adhere to the diversification limits discussed in this subsection.

a. If an Investment Manager exceeds the aforementioned diversification limits, the Investment Manager shall inform CalOptima Health's Treasurer and Investment Advisory consultant (if any) by close of business on the day of the occurrence.

b. Within the parameters authorized by the Code, the Investment Advisory Committee recognizes the practicalities of portfolio management, securities maturing and changing status, and market volatility, and, as such, will consider breaches in the context of.

i. The amount in relation to the total portfolio concentration;

ii. Market and security specific conditions contributing to a breach of this Policy; and

iii. The Investment Managers' actions to enforce the spirit of this Policy and decisions made in the best interest of the portfolio.

F. Maximum Stated Term

1. Maximum stated terms for permitted investments shall be determined based on the settlement date (not the trade date) upon purchase of the security and the stated final maturity of the security.

G. Rating Downgrades

1. CalOptima Health may from time to time be invested in a security whose rating is downgraded below the quality criteria permitted by this Policy.

2. If the rating of any security held as an investment falls below the investment guidelines, the Investment Manager shall notify CalOptima Health's Treasurer, or Designee, within two (2) business days of the downgrade.

a. A decision to retain a downgraded security shall be approved by CalOptima Health's Treasurer, or Designee, within five (5) business days of the downgrade.

H. Investment Restrictions

1. Investment securities shall not be lent to an Investment Manager, or Broker-Dealer.

2. The Investment Portfolio or Investment Portfolios, managed by an Investment Manager, shall not be used as collateral to obtain additional investable funds.

3. Any investment not specifically referred to herein shall be considered a prohibited investment.

4. CalOptima Health reserves the right to prohibit its Investment Managers from making investments in organizations which have a line of business that conflicts with the interests of public health, as determined by the Board of Directors.

5. CalOptima Health reserves the right to prohibit investments in organizations with which it has a business relationship through contracting, purchasing, or other arrangements.

6. Except as expressly permitted by this Policy, investments in derivative securities shall not be allowed.

7. A list of prohibited investments does not currently exist, however, the Board of Directors shall provide CalOptima Health's Treasurer, Investment Managers, Investment Advisory consultant, and Investment Advisory Committee with a list, should such a list be adopted by CalOptima Health in the future, of organizations that do not comply with this Policy and shall immediately notify CalOptima Health's Treasurer, Investment Managers, Investment Advisory consultant and Investment Advisory Committee of any changes.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. California Government Code, §6509.7
B. California Government Code, §53600 et seq.
C. California Government Code, §53601(h), (k), (q)
D. California Government Code, §53635 et seq.
E. California Government Code. §53646, Subdivision (a) and Subdivision (b)
F. Title 31, Code of Federal Regulations (C.F.R.), §306.1 et seq.

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
10/30/2017	Special Meeting of the CalOptima Investment Advisory Committee
11/16/2017	Regular Meeting of the CalOptima Finance and Audit Committee
12/07/2017	Regular Meeting of the CalOptima Board of Directors
11/05/2018	Special Meeting of the CalOptima Investment Advisory Committee
11/15/2018	Regular Meeting of the CalOptima Finance and Audit Committee
12/06/2018	Regular Meeting of the CalOptima Board of Directors

Date	Meeting
10/21/2019	Regular Meeting of the CalOptima Investment Advisory Committee
11/15/2019	Regular Meeting of the CalOptima Finance and Audit Committee
12/05/2019	Regular Meeting of the CalOptima Board of Directors
06/04/2020	Regular Meeting of the CalOptima Board of Directors
10/19/2020	Regular Meeting of the CalOptima Investment Advisory Committee
11/19/2020	Regular Meeting of the CalOptima Finance and Audit Committee
12/03/2020	Regular Meeting of the CalOptima Board of Directors
10/25/2021	Regular Meeting of the CalOptima Investment Advisory Committee
11/18/2021	Regular Meeting of the CalOptima Finance and Audit Committee
12/20/2021	Special Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Health Investment Advisory Committee
TBD	Regular Meeting of the CalOptima Health Finance and Audit Committee
TBD	Special Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2018	GA.3400	Annual Investments	Administrative
Revised	01/01/2019	GA.3400	Annual Investments	Administrative
Revised	01/01/2020	GA.3400	Annual Investments	Administrative
Revised	06/04/2020	GA.3400	Annual Investments	Administrative
Revised	01/01/2021	GA.3400	Annual Investments	Administrative
Revised	01/01/2022	GA.3400	Annual Investments	Administrative
Revised	01/01/2023	GA.3400	Annual Investments	Administrative

IX. GLOSSARY

Term	Definition
Banker's Acceptance (BA)	Time drafts which a bank "accepts" as its financial responsibility as part of a trade finance process. These short-term notes are sold at a discount, and are obligations of the drawer (i.e., the bank's trade finance client) as well as the bank. Once accepted, the bank is irrevocably obligated to pay the banker's acceptance (BA) upon maturity, if the drawer does not. Eligible banker's acceptances: • Are eligible for purchase by the Federal Reserve System, and are drawn on and accepted by a bank rated F1, or better, by Fitch Ratings Service, or are rated A-l for short-term deposits by Standard & Poor's, or P-1 for short-term deposits by Moody's, or are comparably rated by a nationally recognized rating agency; and • May not exceed the five percent (5%) limit of any one (1) commercial bank and may not exceed the five percent (5%) limit for any security of any bank.
Benchmark	Benchmarks are usually constructed using unmanaged indices, exchange-traded Funds or mutual fund categories to represent each asset class. Benchmarks are often used as a tool to assess the allocation, Risk and return of a portfolio.
Board-Designated Reserve Funds	Funds established to address unexpected agency needs and not intended for use in the normal course of business. The amount of Board-Designated Reserve Funds should be offset by any working Capital or net current asset deficits. The desired level for these funds is a minimum of 1.4 and maximum of 2.0 months of capitation revenues as specified by CalOptima Health Policy GA.3001: Board-Designated Reserve Funds. The Board-Designated Reserve Funds shall be managed and invested as follows: 1. Tier One a. Used for the benefit and protection of CalOptima Health's long-term financial viability; b. Used to cover "Special Purposes" as defined in CalOptima Health Policy GA.3001: Board-Designated Reserve Funds; or c. May be used for operational cash flow needs in lieu of a bank line of credit in the event of disruption of monthly capitation revenue receipts from the State, subject to the Board-Designated Reserve Funds having a "floor" equal to Tier Two requirements. 2. Tier Two a. Used to meet CalOptima Health's regulatory compliance requirements; or b. Currently defined as CalOptima Health's tangible net equity requirements as defined by Subdivision (e) of Section 1300.76 of Title 28 of the California Code of Regulations.
Bonds	A debt security, under which the issuer owes the holders a debt and, depending on the terms of the bond, is obliged to pay them interest (the coupon) and/or to repay the principal at a later date, termed the maturity date.

Term	Definition
Broker-Dealer	In financial services, a Broker-Dealer is a natural person, a company or other organization that engages in the business of trading securities for its own account or on behalf of its customers.
CalOptima Health Treasurer	Appointed by CalOptima Health's Board of Directors, the treasurer is a person responsible for overseeing CalOptima Health's investment funds.
Capital	Capital refers to financial assets or the financial value of assets, in the form of money or other assets owned by an organization.
Cash Flow Draws	Amount of cash needs to support CalOptima Health business operation.
Chief Officers	For the purposes of this policy, may include, but is not limited to, the Chief Executive Officer (CEO), Chief Financial Officer (CFO), and/or Chief Counsel.
Collateral Securities	A security given in addition to the direct security, and subordinate to it, intended to guarantee its validity or convertibility or insure its performance; so that, if the direct security fails, the creditor may fall back upon the collateral security.
Commercial Paper (CP)	Unsecured promissory notes issued by companies and government entities at a discount.
Consumer Price Index (CPI)	The Consumer Price Indexes (CPI) program produces monthly data on changes in the prices paid by urban consumers for a representative basket of goods and services.
Corporate Securities	Notes issued by corporations organized and operating within the U.S. or by depository institutions licensed by the U.S. or any state, and operating within the U.S.
Credit Risk	The Risk of loss due to failure of the issuer of a security.
Custodian Bank	A specialized financial institution responsible for safeguarding a firm's or individual's financial assets and is not engaged in "traditional" commercial or consumer/retail banking such as mortgage or personal lending, branch banking, personal accounts, automated teller machines (ATMs) and so forth.
Custom Peer Group Report	Developed based on a small peer universe with similar investment guidelines. The Purpose of the report is to provide more accurate performance comparison.
Designee	For purposes of this policy, a person who has been designated to act on behalf of the CalOptima Health Treasurer.
Economic Cycles	The natural fluctuation of the economy between periods of expansion (growth) and contraction (recession).
Finance and Audit Committee (FAC)	A standing committee of the CalOptima Health Board of Directors with oversight responsibilities for all financial matters of CalOptima Health including but not limited to: budget development and approval, financial reporting, investment practices and policies, purchasing and procurement practices and policies, insurance issues, and capitation and claims. The Committee serves as the primary level of Board review for any finance-related issues or policies affecting the CalOptima Health program.
Inflation	Inflation is the rate at which the general level of prices for goods and services is rising and, consequently, the purchasing power of currency is falling.
Instrument	Refers to a financial Instrument or asset that can be traded. These assets can be cash, Bonds, or shares in a company
Investment Advisor(s)	Registered or non-registered person or group that makes investment recommendations or conducts securities analysis in return for a fee.

Term	Definition
Investment Advisory Committee (IAC)	A standing committee of the CalOptima Health Board of Directors who provide advice and recommendations regarding CalOptima Health's Investment Policies, Procedures and Practices.
Investment Manager(s)	A person or organization that makes investments in portfolios of securities on behalf of clients, in accordance with the investment objectives and parameters defined by these clients.
Investment Portfolio	A grouping of financial assets such as stocks, Bonds and cash equivalents, as well as their funds counterparts, including mutual, exchange-traded and closed funds. Portfolios are held directly by investors and/or managed by financial professionals.
Joint Powers Authority Pool	Shares of beneficial interest issued by a joint powers authority organized pursuant to California Government Code, Section 6509.7; each share represents an equal proportional interest in the Underlying Pool of Securities owned by the joint powers authority.
Lien	A legal right granted by the owner of property, by a law or otherwise acquired by a creditor
Liquidity	Liquidity describes the degree to which an asset or security can be quickly bought or sold in the market without affecting the asset's price.
Market Indices	Measurements of the value of a section of the stock market. It is computed from the prices of selected stocks (typically a weighted average).
Market Risk	The Risk of market value fluctuations due to overall changes in the general level of interest rates.
Maturity Dates	The date on which the principal amount of a note, draft, acceptance bond or another debt Instrument becomes due and is repaid to the investor and interest payments stop. It is also the termination or due date on which an installment loan must be paid in full.
Medium Term Notes (MTN)	A debt note that usually matures (is paid back) in five (5) – ten (10) years, but the term may be less than one (1) year or as long as one hundred (100) years. They can be issued on a fixed or floating coupon basis.
Nationally Recognized Statistical Ratings Organization (NRSRO)	A credit rating agency that the Securities and Exchange Commission in the United States registers and uses for regulatory purposes. Current NRSROs listed at www.sec.gov/ocr/ocr-current-nrsros.html.
Negotiable Certificates of Deposit	A negotiable (i.e., marketable or transferable) receipt for a time deposit at a bank or other financial institution, for a fixed time and interest rate.
Operating Funds	Funds intended to serve as a money market account for CalOptima Health to meet daily operating requirements. Deposits to this fund are comprised of State warrants that represent CalOptima Health's monthly capitation revenues from its State contracts. Disbursements from this fund to CalOptima Health's operating cash accounts are intended to meet operating expenses, payments to providers and other payments required in day-to-day operations.
Prudent Person Standard	When investing, reinvesting, purchasing, acquiring, exchanging, selling, or managing public funds, a trustee shall act with care, skill, prudence, and diligence under the circumstances then prevailing, including but not limited to, the general economic conditions and the anticipated needs of the agency, that a prudent person acting in a like capacity and familiarity with those matters would use in the conduct of funds of a like character and with like aims, to safeguard the principal and maintain the Liquidity needs of the agency (California Government Code, Section 53600.3)

Term	Definition
Rate of Return	The gain or loss on an investment over a specified time period, expressed as a percentage of the investment's cost. Gains on investments are defined as income received plus any Capital gains realized on the sale of the investment.
Rating Category	With respect to any long-term category, all ratings designated by a particular letter or combination of letters, without regard to any numerical modifier, plus or minus sign or other modifier.
Repurchase Agreements	A purchase of securities under a simultaneous agreement to sell these securities back at a fixed price on some future date.
Risk	Investment Risk can be defined as the probability or likelihood of occurrence of losses relative to the expected return on any particular investment. Description: Stating simply, it is a measure of the level of uncertainty of achieving the returns as per the expectations of the investor.
State and California Local Agency Obligations	Registered warrants, notes or Bonds of any of the fifty (50) U.S. states, including Bonds payable solely out of the revenues from a revenue-producing property owned, controlled, or operated by a state or by a department, board, agency, or authority of any of the fifty (50) U.S. states. Additionally, Bonds, notes, warrants, or other evidences of indebtedness of any local agency within the State of California, including Bonds payable solely out of revenues from a revenue producing property owned, controlled, or operated by the state or local agency, or by a department, board, agency or authority of the State or local agency.
Supranational Institutions	International institutions formed by two (2) or more governments that transcend boundaries to pursue mutually beneficial economic or social goals.
Surplus	Assets beyond liabilities.
Underlying Pool of Securities	Those securities and obligations that are eligible for direct investment by local public agencies.
Valuation	An estimation of the worth of a financial Instrument or asset. CalOptima Health's asset managers provide CalOptima Health with reporting that shows the Valuation of each financial Instrument that they own on behalf of CalOptima Health. Each asset manager uses a variety of market sources to determine individual Valuations.

1

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 1, 2022
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

19. Authorize Expenditures in Support of CalOptima Health's Participation in a Community Event

Contacts

Michael Hunn, Chief Executive Officer, (657) 900-1481
Deanne Thompson, Executive Director, Marketing and Communications, (714) 954-2141

Recommended Actions

1. Authorize expenditures for CalOptima Health's participation in the following community event:
    - Up to $15,000 and staff participation at Viet-America Society's 2023 Year of the Cat Lunar Tet Festival on January 20-22, 2023, in Fountain Valley;
2. Make a finding that such an expenditure is for a public purpose and in furtherance of CalOptima Health's mission and statutory purpose; and
3. Authorize the Chief Executive Officer to execute agreements as necessary for the event and expenditures.

Background

CalOptima Health has a long history of participating in community events, health and resource fairs, and other public activities in furtherance of the organization's statutory purpose. CalOptima Health has offered financial participation from time to time when participation is in the public good, in furtherance of CalOptima Health's mission and statutory purpose, and encourages broader participation in CalOptima Health's programs and services or promotes health and wellness. As a result, CalOptima Health has developed a strong reputation with Orange County's community partners, providers, and key stakeholders.

Requests for participation are considered based on the following factors: the number of people that will be reached; the outreach and education benefits accrued to CalOptima Health; the strength of the partnership or level of involvement with the requesting entity; past participation; staff availability; and available budget.

Discussion

Staff is recommending support for the Tet Festival to celebrate the new lunar year, preserve the Vietnamese culture, and share Vietnamese traditions with the surrounding communities. The event will provide opportunities to conduct outreach and education to current and potential members who identify as Vietnamese, increase access to healthcare services, and strengthen relationships with community partners. As of September 2022, approximately twelve percent of CalOptima Health's total membership identifies as Vietnamese.

Staff recommends the authorization of expenditures for participation in the Viet-America Society's 2023 Year of the Cat Lunar Tet Festival in Fountain Valley. CalOptima Health has participated in this event for nine years. Staff recommends CalOptima Health's continued support for this event with a $15,000 financial commitment for 2023, which includes the following: One 20' x 20' exhibitor booth in a prime location, three 3' x 8' banner displays, 20 mentions on stage, 25 radio impressions, 15

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television impressions, 5.5" x 8" full advertisements on 10,000 fliers distributed throughout Orange County, and two 8'x 8' backdrops on the Tet Festival stage. The event organizer anticipates more than 80,000 visitors throughout the three-day event.

This is an educational event that will allow staff to provide outreach and education to the Vietnamese community and serve members speaking one or more of CalOptima Health's threshold languages. Employee time will be used to participate in this event.

CalOptima Health staff reviewed Viet-America's request for CalOptima Health's participation, and has determined that the request meets the requirements for participation as established in CalOptima Health Policy AA. 1223: Participation in Community Events Involving External Entities, including the following:

1. The number of people the activity/event will reach;
2. The marketing benefits accrued to CalOptima Health;
3. The strength of the partnership or level of involvement with the requesting entity;
4. Past participation;
5. Staff availability; and
6. Available budget.

As part of its consideration of the recommended actions, approval of this item is based on the Board making a finding that proposed activities and expenditures are in the public interest and in furtherance of CalOptima Health's statutory purpose.

Fiscal Impact

Funding for the recommended action of up to $15,000 is included as part of the Community Events budget under the CalOptima Health Fiscal Year 2022-23 Operating Budget.

Rationale for Recommendation

Staff recommends approval of the recommended actions as an opportunity to educate the community, specifically CalOptima Health's Vietnamese-speaking members, potential members, and the community about CalOptima Health and Medi-Cal programs and services.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Entities Covered by this Recommended Action
2. Sponsorship Request from the Viet-America Society

/s/ Michael Hunn *11/23/2022*
Authorized Signature **Date**

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Attachment to December 1, 2022 Board of Directors Meeting – Agenda Item 19

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip Code
Viet-America Society	8907 Warner Ave., Suite 135	Huntington Beach	CA	92647

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Viet-America Society
8907 Warner Ave. Suite #135
Huntington Beach CA 92647
vietamericasociety@gmail.com | 714-390-5591

November 7, 2022

Mr. Michael Hunn
Chief Executive Officer
CalOptima Health
505 City Parkway West
Orange, CA 92868

Re: Sponsorship for the 2023 Orange County Têt Festival – January 20-22, 2023

Dear Mr. Hunn,

We are writing you to request your sponsorship of the upcoming Lunar New Year 2023 OC Têt Festival, celebrating the Year of the Cat.

Viet America Society (VAS) has the honor of being selected to work with the County of Orange and OC Parks for the celebration event of the 2023 OC Têt Festival, at Mile Square Regional Park in Fountain Valley. The 3-day event will commence on Friday afternoon, January 20, 2023 and ends on Sunday evening, January 22, 2023.

The OC Têt Festival represents a cost-effective and high-visibility opportunity for CalOptima Health to promote its positive image to the Vietnamese community at large as well as other Asian communities in Southern California. This will be the Sixth Annual OC Têt Festival held at Mile Square Park, which, in past years, has successfully attracted thousands of Southern Californians and out-of-state visitors to this annual event. This special event is free and open to the general public.

A $15,000.00 sponsorship will provide you with the following:

- 20’ x 20’ booth in prime location at the OC Têt Festival Mile Square Park
- Three (3) 3’ x 8’ banner displays
- Twenty (20) mentions on stage
- Twenty-five (25) radio impressions
- Fifteen (15) television impressions
- Full ad size 5.5 x 8 inches (the other side will be OC Têt Festival announcement) on 10,000 flyers distributed throughout Orange County prior to the event.
- Two (2) 8’ x8’back drop on OC Têt Festival Stage.

I look forward to having CalOptima Health’s continued support in this grand event, as one of our loyal sponsors and to see you be a part of program event on stage. Should you have any questions please contact me at (714) 390-5591 or by e-mail at vietamericasociety@gmail.com.

Sincerely,

Peter Pham
CEO
Viet America Society

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Financial Summary

October 31, 2022

Board of Directors Meeting
December 1, 2022

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.

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Financial Highlights: October 2022

October					July - October			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
937,584	913,579	24,005	2.6%	Member Months	3,723,682	3,660,421	63,261	1.7%
302,421,366	332,068,403	(29,647,037)	(8.9%)	Revenues	1,415,869,993	1,329,510,548	86,359,445	6.5%
289,802,862	313,248,650	23,445,788	7.5%	Medical Expenses	1,340,186,038	1,244,967,734	(95,218,304)	(7.6%)
14,557,362	17,327,883	2,770,521	16.0%	Administrative Expenses	57,727,398	69,105,803	11,378,405	16.5%
(1,938,858)	**1,491,870**	**(3,430,728)**	**(230.0%)**	**Operating Margin**	**17,956,557**	**15,437,011**	**2,519,546**	**16.3%**
				Non-Operating Income (Loss)				
2,531,326	500,000	2,031,326	406.3%	Net Investment Income/Expense	5,259,945	2,000,000	3,259,945	163.0%
111,434	90,835	20,599	22.7%	Net Rental Income/Expense	428,891	363,340	65,551	18.0%
(1,244)	-	(1,244)	(100.0%)	Net MCO Tax	23,667	-	23,667	100.0%
(863,636)	(1,363,636)	500,000	36.7%	Grant Expense	(3,454,545)	(4,090,908)	636,363	15.6%
-	-	-	0.0%	Other Income/Expense	25,878	-	25,878	100.0%
1,777,879	**(772,801)**	**2,550,680**	**330.1%**	**Total Non-Operating Income (Loss)**	**2,283,835**	**(1,727,568)**	**4,011,403**	**232.2%**
(160,979)	**719,069**	**(880,048)**	**(122.4%)**	**Change in Net Assets**	**20,240,392**	**13,709,443**	**6,530,949**	**47.6%**
95.8%	94.3%	1.5%		Medical Loss Ratio	94.7%	93.6%	1.0%	
4.8%	5.2%	0.4%		Administrative Loss Ratio	4.1%	5.2%	1.1%	
(0.6%)	0.4%	(1.1%)		Operating Margin Ratio	1.3%	1.2%	0.1%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
95.8%	94.3%	1.5%		*MLR (excluding Directed Payments)	94.2%	93.6%	0.6%	
4.8%	5.2%	0.4%		*ALR (excluding Directed Payments)	4.5%	5.2%	0.7%	

*CalOptima Health updated the category of Directed Payments per Department of Health Care Services instructions

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CalOptima Health

Consolidated Performance: October 2022 (in millions)

October				July-October		
Actual	Budget	Variance	**Operating Income (Loss)**	Actual	Budget	Variance
(3.0)	2.8	(5.8)	Medi-Cal	21.4	20.0	1.5
0.2	(0.6)	0.8	OCC	(3.1)	(1.8)	(1.3)
0.4	(0.7)	1.0	OneCare	(0.3)	(2.3)	2.1
0.6	(0.1)	0.6	PACE	0.1	(0.2)	0.4
(0.1)	(0.0)	(0.0)	MSSP	(0.3)	(0.2)	(0.1)
(1.9)	**1.5**	**(3.4)**	**Total Operating Income (Loss)**	**18.0**	**15.4**	**2.5**
			Non-Operating Income (Loss)			
2.5	0.5	2.0	Net Investment Income/Expense	5.3	2.0	3.3
0.1	0.1	0.0	Net Rental Income/Expense	0.4	0.4	0.1
(0.0)	0.0	(0.0)	Net Operating Tax	0.0	0.0	0.0
(0.9)	(1.4)	0.5	Grant Expense	(3.5)	(4.1)	0.6
0.0	0.0	0.0	Net Other Income/Expense	0.0	0.0	0.0
1.8	**(0.8)**	**2.6**	**Total Non-Operating Income/(Loss)**	**2.3**	**(1.7)**	**4.0**
(0.2)	**0.7**	**(0.9)**	**TOTAL**	**20.2**	**13.7**	**6.5**

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CalOptima Health

FY 2022-23: Management Summary

- Change in Net Assets Surplus or (Deficit)
  - Month To Date (MTD) October 2022: ($0.2) million, unfavorable to budget $0.9 million or 122.4%
  - Year To Date (YTD) July – October 2022: $20.2 million, favorable to budget $6.5 million or 47.6%
- Enrollment
  - MTD: 937,584 members, favorable to budget 24,005 or 2.6%
  - YTD: 3,723,682 members, favorable to budget 63,261 or 1.7%

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CalOptima Health

FY 2022-23:Management Summary (cont.)

- Revenue
  - MTD: $302.4 million, unfavorable to budget $29.6 million or 8.9% driven by Medi-Cal Line of Business (MC LOB):
    - $5.1 million due to favorable volume related variance and prior year retroactive eligibility changes
    - Offset by $43.3 million due to net of Proposition 56, COVID-19 and Enhanced Care Management (ECM) risk corridor reserves
  - YTD: $1,415.9 million, favorable to budget $86.4 million or 6.5% driven by MC LOB:
    - $135.2 million of Fiscal Year (FY) 2021 hospital Directed Payments (DP)
    - $25.8 million due to favorable volume related variance and prior year retroactive eligibility changes
    - Offset by $85.1 million due to net of Proposition 56, COVID-19 and ECM risk corridor reserves

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CalOptima Health

FY 2022-23:Management Summary (cont.)

- Medical Expenses
  - MTD: $289.8 million, favorable to budget $23.4 million or 7.5% driven by MC LOB:
    - Managed Long-Term Services and Supports (MLTSS) expense favorable variance of $10.0 million due to Incurred But Not Reported (IBNR) claims
    - Provider Capitation expense favorable variance of $9.1 million primarily due to Proposition 56 estimates
    - Facilities Claims expense favorable variance of $8.5 million due to low utilization
    - Offset by:
      - Incentive Payments expense unfavorable variance of $8.3 million due to Prior Year (PY) hospital shared risk pool

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CalOptima Health

FY 2022-23:Management Summary (cont.)

- Medical Expenses
  - YTD: $1,340.2 million, unfavorable to budget $95.2 million or 7.6% driven by MC LOB:
    - Other Medical Expenses unfavorable variance of $130.1 million due to FY 2021 hospital DP
    - Offset by:
      - Provider Capitation expense favorable variance of $27.0 million due primarily to Proposition 56
      - All other expenses favorable variance of $7.5 million

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CalOptima Health

FY 2022-23:Management Summary (cont.)

- Administrative Expenses
  - MTD: $14.6 million, favorable to budget $2.8 million or 16.0%
    - Other Non-Salary expenses favorable variance of $1.9 million
    - Salaries & Benefits expense favorable variance of $0.9 million
  - YTD: $57.7 million, favorable to budget $11.4 million or 16.5%
    - Other Non-Salary expenses favorable variance of $7.4 million
    - Salaries & Benefits expense favorable variance of $4.0 million

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FY 2022-23:Management Summary (cont.)

- Non-Operating Income (Loss)
  - MTD: $1.8 million, favorable to budget $2.6 million or 330.1%
    - Non-operating income is primarily driven by interest income from coupon payments, offset by both realized and unrealized investment losses due to decreased bond values from continued high interest rates
  - YTD: $2.3 million, favorable to budget $4.0 million or 232.2%

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CalOptima Health

FY 2022-23: Key Financial Ratios

- Medical Loss Ratio (MLR)
  - MTD: Actual 95.8% (95.8% excluding DP), Budget 94.3%
  - YTD: Actual 94.7% (94.2% excluding DP), Budget 93.6%
- Administrative Loss Ratio (ALR)
  - MTD: Actual 4.8% (4.8% excluding DP), Budget 5.2%
  - YTD: Actual 4.1% (4.5% excluding DP), Budget 5.2%
- Balance Sheet Ratios
  - *Current ratio: 1.5
  - Board-designated reserve funds level: 1.80
  - Net-position: $1.4 billion, including required Tangible Net Equity (TNE) of $101.9 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: October 2022

October					July - October			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category	Actual	Budget	$ Variance	% Variance
121,371	122,811	(1,440)	(1.2%)	SPD	497,207	489,623	7,584	1.5%
303,915	306,206	(2,291)	(0.7%)	TANF Child	1,214,031	1,226,319	(12,288)	(1.0%)
137,621	134,896	2,725	2.0%	TANF Adult	535,113	542,488	(7,375)	(1.4%)
3,234	3,339	(105)	(3.1%)	LTC	12,950	13,304	(354)	(2.7%)
342,034	316,769	25,265	8.0%	MCE	1,346,157	1,270,665	75,492	5.9%
11,817	11,769	48	0.4%	WCM	47,404	46,971	433	0.9%
919,992	**895,790**	**24,202**	**2.7%**	**Medi-Cal Total**	**3,652,862**	**3,589,370**	**63,492**	**1.8%**
14,198	**14,659**	**(461)**	**(3.1%)**	**OneCare Connect**	**57,577**	**58,650**	**(1,073)**	**(1.8%)**
2,964	**2,666**	**298**	**11.2%**	**OneCare**	**11,507**	**10,575**	**932**	**8.8%**
430	**464**	**(34)**	**(7.3%)**	**PACE**	**1,736**	**1,826**	**(90)**	**(4.9%)**
478	**568**	**(90)**	**(15.8%)**	**MSSP**	**1,892**	**2,272**	**(380)**	**(16.7%)**
937,584	**913,579**	**24,005**	**2.6%**	**CalOptima Total**	**3,723,682**	**3,660,421**	**63,261**	**1.7%**

*CalOptima Health Total does not include MSSP

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CalOptima Health

Consolidated Revenue & Expenses: October 2022 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS	566,141	342,034	11,817	919,992	14,198	2,964	430	478	937,584
REVENUES									
Capitation Revenue	133,154,669	$ 111,692,799	$ 20,969,293	$ 265,816,761	$ 28,849,174	$ 3,959,747	$ 3,598,829	$ 196,855	$ 302,421,366
Total Operating Revenue	133,154,669	111,692,799	20,969,293	265,816,761	28,849,174	3,959,747	3,598,829	196,855	302,421,366
MEDICAL EXPENSES									
Provider Capitation	40,691,043	47,864,119	8,709,641	97,264,803	11,728,332	1,039,945			110,033,080
Facilities	29,932,548	27,110,477	3,295,467	60,338,491	4,160,582	878,728	592,586		65,970,388
Professional Claims	21,907,406	16,048,940	1,346,364	39,302,709	1,331,723	123,245	866,547		41,624,225
Prescription Drugs	(22,473)	(27,565)	6,105	(43,933)	6,874,898	1,159,507	425,643		8,416,114
MLTSS	35,187,839	3,761,543	1,634,786	40,584,167	1,651,691		116,877	45,663	42,398,398
Incentive Payments	5,878,500	6,786,599	308,040	12,973,139	564,039	16,568	5,375		13,559,120
Medical Management	2,577,620	1,810,667	340,171	4,728,458	909,175	45,792	892,428	146,211	6,722,063
Other Medical Expenses	603,768	463,540	12,166	1,079,474					1,079,474
Total Medical Expenses	136,756,251	103,818,320	15,652,738	256,227,309	27,220,439	3,263,784	2,899,456	191,874	289,802,862
Medical Loss Ratio	102.7%	92.9%	74.6%	96.4%	94.4%	82.4%	80.6%	97.5%	95.8%
GROSS MARGIN	**(3,601,582)**	**7,874,479**	**5,316,555**	**9,589,452**	**1,628,735**	**695,963**	**699,373**	**4,981**	**12,618,504**
ADMINISTRATIVE EXPENSES									
Salaries & Benefits				9,010,964	692,184	168,683	123,769	68,847	10,064,447
Professional Fees				673,701	838	24,771	(22)	1,333	700,621
Purchased Services				1,188,564	110,656	23,038	(12,435)		1,309,823
Printing & Postage				85,805	(41,466)	44,839	9,614		98,791
Depreciation & Amortization				348,615			557		349,172
Other Expenses				1,611,064	929		5,530	5,994	1,623,517
Indirect Cost Allocation, Occupancy				(327,033)	640,809	79,498	12,466	5,252	410,991
Total Administrative Expenses				**12,591,679**	**1,403,948**	**340,829**	**139,479**	**81,426**	**14,557,362**
Admin Loss Ratio				4.7%	4.9%	8.6%	3.9%	41.4%	4.8%
INCOME (LOSS) FROM OPERATIONS				(3,002,227)	224,787	355,134	559,894	(76,445)	(1,938,858)
INVESTMENT INCOME									2,531,326
NET RENTAL INCOME									111,434
TOTAL MCO TAX				(1,244)					(1,244)
TOTAL GRANT EXPENSE				(863,636)					(863,636)
CHANGE IN NET ASSETS				**$ (3,867,107)**	**$ 224,787**	**$ 355,134**	**$ 559,894**	**$ (76,445)**	**$ (160,979)**
BUDGETED CHANGE IN NET ASSETS				1,450,958	(567,709)	(655,026)	(59,135)	(40,854)	719,069
VARIANCE TO BUDGET - FAV (UNFAV)				$ (5,318,065)	$ 792,496	$ 1,010,160	$ 619,029	$ (35,591)	$ (880,048)

Note:* Total membership does not include MSSP

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CalOptima Health

Consolidated Revenue & Expenses: October 2022 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS	2,259,301	1,346,157	47,404	3,652,862	57,577	11,507	1,736	1,892	3,723,682
REVENUES									
Capitation Revenue	656,952,723	$ 524,060,249	$ 95,370,689	$ 1,276,383,661	$ 110,408,673	$ 14,077,913	$ 14,172,019	$ 827,727	$ 1,415,869,993
Total Operating Revenue	656,952,723	524,060,249	95,370,689	1,276,383,661	110,408,673	14,077,913	14,172,019	827,727	1,415,869,993
MEDICAL EXPENSES									
Provider Capitation	165,568,956	194,857,653	39,076,430	399,503,039	44,780,399	3,952,869			448,236,307
Facilities	135,553,395	121,228,393	24,540,886	281,322,674	17,631,217	3,855,081	3,721,181		306,530,153
Professional Claims	87,835,460	58,066,547	6,060,383	151,962,390	5,762,683	581,209	3,712,619		162,018,901
Prescription Drugs	(1,561,723)	(195,164)	6,105	(1,750,782)	26,986,714	4,516,287	1,636,146		31,388,365
MLTSS	166,235,279	17,926,305	7,946,163	192,107,747	6,862,602		599,701	135,095	199,705,146
Incentive Payments	11,732,580	13,826,082	431,310	25,989,972	1,736,045	20,669	21,700		27,768,386
Medical Management	10,878,591	7,422,197	1,460,766	19,761,554	4,004,752	178,671	3,629,088	600,263	28,174,328
Other Medical Expenses	73,016,706	55,088,869	8,258,877	136,364,452					136,364,452
Total Medical Expenses	649,259,245	468,220,881	87,780,920	1,205,261,046	107,764,411	13,104,786	13,320,436	735,357	1,340,186,038
Medical Loss Ratio	98.8%	89.3%	92.0%	94.4%	97.6%	93.1%	94.0%	88.8%	94.7%
GROSS MARGIN	**7,693,478**	**55,839,368**	**7,589,769**	**71,122,615**	**2,644,262**	**973,126**	**851,583**	**92,369**	**75,683,955**
ADMINISTRATIVE EXPENSES									
Salaries & Benefits				36,454,007	2,672,438	503,728	534,959	302,190	40,467,322
Professional Fees				2,153,634	19,651	113,106	1,553	5,333	2,293,278
Purchased Services				3,604,583	391,285	84,009	57,626		4,137,502
Printing & Postage				1,116,960	92,701	209,983	59,580		1,479,224
Depreciation & Amortization				1,448,487			2,193		1,450,680
Other Expenses				6,107,942	4,408	(0)	22,795	23,321	6,158,466
Indirect Cost Allocation, Occupancy				(1,211,174)	2,563,235	317,992	49,865	21,009	1,740,926
Total Administrative Expenses				**49,674,439**	**5,743,717**	**1,228,818**	**728,571**	**351,853**	**57,727,398**
Admin Loss Ratio				3.9%	5.2%	8.7%	5.1%	42.5%	4.1%
INCOME (LOSS) FROM OPERATIONS				21,448,176	(3,099,456)	(255,691)	123,012	(259,484)	17,956,557
INVESTMENT INCOME									5,259,945
NET RENTAL INCOME									428,891
TOTAL MCO TAX				23,667					23,667
TOTAL GRANT EXPENSE				(3,454,545)					(3,454,545)
OTHER INCOME				25,878					25,878
CHANGE IN NET ASSETS				**$ 18,043,175**	**$ (3,099,456)**	**$ (255,691)**	**$ 123,012**	**$ (259,484)**	**$ 20,240,392**
BUDGETED CHANGE IN NET ASSETS				15,887,778	(1,803,080)	(2,333,735)	(231,894)	(172,966)	13,709,443
VARIANCE TO BUDGET - FAV (UNFAV)				$ 2,155,397	$ (1,296,376)	$ 2,078,044	$ 354,906	$ (86,518)	$ 6,530,949

Note:* Total membership does not include MSSP

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CalOptima Health

Balance Sheet: As of October 2022

ASSETS		LIABILITIES & NET POSITION	
Current Assets		**Current Liabilities**	
Operating Cash	$719,882,499	Accounts Payable	$24,930,951
Short-term Investments	1,255,555,190	Medical Claims Liability	1,404,913,775
Capitation Receivable	391,896,898	Accrued Payroll Liabilities	18,232,637
Receivables - Other	82,160,680	Deferred Revenue	6,393,396
Prepaid Expenses	20,447,423	Deferred Lease Obligations	80,077
		Capitation and Withholds	202,195,668
Total Current Assets	**2,469,942,689**	**Total Current Liabilities**	**1,656,746,505**
Capital Assets			
Furniture & Equipment	48,861,260		
Building/Leasehold Improvements	5,059,408		
Construction in Progress	5,245,751		
505 City Parkway West	52,782,700		
500 City Parkway West	22,631,500		
	134,580,618		
Less: Accumulated Depreciation	(66,651,601)	**Other Liabilities**	
Capital Assets, Net	67,929,017	GASB 96 Subscription Liabilities	-
GASB 96 Capital Assets		**Other (than pensions) Post**	
GASB 96 Subscription Assets	-	Employment Benefits Liability	22,335,544
		Net Pension Liabilities	577,854
Less: GASB 96 Accumulated Depreciation	-	Bldg. 505 Development Rights	-
GASB 96 Capital Assets, Net	-		
Total Capital Assets	67,929,017		
Other Assets			
Restricted Deposit & Other	300,000	**TOTAL LIABILITIES**	**1,679,659,903**
Homeless Health Reserve	40,636,739		
Board-Designated Assets:			
Cash and Cash Equivalents	10,424,070		
Investments	552,300,459	**Deferred Inflows**	
Total Board-Designated Assets	562,724,528	Excess Earnings	686,563
		OPEB 75 Difference in Experience	4,822,000
		Change in Assumptions	1,909,305
Total Other Assets	603,661,267	OPEB Changes in Assumptions	3,389,000
		Diff in Proj vs Act	20,982,636
		Net Position	
TOTAL ASSETS	**3,141,532,974**	TNE	101,871,590
		Funds in Excess of TNE	1,337,837,570
Deferred Outflows		**TOTAL NET POSITION**	1,439,709,160
Contributions	1,931,845		
Difference in Experience	2,353,671		
Excess Earning	-		
Changes in Assumptions	2,325,077		
OPEB 75 Changes in Assumptions	2,486,000		
Pension Contributions	529,000		
TOTAL ASSETS & DEFERRED OUTFLOWS	**3,151,158,567**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**3,151,158,567**

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CalOptima Health

Board Designated Reserve and TNE Analysis: As of October 2022

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Ryge	229,381,386				
	Tier 1 - MetLife	227,765,181				
Board-designated Reserve		457,146,567	335,041,370	522,289,782	122,105,197	(65,143,215)
	Tier 2 - Payden & Ryge	53,012,026				
	Tier 2 - MetLife	52,565,935				
TNE Requirement		105,577,961	101,871,590	101,871,590	3,706,371	3,706,371
	Consolidated:	**562,724,528**	**436,912,961**	**624,161,372**	**125,811,567**	**(61,436,844)**
	Current reserve level	*1.80*	*1.40*	*2.00*		

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CalOptima Health

Net Assets Analysis: As of October 2022

Category	Item Description	Amount (millions)	Spend to Date	%
	Total Net Position @ 10/31/2022:	**$1,439.7**		**100.0%**
Resources Assigned	Board Designated Reserve*	**562.7**		**39.1%**
	Capital Assets, net of depreciation	**67.9**		**4.7%**
Resources Allocated	Homeless Health Initiative**	$100.0	$35.0	6.9%
	Intergovernmental Transfers (IGT)	111.7	47.8	7.8%
	Mind OC Grant	1.0	1.0	0.1%
	CalFresh Outreach Strategy	2.0	0.8	0.1%
	Digital Transformation and Workplace Modernization	100.0	2.3	6.9%
	Coalition of Orange County Community Health Centers Grant	50.0	10.0	3.5%
	Subtotal:	**$364.7**	**$96.9**	**25.3%**
Resources Available for New Initiatives:	Unallocated/Unassigned*	**$444.4**		**30.9%**

*Total of Board Designated reserve and unallocated reserve amount can support approximately 98 days of CalOptima Health's current operations

**See Summary of Homeless Health Initiatives and Allocated Funds for list of Board approved initiatives

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CalOptima Health

Homeless Health Initiative and Allocated Funds: As of October 2022

Summary of Homeless Health Initiatives and Allocated Funds
As of October 31, 2022

		Amount
Program Commitment		**$ 100,000,000**
Funds Allocation, approved initiatives:		
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000	
Recuperative Care	8,250,000	
Medical Respite	250,000	
Day Habilitation (County for HomeKey)	2,500,000	
Clinical Field Team (CFT) Start-up & Federal Qualified Health Center (FQHC)	1,600,000	
CalOptima Homeless Response Team	6,000,000	
Homeless Coordination at Hospitals	10,000,000	
CalOptima Days & QI Program - Homeless Clinic Access Program (HCAP)	1,693,261	
FQHC (Community Health Center) Expansion and HHI Support	570,000	
HCAP Expansion for Telehealth and CFT On Call Days	1,700,000	
Vaccination Intervention and Member Incentive Strategy	400,000	
Street Medicine	8,000,000	
Outreach and Engagement Team	7,000,000	
Funds Allocation Total		**$ 59,363,261**
Program Commitment Balance, available for new initiatives*		**$ 40,636,739**

*Funding sources of the remaining balance are IGT8 and CalOptima Health's operating income, which must be used for Medi-Cal covered services for the Medi-Cal population

Note: Staff will include the Housing and Homelessness Incentive Program (approved by the Board on September 1, 2022) in the Approved Initiatives list on the November 2022 report.

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UNAUDITED FINANCIAL STATEMENTS

October 31, 2022

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CalOptima Health - Consolidated
Financial Highlights
For the Four Months Ended October 31, 2022

October					July - October			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
937,584	913,579	24,005	2.6%	Member Months	3,723,682	3,660,421	63,261	1.7%
302,421,366	332,068,403	(29,647,037)	(8.9%)	Revenues	1,415,869,993	1,329,510,548	86,359,445	6.5%
289,802,862	313,248,650	23,445,788	7.5%	Medical Expenses	1,340,186,038	1,244,967,734	(95,218,304)	(7.6%)
14,557,362	17,327,883	2,770,521	16.0%	Administrative Expenses	57,727,398	69,105,803	11,378,405	16.5%
(1,938,858)	**1,491,870**	**(3,430,728)**	**(230.0%)**	**Operating Margin**	**17,956,557**	**15,437,011**	**2,519,546**	**16.3%**
				Non-Operating Income (Loss)				
2,531,326	500,000	2,031,326	406.3%	Net Investment Income/Expense	5,259,945	2,000,000	3,259,945	163.0%
111,434	90,835	20,599	22.7%	Net Rental Income/Expense	428,891	363,340	65,551	18.0%
(1,244)	-	(1,244)	(100.0%)	Net MCO Tax	23,667	-	23,667	100.0%
(863,636)	(1,363,636)	500,000	36.7%	Grant Expense	(3,454,545)	(4,090,908)	636,363	15.6%
-	-	-	0.0%	Other Income/Expense	25,878	-	25,878	100.0%
1,777,879	**(772,801)**	**2,550,680**	**330.1%**	**Total Non-Operating Income (Loss)**	**2,283,835**	**(1,727,568)**	**4,011,403**	**232.2%**
(160,979)	**719,069**	**(880,048)**	**(122.4%)**	**Change in Net Assets**	**20,240,392**	**13,709,443**	**6,530,949**	**47.6%**
95.8%	94.3%	1.5%		Medical Loss Ratio	94.7%	93.6%	1.0%	
4.8%	5.2%	0.4%		Administrative Loss Ratio	4.1%	5.2%	1.1%	
(0.6%)	0.4%	(1.1%)		Operating Margin Ratio	1.3%	1.2%	0.1%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
95.8%	94.3%	1.5%		*MLR (excluding Directed Payments)	94.2%	93.6%	0.6%	
4.8%	5.2%	0.4%		*ALR (excluding Directed Payments)	4.5%	5.2%	0.7%	

*CalOptima Health updated the category of Directed Payments per Department of Health Care Services instructions

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CalOptima Health
Financial Dashboard
For the Four Months Ended October 31, 2022

MONTH - TO - DATE

Enrollment	Actual	Budget	Fav / (Unfav)	
Medi-Cal	919,992	895,790	24,202	2.7%
OneCare Connect	14,198	14,659	(461)	(3.1%)
OneCare	2,964	2,666	298	11.2%
PACE	430	464	(34)	(7.3%)
MSSP	478	568	(90)	(15.8%)
Total*	937,584	913,579	24,005	2.6%

Change in Net Assets (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ (3,867)	$ 1,451	(5,318)	(366.5%)
OneCare Connect	225	(568)	793	139.6%
OneCare	355	(655)	1,010	154.2%
PACE	560	(59)	619	1049.2%
MSSP	(76)	(41)	(35)	(85.4%)
Buildings	111	91	20	22.0%
Investment Income/Expense	2,531	500	2,031	406.2%
Total	$ (161)	$ 719	(880)	(122.4%)

MLR	Actual	Budget	% Point Var
Medi-Cal	96.4%	94.1%	2.3
OneCare Connect	94.4%	95.5%	(1.2)
OneCare	82.4%	110.1%	(27.6)

Administrative Cost (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 12,592	$ 14,813	$ 2,221	15.0%
OneCare Connect	1,404	1,822	418	22.9%
OneCare	341	339	(1)	(0.4%)
PACE	139	259	120	46.2%
MSSP	81	95	13	14.2%
Total	$ 14,557	$ 17,328	$ 2,771	16.0%

Total FTE's Month	Actual	Budget	Fav / (Unfav)
Medi-Cal	1,152	1,315	163
OneCare Connect	159	197	38
OneCare	21	27	7
PACE	95	114	18
MSSP	20	23	3
Total	1,448	1,675	228

MM per FTE	Actual	Budget	Fav / (Unfav)
Medi-Cal	799	681	(117)
OneCare Connect	89	75	(15)
OneCare	144	98	(46)
PACE	5	4	(0)
MSSP	23	25	1
Total	648	545	(102)

YEAR - TO - DATE

Year To Date Enrollment	Actual	Budget	Fav / (Unfav)	
Medi-Cal	3,652,862	3,589,370	63,492	1.8%
OneCare Connect	57,577	58,650	(1,073)	(1.8%)
OneCare	11,507	10,575	932	8.8%
PACE	1,736	1,826	(90)	(4.9%)
MSSP	1,892	2,272	(380)	(16.7%)
Total*	3,723,682	3,660,421	63,261	1.7%

Change in Net Assets (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 18,043	$ 15,888	2,155	13.6%
OneCare Connect	(3,099)	(1,803)	(1,296)	(71.9%)
OneCare	(256)	(2,334)	2,078	89.0%
PACE	123	(232)	355	153.0%
MSSP	(259)	(173)	(86)	(49.7%)
Buildings	429	363	66	18.2%
Investment Income/Expense	5,260	2,000	3,260	163.0%
Total	$ 20,241	$ 13,709	6,532	47.6%

MLR	Actual	Budget	% Point Var
Medi-Cal	94.4%	93.4%	1.1
OneCare Connect	97.6%	95.0%	2.6
OneCare	93.1%	108.2%	(15.1)

Administrative Cost (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 49,674	$ 58,952	$ 9,278	15.7%
OneCare Connect	5,744	7,392	1,649	22.3%
OneCare	1,229	1,315	86	6.6%
PACE	729	1,057	329	31.1%
MSSP	352	389	37	9.6%
Total	$ 57,727	$ 69,106	$ 11,378	16.5%

Total FTE's YTD	Actual	Budget	Fav / (Unfav)
Medi-Cal	4,565	5,215	650
OneCare Connect	648	787	139
OneCare	60	91	31
PACE	371	454	83
MSSP	81	92	11
Total	5,724	6,639	915

MM per FTE	Actual	Budget	Fav / (Unfav)
Medi-Cal	800	688	(112)
OneCare Connect	89	75	(14)
OneCare	192	116	(76)
PACE	5	4	(1)
MSSP	23	25	1
Total	651	551	(99)

Note:* Total membership does not include MSSP

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CalOptima Health - Consolidated
Statement of Revenues and Expenses
For the One Month Ended October 31, 2022

	Actual		Budget		Variance	
	$	**PMPM**	**$**	**PMPM**	**$**	**PMPM**
MEMBER MONTHS	937,584		913,579		24,005	
REVENUE						
Medi-Cal	$ 265,816,761	$ 288.93	$ 296,933,736	$ 331.48	$ (31,116,975)	$ (43)
OneCare Connect	28,849,174	2,031.92	27,928,779	1,905.23	920,395	126.69
OneCare	3,959,747	1,335.95	3,137,102	1,176.71	822,645	159.24
PACE	3,598,829	8,369.37	3,815,269	8,222.56	(216,440)	146.81
MSSP	196,855	411.83	253,517	446.33	(56,662)	(34.50)
Total Operating Revenue	302,421,366	322.55	332,068,403	363.48	(29,647,037)	(40.93)
MEDICAL EXPENSES						
Medi-Cal	256,227,309	278.51	279,306,472	311.80	23,079,163	33.29
OneCare Connect	27,220,439	1,917.20	26,674,562	1,819.67	(545,877)	(97.53)
OneCare	3,263,784	1,101.14	3,452,763	1,295.11	188,979	193.97
PACE	2,899,456	6,742.92	3,615,373	7,791.75	715,917	1,048.83
MSSP	191,874	401.41	199,480	351.20	7,606	(50.21)
Total Medical Expenses	289,802,862	309.10	313,248,650	342.88	23,445,788	33.78
GROSS MARGIN	12,618,504	13.45	18,819,753	20.60	(6,201,249)	(7.15)
ADMINISTRATIVE EXPENSES						
Salaries and Benefits	10,064,447	10.73	10,936,725	11.97	872,278	1.24
Professional Fees	700,621	0.75	970,317	1.06	269,696	0.31
Purchased Services	1,309,823	1.40	1,420,046	1.55	110,223	0.15
Printing & Postage	98,791	0.11	513,454	0.56	414,663	0.45
Depreciation & Amortization	349,172	0.37	525,900	0.58	176,728	0.21
Other Expenses	1,623,517	1.73	2,434,315	2.66	810,799	0.93
Indirect Cost Allocation, Occupancy	410,991	0.44	527,126	0.58	116,135	0.14
Total Administrative Expenses	14,557,362	15.53	17,327,883	18.97	2,770,521	3.44
INCOME (LOSS) FROM OPERATIONS	(1,938,858)	(2.07)	1,491,870	1.63	(3,430,728)	(3.70)
INVESTMENT INCOME						
Interest Income	6,177,903	6.59	500,000	0.55	5,677,903	6.04
Realized Gain/(Loss) on Investments	(1,665,172)	(1.78)	-	-	(1,665,172)	(1.78)
Unrealized Gain/(Loss) on Investments	(1,981,406)	(2.11)	-	-	(1,981,406)	(2.11)
Total Investment Income	2,531,326	2.70	500,000	0.55	2,031,326	2.15
NET RENTAL INCOME	111,434	0.12	90,835	0.10	20,599	0.02
TOTAL MCO TAX	(1,244)	-	-	-	(1,244)	-
TOTAL GRANT EXPENSE	(863,636)	(0.92)	(1,363,636)	(1.49)	500,000	0.57
CHANGE IN NET ASSETS	**(160,979)**	**(0.17)**	**719,069**	**0.79**	**(880,048)**	**(0.96)**
MEDICAL LOSS RATIO	**95.8%**		**94.3%**		**1.5%**	
ADMINISTRATIVE LOSS RATIO	**4.8%**		**5.2%**		**0.4%**	

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CalOptima Health- Consolidated
Statement of Revenues and Expenses
For the Four Months Ended October 31, 2022

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	3,723,682		3,660,421		63,261	
REVENUE						
Medi-Cal	$ 1,276,383,661	$ 349.42	1,188,708,747	$ 331.17	$ 87,674,914	$ 18.25
OneCare Connect	110,408,673	1,917.58	112,241,975	1,913.76	(1,833,302)	3.82
OneCare	14,077,913	1,223.42	12,455,474	1,177.82	1,622,439	45.60
PACE	14,172,019	8,163.61	15,090,284	8,264.12	(918,265)	(100.51)
MSSP	827,727	437.49	1,014,068	446.33	(186,341)	(8.84)
Total Operating Revenue	1,415,869,993	380.23	1,329,510,548	363.21	86,359,445	17.02
MEDICAL EXPENSES						
Medi-Cal	1,205,261,046	329.95	1,109,777,858	309.18	(95,483,188)	(20.77)
OneCare Connect	107,764,411	1,871.66	106,652,732	1,818.46	(1,111,679)	(53.20)
OneCare	13,104,786	1,138.85	13,474,176	1,274.15	369,390	135.30
PACE	13,320,436	7,673.06	14,265,048	7,812.18	944,612	139.12
MSSP	735,357	388.67	797,920	351.20	62,563	(37.47)
Total Medical Expenses	1,340,186,038	359.91	1,244,967,734	340.12	(95,218,304)	(19.79)
GROSS MARGIN	75,683,955	20.32	84,542,814	23.09	(8,858,859)	(2.77)
ADMINISTRATIVE EXPENSES						
Salaries and Benefits	40,467,322	10.87	44,428,772	12.14	3,961,450	1.27
Professional Fees	2,293,278	0.62	3,663,907	1.00	1,370,629	0.38
Purchased Services	4,137,502	1.11	5,013,517	1.37	876,015	0.26
Printing & Postage	1,479,224	0.40	2,053,447	0.56	574,223	0.16
Depreciation & Amortization	1,450,680	0.39	2,103,600	0.57	652,920	0.18
Other Expenses	6,158,466	1.65	9,737,627	2.66	3,579,161	1.01
Indirect Cost Allocation, Occupancy	1,740,926	0.47	2,104,933	0.58	364,007	0.11
Total Administrative Expenses	57,727,398	15.50	69,105,803	18.88	11,378,405	3.38
INCOME (LOSS) FROM OPERATIONS	17,956,557	4.82	15,437,011	4.22	2,519,546	0.60
INVESTMENT INCOME						
Interest Income	18,040,662	4.84	2,000,000	0.55	16,040,662	4.29
Realized Gain/(Loss) on Investments	(3,555,650)	(0.95)	-	0.00	(3,555,650)	(0.95)
Unrealized Gain/(Loss) on Investments	(9,225,068)	(2.48)	-	0.00	(9,225,068)	(2.48)
Total Investment Income	5,259,945	1.41	2,000,000	0.55	3,259,945	0.86
NET RENTAL INCOME	428,891	0.12	363,340	0.10	65,551	0.02
TOTAL MCO TAX	23,667	0.01	-	0.00	23,667	0.01
TOTAL GRANT EXPENSE	(3,454,545)	(0.93)	(4,090,908)	(1.12)	636,363	0.19
OTHER INCOME	25,878	0.01	-	0.00	25,878	0.01
CHANGE IN NET ASSETS	**20,240,392**	**5.44**	**13,709,443**	**3.75**	**6,530,949**	**1.69**
MEDICAL LOSS RATIO	**94.7%**		**93.6%**		**1.0%**	
ADMINISTRATIVE LOSS RATIO	**4.1%**		**5.2%**		**1.1%**	

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CalOptima Health - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ended October 31, 2022

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS	566,141	342,034	11,817	919,992	14,198	2,964	430	478	937,584
REVENUES									
Capitation Revenue	133,154,669	$ 111,692,799	$ 20,969,293	$ 265,816,761	$ 28,849,174	$ 3,959,747	$ 3,598,829	$ 196,855	$ 302,421,366
Total Operating Revenue	133,154,669	111,692,799	20,969,293	265,816,761	28,849,174	3,959,747	3,598,829	196,855	302,421,366
MEDICAL EXPENSES									
Provider Capitation	40,691,043	47,864,119	8,709,641	97,264,803	11,728,332	1,039,945			110,033,080
Facilities	29,932,548	27,110,477	3,295,467	60,338,491	4,160,582	878,728	592,586		65,970,388
Professional Claims	21,907,406	16,048,940	1,346,364	39,302,709	1,331,723	123,245	866,547		41,624,225
Prescription Drugs	(22,473)	(27,565)	6,105	(43,933)	6,874,898	1,159,507	425,643		8,416,114
MLTSS	35,187,839	3,761,543	1,634,786	40,584,167	1,651,691		116,877	45,663	42,398,398
Incentive Payments	5,878,500	6,786,599	308,040	12,973,139	564,039	16,568	5,375		13,559,120
Medical Management	2,577,620	1,810,667	340,171	4,728,458	909,175	45,792	892,428	146,211	6,722,063
Other Medical Expenses	603,768	463,540	12,166	1,079,474					1,079,474
Total Medical Expenses	136,756,251	103,818,320	15,652,738	256,227,309	27,220,439	3,263,784	2,899,456	191,874	289,802,862
Medical Loss Ratio	102.7%	92.9%	74.6%	96.4%	94.4%	82.4%	80.6%	97.5%	95.8%
GROSS MARGIN	**(3,601,582)**	**7,874,479**	**5,316,555**	**9,589,452**	**1,628,735**	**695,963**	**699,373**	**4,981**	**12,618,504**
ADMINISTRATIVE EXPENSES									
Salaries & Benefits				9,010,964	692,184	168,683	123,769	68,847	10,064,447
Professional Fees				673,701	838	24,771	(22)	1,333	700,621
Purchased Services				1,188,564	110,656	23,038	(12,435)		1,309,823
Printing & Postage				85,805	(41,466)	44,839	9,614		98,791
Depreciation & Amortization				348,615			557		349,172
Other Expenses				1,611,064	929		5,530	5,994	1,623,517
Indirect Cost Allocation, Occupancy				(327,033)	640,809	79,498	12,466	5,252	410,991
Total Administrative Expenses				**12,591,679**	**1,403,948**	**340,829**	**139,479**	**81,426**	**14,557,362**
Admin Loss Ratio				4.7%	4.9%	8.6%	3.9%	41.4%	4.8%
INCOME (LOSS) FROM OPERATIONS				(3,002,227)	224,787	355,134	559,894	(76,445)	(1,938,858)
INVESTMENT INCOME									2,531,326
NET RENTAL INCOME									111,434
TOTAL MCO TAX				(1,244)					(1,244)
TOTAL GRANT EXPENSE				(863,636)					(863,636)
CHANGE IN NET ASSETS				**$ (3,867,107)**	**$ 224,787**	**$ 355,134**	**$ 559,894**	**$ (76,445)**	**$ (160,979)**
BUDGETED CHANGE IN NET ASSETS				1,450,958	(567,709)	(655,026)	(59,135)	(40,854)	719,069
VARIANCE TO BUDGET - FAV (UNFAV)				$ (5,318,065)	$ 792,496	$ 1,010,160	$ 619,029	$ (35,591)	$ (880,048)

Note:* Total membership does not include MSSP

CalOptima Health - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Four Months Ended October 31, 2022

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS	2,259,301	1,346,157	47,404	3,652,862	57,577	11,507	1,736	1,892	3,723,682
REVENUES									
Capitation Revenue	656,952,723	$ 524,060,249	$ 95,370,689	$ 1,276,383,661	$ 110,408,673	$ 14,077,913	$ 14,172,019	$ 827,727	$ 1,415,869,993
Total Operating Revenue	656,952,723	524,060,249	95,370,689	1,276,383,661	110,408,673	14,077,913	14,172,019	827,727	1,415,869,993
MEDICAL EXPENSES									
Provider Capitation	165,568,956	194,857,653	39,076,430	399,503,039	44,780,399	3,952,869			448,236,307
Facilities	135,553,395	121,228,393	24,540,886	281,322,674	17,631,217	3,855,081	3,721,181		306,530,153
Professional Claims	87,835,460	58,066,547	6,060,383	151,962,390	5,762,683	581,209	3,712,619		162,018,901
Prescription Drugs	(1,561,723)	(195,164)	6,105	(1,750,782)	26,986,714	4,516,287	1,636,146		31,388,365
MLTSS	166,235,279	17,926,305	7,946,163	192,107,747	6,862,602		599,701	135,095	199,705,146
Incentive Payments	11,732,580	13,826,082	431,310	25,989,972	1,736,045	20,669	21,700		27,768,386
Medical Management	10,878,591	7,422,197	1,460,766	19,761,554	4,004,752	178,671	3,629,088	600,263	28,174,328
Other Medical Expenses	73,016,706	55,088,869	8,258,877	136,364,452					136,364,452
Total Medical Expenses	649,259,245	468,220,881	87,780,920	1,205,261,046	107,764,411	13,104,786	13,320,436	735,357	1,340,186,038
Medical Loss Ratio	98.8%	89.3%	92.0%	94.4%	97.6%	93.1%	94.0%	88.8%	94.7%
GROSS MARGIN	**7,693,478**	**55,839,368**	**7,589,769**	**71,122,615**	**2,644,262**	**973,126**	**851,583**	**92,369**	**75,683,955**
ADMINISTRATIVE EXPENSES									
Salaries & Benefits				36,454,007	2,672,438	503,728	534,959	302,190	40,467,322
Professional Fees				2,153,634	19,651	113,106	1,553	5,333	2,293,278
Purchased Services				3,604,583	391,285	84,009	57,626		4,137,502
Printing & Postage				1,116,960	92,701	209,983	59,580		1,479,224
Depreciation & Amortization				1,448,487			2,193		1,450,680
Other Expenses				6,107,942	4,408	(0)	22,795	23,321	6,158,466
Indirect Cost Allocation, Occupancy				(1,211,174)	2,563,235	317,992	49,865	21,009	1,740,926
Total Administrative Expenses				**49,674,439**	**5,743,717**	**1,228,818**	**728,571**	**351,853**	**57,727,398**
Admin Loss Ratio				3.9%	5.2%	8.7%	5.1%	42.5%	4.1%
INCOME (LOSS) FROM OPERATIONS				21,448,176	(3,099,456)	(255,691)	123,012	(259,484)	17,956,557
INVESTMENT INCOME									5,259,945
NET RENTAL INCOME									428,891
TOTAL MCO TAX				23,667					23,667
TOTAL GRANT EXPENSE				(3,454,545)					(3,454,545)
OTHER INCOME				25,878					25,878
CHANGE IN NET ASSETS				**$ 18,043,175**	**$ (3,099,456)**	**$ (255,691)**	**$ 123,012**	**$ (259,484)**	**$ 20,240,392**
BUDGETED CHANGE IN NET ASSETS				15,887,778	(1,803,080)	(2,333,735)	(231,894)	(172,966)	13,709,443
VARIANCE TO BUDGET - FAV (UNFAV)				$ 2,155,397	$ (1,296,376)	$ 2,078,044	$ 354,906	$ (86,518)	$ 6,530,949

Note:* Total membership does not include MSSP

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CalOptima Health

October 31, 2022 Unaudited Financial Statements

SUMMARY MONTHLY RESULTS:

- Change in Net Assets is ($0.2) million, $0.9 million unfavorable to budget
- Operating deficit is $1.9 million, with a surplus in non-operating income of $1.8 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $20.2 million, $6.5 million favorable to budget
- Operating surplus is $18.0 million, with a surplus in non-operating income of $2.3 million

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

October				July-October		
Actual	Budget	Variance	**Operating Income (Loss)**	Actual	Budget	Variance
(3.0)	2.8	(5.8)	Medi-Cal	21.4	20.0	1.5
0.2	(0.6)	0.8	OCC	(3.1)	(1.8)	(1.3)
0.4	(0.7)	1.0	OneCare	(0.3)	(2.3)	2.1
0.6	(0.1)	0.6	PACE	0.1	(0.2)	0.4
(0.1)	(0.0)	(0.0)	MSSP	(0.3)	(0.2)	(0.1)
(1.9)	**1.5**	**(3.4)**	**Total Operating Income (Loss)**	**18.0**	**15.4**	**2.5**
			Non-Operating Income (Loss)			
2.5	0.5	2.0	Net Investment Income/Expense	5.3	2.0	3.3
0.1	0.1	0.0	Net Rental Income/Expense	0.4	0.4	0.1
(0.0)	0.0	(0.0)	Net Operating Tax	0.0	0.0	0.0
(0.9)	(1.4)	0.5	Grant Expense	(3.5)	(4.1)	0.6
0.0	0.0	0.0	Net Other Income/Expense	0.0	0.0	0.0
1.8	**(0.8)**	**2.6**	**Total Non-Operating Income/(Loss)**	**2.3**	**(1.7)**	**4.0**
(0.2)	**0.7**	**(0.9)**	**TOTAL**	**20.2**	**13.7**	**6.5**

CalOptima Health - Consolidated
Enrollment Summary
For the Four Months Ended October 31, 2022

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
121,371	122,811	(1,440)	(1.2%)	SPD	497,207	489,623	7,584	1.5%
303,915	306,206	(2,291)	(0.7%)	TANF Child	1,214,031	1,226,319	(12,288)	(1.0%)
137,621	134,896	2,725	2.0%	TANF Adult	535,113	542,488	(7,375)	(1.4%)
3,234	3,339	(105)	(3.1%)	LTC	12,950	13,304	(354)	(2.7%)
342,034	316,769	25,265	8.0%	MCE	1,346,157	1,270,665	75,492	5.9%
11,817	11,769	48	0.4%	WCM	47,404	46,971	433	0.9%
919,992	**895,790**	**24,202**	**2.7%**	**Medi-Cal Total**	**3,652,862**	**3,589,370**	**63,492**	**1.8%**
14,198	**14,659**	**(461)**	**(3.1%)**	**OneCare Connect**	**57,577**	**58,650**	**(1,073)**	**(1.8%)**
2,964	**2,666**	**298**	**11.2%**	**OneCare**	**11,507**	**10,575**	**932**	**8.8%**
430	**464**	**(34)**	**(7.3%)**	**PACE**	**1,736**	**1,826**	**(90)**	**(4.9%)**
478	**568**	**(90)**	**(15.8%)**	**MSSP**	**1,892**	**2,272**	**(380)**	**(16.7%)**
937,584	**913,579**	**24,005**	**2.6%**	**CalOptima Total**	**3,723,682**	**3,660,421**	**63,261**	**1.7%**
				Enrollment (by Network)				
213,118	211,014	2,104	1.0%	HMO	846,021	846,169	(148)	(0.0%)
238,306	239,031	(725)	(0.3%)	PHC	950,223	957,716	(7,493)	(0.8%)
227,194	221,877	5,317	2.4%	Shared Risk Group	903,327	890,185	13,142	1.5%
241,374	223,868	17,506	7.8%	Fee for Service	953,291	895,300	57,991	6.5%
919,992	**895,790**	**24,202**	**2.7%**	**Medi-Cal Total**	**3,652,862**	**3,589,370**	**63,492**	**1.8%**
14,198	**14,659**	**(461)**	**(3.1%)**	**OneCare Connect**	**57,577**	**58,650**	**(1,073)**	**(1.8%)**
2,964	**2,666**	**298**	**11.2%**	**OneCare**	**11,507**	**10,575**	**932**	**8.8%**
430	**464**	**(34)**	**(7.3%)**	**PACE**	**1,736**	**1,826**	**(90)**	**(4.9%)**
478	**568**	**(90)**	**(15.8%)**	**MSSP**	**1,892**	**2,272**	**(380)**	**(16.7%)**
937,584	**913,579**	**24,005**	**2.6%**	**CalOptima Total**	**3,723,682**	**3,660,421**	**63,261**	**1.7%**

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CalOptima Health
Enrollment Trend by Network
Fiscal Year 2023

	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	YTD Actual	YTD Budget	Variance
HMOs															
SPD	11,237	11,250	11,290	11,288									45,065	43,818	1,247
BCCTP													-		0
Disabled													-		0
TANF Child	58,966	58,892	58,837	58,847									235,542	238,196	(2,654)
TANF Adult	38,926	38,983	39,331	39,640									156,880	168,128	(11,248)
LTC	1	2	2	1									6		6
MCE	99,022	99,788	100,301	101,292									400,403	387,574	12,829
WCM	2,034	2,020	2,021	2,050									8,125	8,453	(328)
Total	**210,186**	**210,935**	**211,782**	**213,118**									**846,021**	**846,169**	**(148)**
PHCs															
SPD	7,040	7,022	7,037	7,029									28,128	27,981	147
BCCTP													-		0
Disabled													-		0
TANF Child	158,385	158,345	158,767	159,067									634,564	639,731	(5,167)
TANF Adult	16,704	16,780	16,830	16,855									67,169	71,128	(3,959)
LTC		1	1	3									5		5
MCE	47,505	47,574	47,748	48,051									190,878	189,916	962
WCM	7,366	7,472	7,340	7,301									29,479	28,960	519
Total	**237,000**	**237,194**	**237,723**	**238,306**									**950,223**	**957,716**	**(7,493)**
Shared Risk Groups															
SPD	10,824	10,928	10,995	10,954									43,701	40,772	2,929
BCCTP													-		0
Disabled													-		0
TANF Child	57,419	57,075	56,762	56,460									227,716	238,558	(10,842)
TANF Adult	40,518	40,260	40,370	40,566									161,714	164,438	(2,724)
LTC	2	1	3	6									12		12
MCE	114,819	115,585	116,539	117,839									464,782	440,851	23,931
WCM	1,360	1,341	1,332	1,369									5,402	5,566	(164)
Total	**224,942**	**225,190**	**226,001**	**227,194**									**903,327**	**890,185**	**13,142**
Fee for Service (Dual)															
SPD	82,253	82,742	82,935	83,572									331,502	332,248	(746)
BCCTP													-		0
Disabled													-		0
TANF Child	1	1	1	1									4		4
TANF Adult	1,675	1,712	1,743	1,742									6,872	7,367	(495)
LTC	2,894	2,874	2,845	2,879									11,492	11,976	(484)
MCE	6,480	6,749	7,030	7,314									27,573	23,934	3,639
WCM	20	18	24	17									79	61	18
Total	**93,323**	**94,096**	**94,578**	**95,525**									**377,522**	**375,586**	**1,936**
Fee for Service (Non-Dual - Total)															
SPD	11,984	12,003	16,296	8,528									48,811	44,804	4,007
BCCTP													-		0
Disabled													-		0
TANF Child	28,613	28,702	29,350	29,540									116,205	109,834	6,371
TANF Adult	32,830	33,442	37,388	38,818									142,478	131,427	11,051
LTC	360	364	366	345									1,435	1,328	107
MCE	63,450	64,657	66,876	67,538									262,521	228,390	34,131
WCM	1,096	1,094	1,049	1,080									4,319	3,931	388
Total	**138,333**	**140,262**	**151,325**	**145,849**									**575,769**	**519,714**	**56,055**
Grand Totals															
SPD	123,338	123,945	128,553	121,371									497,207	489,623	7,584
BCCTP													-		0
Disabled													-		0
TANF Child	303,384	303,015	303,717	303,915									1,214,031	1,226,319	(12,288)
TANF Adult	130,653	131,177	135,662	137,621									535,113	542,488	(7,375)
LTC	3,257	3,242	3,217	3,234									12,950	13,304	(354)
MCE	331,276	334,353	338,494	342,034									1,346,157	1,270,665	75,492
WCM	11,876	11,945	11,766	11,817									47,404	46,971	433
Total MediCal MM	**903,784**	**907,677**	**921,409**	**919,992**									**3,652,862**	**3,589,370**	**63,492**
OneCare Connect	**14,203**	**14,771**	**14,405**	**14,198**									**57,577**	**58,650**	**(1,073)**
OneCare	**2,764**	**2,874**	**2,905**	**2,964**									**11,507**	**10,575**	**932**
PACE	**435**	**434**	**437**	**430**									**1,736**	**1,826**	**(90)**
MSSP	**466**	**470**	**478**	**478**									**1,892**	**2,272**	**(380)**
Grand Total	**921,186**	**925,756**	**939,156**	**937,584**									**3,723,682**	**3,660,421**	**63,261**

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ENROLLMENT:

Overall, October enrollment was 937,584

- Favorable to budget 24,005 or 2.6%
- Decreased 1,572 or 0.2% from Prior Month (PM) (September 2022)
- Increased 93,821 or 11.1% from Prior Year (PY) (October 2021)

Medi-Cal enrollment was 919,992

- Favorable to budget 24,202 or 2.7%
  - Medi-Cal Expansion (MCE) favorable 25,265
  - Temporary Assistance for Needy Families (TANF) favorable 434
  - Whole Child Model (WCM) favorable 48
  - Seniors and Persons with Disabilities (SPD) unfavorable 1,440
  - Long-Term Care (LTC) unfavorable 105
- Decreased 1,417 from PM

OneCare Connect enrollment was 14,198

- Unfavorable to budget 461 or 3.1%
- Decreased 207 from PM

OneCare enrollment was 2,964

- Favorable to budget 298 or 11.2%
- Increased 59 from PM

PACE enrollment was 430

- Unfavorable to budget 34 or 7.3%
- Decreased 7 from PM

MSSP enrollment was 478

- Unfavorable to budget 90 or 15.8% due to MSSP currently being understaffed. There is a staff to member ratio that must be met
- No change from PM

CalOptima Health
Medi-Cal
Statement of Revenues and Expenses
For the Four Months Ending October 31, 2022

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
919,992	**895,790**	**24,202**	**2.7%**	**Member Months**	**3,652,862**	**3,589,370**	**63,492**	**1.8%**
				Revenues				
265,816,761	296,933,736	(31,116,975)	(10.5%)	Medi-Cal Capitation Revenue	1,276,383,661	1,188,708,747	87,674,914	7.4%
265,816,761	**296,933,736**	**(31,116,975)**	**(10.5%)**	**Total Operating Revenue**	**1,276,383,661**	**1,188,708,747**	**87,674,914**	**7.4%**
				Medical Expenses				
97,264,803	106,402,120	9,137,317	8.6%	Provider Capitation	399,503,039	426,552,609	27,049,570	6.3%
60,338,491	68,869,733	8,531,242	12.4%	Facilities Claims	281,322,674	272,570,809	(8,751,865)	(3.2%)
39,302,709	40,614,879	1,312,170	3.2%	Professional Claims	151,962,390	160,570,989	8,608,599	5.4%
40,584,167	50,562,526	9,978,359	19.7%	MLTSS	192,107,747	197,968,681	5,860,934	3.0%
(43,933)	-	43,933	100.0%	Prescription Drugs	(1,750,782)	-	1,750,782	100.0%
12,973,139	4,683,881	(8,289,258)	(177.0%)	Incentive Payments	25,989,972	18,764,121	(7,225,851)	(38.5%)
4,728,458	6,599,261	1,870,803	28.3%	Medical Management	19,761,554	27,054,361	7,292,807	27.0%
1,079,474	1,574,072	494,598	31.4%	Other Medical Expenses	136,364,452	6,296,288	(130,068,164)	(2065.8%)
256,227,309	**279,306,472**	**23,079,163**	**8.3%**	**Total Medical Expenses**	**1,205,261,046**	**1,109,777,858**	**(95,483,188)**	**(8.6%)**
9,589,452	**17,627,264**	**(8,037,812)**	**(45.6%)**	**Gross Margin**	**71,122,615**	**78,930,889**	**(7,808,274)**	**(9.9%)**
				Administrative Expenses				
9,010,964	9,645,168	634,204	6.6%	Salaries, Wages & Employee Benefits	36,454,007	39,166,223	2,712,216	6.9%
673,701	923,156	249,455	27.0%	Professional Fees	2,153,634	3,475,262	1,321,628	38.0%
1,188,564	1,252,067	63,503	5.1%	Purchased Services	3,604,583	4,341,602	737,019	17.0%
85,805	383,940	298,135	77.7%	Printing & Postage	1,116,960	1,535,394	418,434	27.3%
348,615	525,000	176,385	33.6%	Depreciation & Amortization	1,448,487	2,100,000	651,513	31.0%
1,611,064	2,408,999	797,935	33.1%	Other Operating Expenses	6,107,942	9,636,362	3,528,420	36.6%
(327,033)	(325,660)	1,373	0.4%	Indirect Cost Allocation, Occupancy	(1,211,174)	(1,302,640)	(91,466)	(7.0%)
12,591,679	**14,812,670**	**2,220,991**	**15.0%**	**Total Administrative Expenses**	**49,674,439**	**58,952,203**	**9,277,764**	**15.7%**
				Non-Operating Income (Loss)				
(1,244)	-	(1,244)	(100.0%)	Net Operating Tax	23,667	-	23,667	100.0%
(863,636)	(1,363,636)	500,000	36.7%	Grant Expense	(3,454,545)	(4,090,908)	636,363	15.6%
-	-	-	0.0%	Net QAF & IGT Income/Expense	-	-	-	0.0%
-	-	-	0.0%	Other Income	25,878	-	25,878	100.0%
(864,880)	**(1,363,636)**	**498,756**	**36.6%**	**Total Non-Operating Income (Loss)**	**(3,405,001)**	**(4,090,908)**	**685,907**	**16.8%**
(3,867,107)	**1,450,958**	**(5,318,065)**	**(366.5%)**	**Change in Net Assets**	**18,043,175**	**15,887,778**	**2,155,397**	**13.6%**
96.4%	***94.1%***	***2.3%***		***Medical Loss Ratio***	***94.4%***	***93.4%***	***1.1%***	
4.7%	***5.0%***	***0.3%***		***Admin Loss Ratio***	***3.9%***	***5.0%***	***1.1%***	

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MEDI-CAL INCOME STATEMENT– OCTOBER MONTH:

REVENUES of $265.8 million are unfavorable to budget $31.1 million driven by:

- Favorable volume related variance of $8.0 million
- Unfavorable price related variance of $39.1 million
  - $43.3 million due to net of Proposition 56, COVID-19 and Enhanced Care Management (ECM) risk corridor reserves

MEDICAL EXPENSES of $256.2 million are favorable to budget $23.1 million driven by:

- Unfavorable volume related variance of $7.5 million
- Favorable price related variance of $30.6 million
  - Provider Capitation expense favorable variance of $12.0 million primarily due to Proposition 56 estimates
  - Managed Long-Term Services and Supports (MLTSS) expense favorable variance of $11.3 million due to Incurred But Not Reported (IBNR) claims
  - Facilities Claims expense favorable variance of $10.4 million due to low utilization
  - Professional Claims expense favorable variance of $2.4 million
  - Medical Management expense favorable variance of $2.0 million
  - Offset by:
    - Incentive Payments expenses unfavorable variance of $8.2 million due to PY hospital shared risk pool

ADMINISTRATIVE EXPENSES of $12.6 million are favorable to budget $2.2 million driven by:

- Other Non-Salary expense favorable to budget $1.6 million
- Salaries & Benefit expense favorable to budget $0.6 million

CHANGE IN NET ASSETS is ($3.9) million, unfavorable to budget $5.3 million

CalOptima Health
OneCare Connect - Total
Statement of Revenue and Expenses
For the Four Months Ending October 31, 2022

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
14,198	**14,659**	**(461)**	**(3.1%)**	**Member Months**	**57,577**	**58,650**	**(1,073)**	**(1.8%)**
				Revenues				
2,559,372	2,829,496	(270,124)	(9.5%)	Medi-Cal Revenue	10,620,594	11,373,278	(752,684)	(6.6%)
19,895,514	19,579,722	315,792	1.6%	Medicare Part C Revenue	74,166,005	78,775,403	(4,609,398)	(5.9%)
6,394,288	5,519,561	874,727	15.8%	Medicare Part D Revenue	25,622,074	22,093,294	3,528,780	16.0%
28,849,174	**27,928,779**	**920,395**	**3.3%**	**Total Operating Revenue**	**110,408,673**	**112,241,975**	**(1,833,302)**	**(1.6%)**
				Medical Expenses				
11,728,332	11,558,855	(169,477)	(1.5%)	Provider Capitation	44,780,399	46,478,377	1,697,978	3.7%
4,160,582	4,168,902	8,320	0.2%	Facilities Claims	17,631,217	16,492,483	(1,138,734)	(6.9%)
1,331,723	1,219,500	(112,223)	(9.2%)	Ancillary	5,762,683	4,818,978	(943,705)	(19.6%)
1,651,691	1,505,970	(145,721)	(9.7%)	MLTSS	6,862,602	5,964,831	(897,771)	(15.1%)
6,874,898	6,458,839	(416,059)	(6.4%)	Prescription Drugs	26,986,714	25,479,444	(1,507,270)	(5.9%)
564,039	535,503	(28,536)	(5.3%)	Incentive Payments	1,736,045	2,221,533	485,488	21.9%
909,175	1,226,993	317,818	25.9%	Medical Management	4,004,752	5,197,086	1,192,334	22.9%
27,220,439	**26,674,562**	**(545,877)**	**(2.0%)**	**Total Medical Expenses**	**107,764,411**	**106,652,732**	**(1,111,679)**	**(1.0%)**
1,628,735	**1,254,217**	**374,518**	**29.9%**	**Gross Margin**	**2,644,262**	**5,589,243**	**(2,944,981)**	**(52.7%)**
				Administrative Expenses				
692,184	895,139	202,955	22.7%	Salaries, Wages & Employee Benefits	2,672,438	3,684,495	1,012,057	27.5%
838	20,833	19,996	96.0%	Professional Fees	19,651	83,332	63,681	76.4%
110,656	109,606	(1,050)	(1.0%)	Purchased Services	391,285	438,424	47,139	10.8%
(41,466)	67,512	108,978	161.4%	Printing & Postage	92,701	270,048	177,347	65.7%
929	6,096	5,167	84.8%	Other Operating Expenses	4,408	24,384	19,976	81.9%
640,809	722,740	81,931	11.3%	Indirect Cost Allocation, Occupancy	2,563,235	2,891,640	328,405	11.4%
1,403,948	**1,821,926**	**417,978**	**22.9%**	**Total Administrative Expenses**	**5,743,717**	**7,392,323**	**1,648,606**	**22.3%**
224,787	**(567,709)**	**792,496**	**139.6%**	**Change in Net Assets**	**(3,099,456)**	**(1,803,080)**	**(1,296,376)**	**(71.9%)**
94.4%	***95.5%***	***(1.2%)***		***Medical Loss Ratio***	***97.6%***	***95.0%***	***2.6%***	
4.9%	***6.5%***	***1.7%***		***Admin Loss Ratio***	***5.2%***	***6.6%***	***1.4%***	

ONECARE CONNECT INCOME STATEMENT– OCTOBER MONTH:

REVENUES of $28.8 million are favorable to budget $0.9 million driven by:

- Unfavorable volume related variance of $0.9 million
- Favorable price related variance of $1.8 million is due to final Calendar Year (CY) 2021 Hierarchical Condition Category (HCC) reconciliation

MEDICAL EXPENSES of $27.2 million are unfavorable to budget $0.5 million driven by:

- Favorable volume related variance of $0.8 million
- Unfavorable price related variance of $1.4 million
  - Prescription Drugs expense unfavorable variance of $0.6 million
  - Provider Capitation expense unfavorable variance of $0.5 million
  - MLTSS expense unfavorable variance of $0.2 million

ADMINISTRATIVE EXPENSES of $1.4 million are favorable to budget $0.4 million driven by:

- Other Non-Salary expense favorable to budget $0.2 million
- Salaries & Benefit expense favorable to budget $0.2 million

CHANGE IN NET ASSETS is $0.2 million, favorable to budget $0.8 million

CalOptima Health
OneCare
Statement of Revenues and Expenses
For the Four Months Ending October 31, 2022

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
2,964	**2,666**	**298**	**11.2%**	**Member Months**	**11,507**	**10,575**	**932**	**8.8%**
				Revenues				
2,677,474	2,088,706	588,768	28.2%	Medicare Part C Revenue	9,855,487	8,288,287	1,567,200	18.9%
1,282,273	1,048,396	233,877	22.3%	Medicare Part D Revenue	4,222,426	4,167,187	55,239	1.3%
3,959,747	**3,137,102**	**822,645**	**26.2%**	**Total Operating Revenue**	**14,077,913**	**12,455,474**	**1,622,439**	**13.0%**
				Medical Expenses				
1,039,945	769,153	(270,792)	(35.2%)	Provider Capitation	3,952,869	3,052,089	(900,780)	(29.5%)
878,728	1,249,392	370,664	29.7%	Inpatient	3,855,081	4,901,979	1,046,898	21.4%
123,245	96,478	(26,767)	(27.7%)	Ancillary	581,209	379,401	(201,808)	(53.2%)
1,159,507	1,185,450	25,943	2.2%	Prescription Drugs	4,516,287	4,638,003	121,716	2.6%
16,568	25,409	8,841	34.8%	Incentive Payments	20,669	100,785	80,116	79.5%
45,792	126,881	81,089	63.9%	Medical Management	178,671	401,919	223,248	55.5%
3,263,784	**3,452,763**	**188,979**	**5.5%**	**Total Medical Expenses**	**13,104,786**	**13,474,176**	**369,390**	**2.7%**
695,963	**(315,661)**	**1,011,624**	**320.5%**	**Gross Margin**	**973,126**	**(1,018,702)**	**1,991,828**	**195.5%**
				Administrative Expenses				
168,683	147,542	(21,141)	(14.3%)	Salaries, Wages & Employee Benefits	503,728	551,461	47,733	8.7%
24,771	24,583	(188)	(0.8%)	Professional Fees	113,106	98,332	(14,774)	(15.0%)
23,038	14,693	(8,345)	(56.8%)	Purchased Services	84,009	58,772	(25,237)	(42.9%)
44,839	41,767	(3,072)	(7.4%)	Printing & Postage	209,983	167,068	(42,915)	(25.7%)
-	-	-	0.0%	Other Operating Expenses	(0)	-	0	100.0%
79,498	110,780	31,282	28.2%	Indirect Cost Allocation, Occupancy	317,992	439,400	121,408	27.6%
340,829	**339,365**	**(1,464)**	**(0.4%)**	**Total Administrative Expenses**	**1,228,818**	**1,315,033**	**86,215**	**6.6%**
355,134	**(655,026)**	**1,010,160**	**154.2%**	**Change in Net Assets**	**(255,691)**	**(2,333,735)**	**2,078,044**	**89.0%**
82.4%	***110.1%***	***(27.6%)***		***Medical Loss Ratio***	***93.1%***	***108.2%***	***(15.1%)***	
8.6%	***10.8%***	***2.2%***		***Admin Loss Ratio***	***8.7%***	***10.6%***	***1.8%***	

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CalOptima Health
PACE
Statement of Revenues and Expenses
For the Four Months Ending October 31, 2022

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
430	**464**	**(34)**	**(7.3%)**	**Member Months**	**1,736**	**1,826**	**(90)**	**(4.9%)**
				Revenues				
2,767,593	2,944,298	(176,705)	(6.0%)	Medi-Cal Capitation Revenue	11,147,945	11,588,776	(440,831)	(3.8%)
629,268	673,424	(44,156)	(6.6%)	Medicare Part C Revenue	2,262,679	2,724,554	(461,875)	(17.0%)
201,967	197,547	4,420	2.2%	Medicare Part D Revenue	761,395	776,954	(15,559)	(2.0%)
3,598,829	**3,815,269**	**(216,440)**	**(5.7%)**	**Total Operating Revenue**	**14,172,019**	**15,090,284**	**(918,265)**	**(6.1%)**
				Medical Expenses				
892,428	1,087,730	195,302	18.0%	Medical Management	3,629,088	4,454,691	825,603	18.5%
592,586	929,862	337,276	36.3%	Facilities Claims	3,721,181	3,609,087	(112,094)	(3.1%)
731,947	934,792	202,845	21.7%	Professional Claims	3,155,581	3,627,418	471,837	13.0%
425,643	397,912	(27,731)	(7.0%)	Prescription Drugs	1,636,146	1,539,514	(96,632)	(6.3%)
116,877	67,378	(49,499)	(73.5%)	MLTSS	599,701	263,009	(336,692)	(128.0%)
134,600	191,792	57,193	29.8%	Patient Transportation	557,038	748,270	191,232	25.6%
5,375	5,907	532	9.0%	Incentive Payments	21,700	23,059	1,359	5.9%
2,899,456	**3,615,373**	**715,917**	**19.8%**	**Total Medical Expenses**	**13,320,436**	**14,265,048**	**944,612**	**6.6%**
699,373	**199,896**	**499,477**	**249.9%**	**Gross Margin**	**851,583**	**825,236**	**26,347**	**3.2%**
				Administrative Expenses				
123,769	171,016	47,247	27.6%	Salaries, Wages & Employee Benefits	534,959	705,603	170,644	24.2%
(22)	412	434	105.3%	Professional Fees	1,553	1,649	96	5.8%
(12,435)	43,680	56,115	128.5%	Purchased Services	57,626	174,719	117,093	67.0%
9,614	20,235	10,621	52.5%	Printing & Postage	59,580	80,937	21,357	26.4%
557	900	343	38.1%	Depreciation & Amortization	2,193	3,600	1,407	39.1%
5,530	10,072	4,542	45.1%	Other Operating Expenses	22,795	40,289	17,494	43.4%
12,466	12,716	250	2.0%	Indirect Cost Allocation, Occupancy	49,865	50,333	468	0.9%
139,479	**259,031**	**119,552**	**46.2%**	**Total Administrative Expenses**	**728,571**	**1,057,130**	**328,559**	**31.1%**
559,894	**(59,135)**	**619,029**	**1046.8%**	**Change in Net Assets**	**123,012**	**(231,894)**	**354,906**	**153.0%**
80.6%	***94.8%***	***(14.2%)***		***Medical Loss Ratio***	***94.0%***	***94.5%***	***(0.5%)***	
3.9%	***6.8%***	***2.9%***		***Admin Loss Ratio***	***5.1%***	***7.0%***	***1.9%***	

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CalOptima Health
Multipurpose Senior Services Program
Statement of Revenues and Expenses
For the Four Months Ending October 31, 2022

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
478	**568**	**(90)**	**(15.8%)**	**Member Months**	**1,892**	**2,272**	**(380)**	**(16.7%)**
				Revenues				
196,855	253,517	(56,662)	(22.4%)	Revenue	827,727	1,014,068	(186,341)	(18.4%)
196,855	**253,517**	**(56,662)**	**(22.4%)**	**Total Operating Revenue**	**827,727**	**1,014,068**	**(186,341)**	**(18.4%)**
				Medical Expenses				
146,211	166,522	20,311	12.2%	Medical Management	600,263	666,088	65,825	9.9%
45,663	32,958	(12,705)	(38.5%)	Waiver Services	135,095	131,832	(3,263)	(2.5%)
146,211	166,522	20,311	12.2%	Total Medical Management	600,263	666,088	65,825	9.9%
45,663	32,958	(12,705)	(38.5%)	Total Waiver Services	135,095	131,832	(3,263)	(2.5%)
191,874	**199,480**	**7,606**	**3.8%**	**Total Program Expenses**	**735,357**	**797,920**	**62,563**	**7.8%**
4,981	**54,037**	**(49,056)**	**(90.8%)**	**Gross Margin**	**92,369**	**216,148**	**(123,779)**	**(57.3%)**
				Administrative Expenses				
68,847	77,860	9,013	11.6%	Salaries, Wages & Employee Benefits	302,190	320,990	18,800	5.9%
1,333	1,333	(0)	(0.0%)	Professional Fees	5,333	5,332	(1)	(0.0%)
5,994	9,148	3,154	34.5%	Other Operating Expenses	23,321	36,592	13,271	36.3%
5,252	6,550	1,298	19.8%	Indirect Cost Allocation, Occupancy	21,009	26,200	5,191	19.8%
81,426	**94,891**	**13,465**	**14.2%**	**Total Administrative Expenses**	**351,853**	**389,114**	**37,261**	**9.6%**
(76,445)	**(40,854)**	**(35,591)**	**(87.1%)**	**Change in Net Assets**	**(259,484)**	**(172,966)**	**(86,518)**	**(50.0%)**
97.5%	***78.7%***	***18.8%***		***Medical Loss Ratio***	***88.8%***	***78.7%***	***10.2%***	
41.4%	***37.4%***	***(3.9%)***		***Admin Loss Ratio***	***42.5%***	***38.4%***	***(4.1%)***	

CalOptima Health
Building 505 - City Parkway
Statement of Revenues and Expenses
For the Four Months Ending October 31, 2022

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
-	-	-	0.0%	Rental Income	-	-	-	0.0%
-	-	-	**0.0%**	**Total Operating Revenue**	-	-	-	**0.0%**
				Administrative Expenses				
42,533	55,650	13,117	23.6%	Purchased Services	161,162	222,600	61,438	27.6%
211,922	224,250	12,328	5.5%	Depreciation & Amortization	847,689	897,000	49,311	5.5%
20,875	22,500	1,625	7.2%	Insurance Expense	83,500	90,000	6,500	7.2%
140,607	138,755	(1,852)	(1.3%)	Repair & Maintenance	488,301	555,020	66,719	12.0%
48,036	48,405	369	0.8%	Other Operating Expenses	298,633	193,620	(105,013)	(54.2%)
(463,974)	(489,560)	(25,586)	(5.2%)	Indirect Cost Allocation, Occupancy	(1,879,286)	(1,958,240)	(78,954)	(4.0%)
-	-	-	**0.0%**	**Total Administrative Expenses**	-	-	-	**0.0%**
-	-	-	**0.0%**	**Change in Net Assets**	-	-	-	**0.0%**

Note: For consolidation purposes only Rental Income mapped

CalOptima Health
Building 500 - City Parkway
Statement of Revenues and Expenses
For the Four Months Ending October 31, 2022

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
182,233	172,500	9,733	5.6%	Rental Income	737,785	690,000	47,785	6.9%
182,233	**172,500**	**9,733**	**5.6%**	**Total Operating Revenue**	**737,785**	**690,000**	**47,785**	**6.9%**
				Administrative Expenses				
-	-	-	0.0%	Professional Fees	-	-	-	0.0%
12,040	13,333	1,293	9.7%	Purchased Services	46,602	53,332	6,730	12.6%
-	-	-	0.0%	Depreciation & Amortization	-	-	-	0.0%
-	2,733	2,733	100.0%	Insurance Expense	-	10,932	10,932	100.0%
27,452	25,666	(1,786)	(7.0%)	Repair & Maintenance	130,813	102,664	(28,149)	(27.4%)
31,307	39,933	8,626	21.6%	Other Operating Expenses	131,479	159,732	28,253	17.7%
-	-	-	0.0%	Indirect Cost Allocation, Occupancy	-	-	-	0.0%
70,799	**81,665**	**10,866**	**13.3%**	**Total Administrative Expenses**	**308,894**	**326,660**	**17,766**	**5.4%**
111,434	**90,835**	**20,599**	**22.7%**	**Change in Net Assets**	**428,891**	**363,340**	**65,551**	**18.0%**

Note: For consolidation purposes only Rental Income mapped

OTHER INCOME STATEMENTS – OCTOBER MONTH:

ONECARE INCOME STATEMENT

CHANGE IN NET ASSETS is $0.4 million, favorable to budget $1.0 million

PACE INCOME STATEMENT

CHANGE IN NET ASSETS is $0.6 million, favorable to budget $0.6 million

MSSP INCOME STATEMENT

CHANGE IN NET ASSETS is ($76,445), unfavorable to budget $35,591

BUILDING 500 INCOME STATEMENT

CHANGE IN NET ASSETS is $0.1 million, favorable to budget $20,599

- Net of $0.2 million in rental income and $0.1 million in expenses for the month of October

INVESTMENT INCOME

- Favorable variance of $2.0 million is driven by interest income from coupon payments, offset by both realized and unrealized investment losses due to decreased bond values from continued high interest rates

CalOptima Health
Balance Sheet
October 31, 2022

ASSETS		**LIABILITIES & NET POSITION**	
Current Assets		Current Liabilities	
Operating Cash	$719,882,499	Accounts Payable	$24,930,951
Short-term Investments	1,255,555,190	Medical Claims Liability	1,404,913,775
Capitation Receivable	391,896,898	Accrued Payroll Liabilities	18,232,637
Receivables - Other	82,160,680	Deferred Revenue	6,393,396
Prepaid Expenses	20,447,423	Deferred Lease Obligations	80,077
		Capitation and Withholds	202,195,668
Total Current Assets	**2,469,942,689**	**Total Current Liabilities**	**1,656,746,505**
Capital Assets			
Furniture & Equipment	48,861,260		
Building/Leasehold Improvements	5,059,408		
Construction in Progress	5,245,751		
505 City Parkway West	52,782,700		
500 City Parkway West	22,631,500		
	134,580,618		
Less: Accumulated Depreciation	(66,651,601)	Other Liabilities	
Capital Assets, Net	67,929,017	GASB 96 Subscription Liabilities	-
GASB 96 Capital Assets		Other (than pensions) Post	
GASB 96 Subscription Assets	-	Employment Benefits Liability	22,335,544
		Net Pension Liabilities	577,854
Less: GASB 96 Accumulated Depreciation	-	Bldg. 505 Development Rights	-
GASB 96 Capital Assets, Net	-		
Total Capital Assets	67,929,017		
Other Assets			
Restricted Deposit & Other	300,000	**TOTAL LIABILITIES**	**1,679,659,903**
Homeless Health Reserve	40,636,739		
Board-Designated Assets:			
Cash and Cash Equivalents	10,424,070		
Investments	552,300,459	Deferred Inflows	
Total Board-Designated Assets	562,724,528	Excess Earnings	686,563
		OPEB 75 Difference in Experience	4,822,000
		Change in Assumptions	1,909,305
Total Other Assets	603,661,267	OPEB Changes in Assumptions	3,389,000
		Diff in Proj vs Act	20,982,636
		Net Position	
TOTAL ASSETS	**3,141,532,974**	TNE	101,871,590
		Funds in Excess of TNE	1,337,837,570
Deferred Outflows		**TOTAL NET POSITION**	1,439,709,160
Contributions	1,931,845		
Difference in Experience	2,353,671		
Excess Earning	-		
Changes in Assumptions	2,325,077		
OPEB 75 Changes in Assumptions	2,486,000		
Pension Contributions	529,000		
TOTAL ASSETS & DEFERRED OUTFLOWS	**3,151,158,567**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**3,151,158,567**

CalOptima Health
Board Designated Reserve and TNE Analysis
as of October 31, 2022

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	229,381,386				
	Tier 1 - MetLife	227,765,181				
Board-designated Reserve		457,146,567	335,041,370	522,289,782	122,105,197	(65,143,215)
	Tier 2 - Payden & Rygel	53,012,026				
	Tier 2 - MetLife	52,565,935				
TNE Requirement		105,577,961	101,871,590	101,871,590	3,706,371	3,706,371
	Consolidated:	**562,724,528**	**436,912,961**	**624,161,372**	**125,811,567**	**(61,436,844)**
	Current reserve level	*1.80*	*1.40*	*2.00*		

CalOptima
Statement of Cash Flows
October 31, 2022

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	(160,979)	20,240,392
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Depreciation and amortization	561,094	2,298,369
Changes in assets and liabilities:		
Prepaid expenses and other	1,137,388	2,144,832
Catastrophic reserves		
Capitation receivable	(2,649,909)	2,807,008
Medical claims liability	(82,743,733)	126,898,426
Deferred revenue	(23,477,398)	(1,710,648)
Payable to health networks	7,725,818	8,981,039
Accounts payable	(31,267,192)	(27,385,937)
Accrued payroll	218,790	(1,177,358)
Other accrued liabilities	(3,042)	(12,094)
Net cash provided by/(used in) operating activities	(130,659,162)	133,084,028
GASB 68 CalPERS Adjustments	-	-
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES:		
Net Asset transfer from Foundation	-	-
Net cash provided by (used in) in capital and related financing activities	-	-
CASH FLOWS FROM INVESTING ACTIVITIES		
Change in Investments	(190,739,414)	(241,094,687)
Change in Property and Equipment	(1,051,482)	(3,363,350)
Change in Restricted Deposit & Other	-	51
Change in Board designated reserves	828,066	7,767,112
Change in Homeless Health Reserve	-	-
Net cash provided by/(used in) investing activities	(190,962,830)	(236,690,874)
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	(321,621,992)	(103,606,846)
CASH AND CASH EQUIVALENTS, beginning of period	$1,041,504,491	823,489,344
CASH AND CASH EQUIVALENTS, end of period	**719,882,499**	**719,882,499**

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BALANCE SHEET – OCTOBER MONTH:

ASSETS of $3.2 billion decreased $129.7 million from September or 4.0%

- Operating Cash and Short-term Investments net decrease of $130.9 million due primarily to:
  - Provider payout of State funds received in the prior month for hospital DP

LIABILITIES of $1.7 billion decreased $129.5 million from September or 7.2%

- Claims Liabilities decreased $82.7 million due to timing of claim payments and FY 2021 hospital DP
- Accounts Payable decreased $31.3 million due to the timing of capitation premium tax payments
- Deferred Revenue decreased $23.5 million due to timing of capitation payments from the Centers for Medicare & Medicaid Services (CMS)
- Capitation and Withholds increased $7.7 million due to timing of capitation payments

NET ASSETS of $1.4 billion, decreased $0.2 million from September

CalOptima Health - Consolidated
Net Assets Analysis
For the Four Months Ended October 31, 2022

Category	Item Description	Amount (millions)	Spend to Date	%
	Total Net Position @ 10/31/2022:	**$1,439.7**		**100.0%**
Resources Assigned	Board Designated Reserve*	**562.7**		**39.1%**
	Capital Assets, net of depreciation	**67.9**		**4.7%**
Resources Allocated	Homeless Health Initiative**	$100.0	$35.0	6.9%
	Intergovernmental Transfers (IGT)	111.7	47.8	7.8%
	Mind OC Grant	1.0	1.0	0.1%
	CalFresh Outreach Strategy	2.0	0.8	0.1%
	Digital Transformation and Workplace Modernization	100.0	2.3	6.9%
	Coalition of Orange County Community Health Centers Grant	50.0	10.0	3.5%
	Subtotal:	**$364.7**	**$96.9**	**25.3%**
Resources Available for New Initiatives:	Unallocated/Unassigned*	**$444.4**		**30.9%**

*Total of Board Designated reserve and unallocated reserve amount can support approximately 98 days of CalOptima Health's current operations
**See Summary of Homeless Health Initiatives and Allocated Funds for list of Board approved initiatives

CalOptima Health
Key Financial Indicators
As of October 2022

Income Statement

Item Name	Month-to-Date (October 2022) Actual	Budget	Variance	%		FY 2023 Year-to-Date (October 2022) Actual	Budget	Variance	%	
Member Months	937,584	913,579	24,005	2.6%		3,723,682	3,660,421	63,261	1.7%	
*Operating Revenue **	302,421,366	332,068,403	(29,647,037)	(8.9%)		1,415,869,993	1,329,510,548	86,359,445	6.5%	
*Medical Expenses **	289,802,862	313,248,650	23,445,788	7.5%		1,340,186,038	1,244,967,734	(95,218,304)	(7.6%)	
General and Administrative Expense	14,557,362	17,327,883	2,770,521	16.0%		57,727,398	69,105,803	11,378,405	16.5%	
Non-Operating Income/(Loss)	1,777,879	(772,801)	2,550,680	330.1%		2,283,835	(1,727,568)	4,011,403	232.2%	
Summary of Income & Expenses	(160,979)	719,069	(880,048)	(122.4%)		20,240,392	13,709,443	6,530,949	47.6%	

Ratios

Medical Loss Ratio (MLR)	Actual	Budget	Variance		Actual	Budget	Variance	
Consolidated	95.8%	94.3%	1.5%		94.7%	93.6%	1.0%	

Administrative Loss Ratio (ALR)	Actual	Budget	Variance		Actual	Budget	Variance	
Consolidated	4.8%	5.2%	0.4%		4.1%	5.2%	1.1%	

Key:

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

Investment

Investment Balance (excluding CCE)	Current Month	Prior Month	Change	%
@10/31/2022	1,801,280,677	1,621,617,096	179,663,581	11.1%

Unallocated/Unassigned Reserve Balance	Current Month @ October 2022	Fiscal Year Ending June 2022	Change	%
Consolidated	444,355,615	448,294,548	(3,938,934)	(0.9%)
*Days Cash On Hand***	98			

*$135M of Directed Payments (DP) are included in revenue and $133M of DP are included in expenses
**Total of Board Designated reserve and unallocated reserve amount can support approximatley 98 days of CalOptima Health's current operations

CalOptima Health
Digital Transformation Strategy ($100 million total reserve)
Funding Balance Tracking Summary
For the Four Months Ending October 31, 2022

	FY 2022-23 Month-to-Date				FY 2022-23 Year-to-Date			
	Actual Spend	**Approved Budget**	**Variance $**	**Variance %**	**Actual Spend**	**Approved Budget**	**Variance $**	**Variance %**
Capital Assets (Cost, Information Only):								
Total Capital Assets	**501,478**	**2,701,000**	**2,199,522**	**81.4%**	**1,942,129**	**28,108,000**	**26,165,871**	**93.1%**
Operating Expenses:								
Salaries, Wages & Benefits	136,343	408,500	272,157	66.6%	218,935	1,209,572	990,637	81.9%
Professional Fees	-	186,041	186,041	100.0%	-	744,164	744,164	100.0%
Purchased Services	-	13,333	13,333	100.0%	-	53,332	53,332	100.0%
Depreciation Expenses	-	-	-	0.0%	-	-	-	0.0%
Other Expenses	110,252	274,365	164,113	59.8%	110,252	1,097,460	987,208	90.0%
Total Operating Expenses	**246,595**	**882,239**	**635,644**	**72.0%**	**329,187**	**3,104,528**	**2,775,341**	**89.4%**

Funding Balance Tracking:	**Actual Spend**	**Approved Budget**
Beginning Funding Balance	100,000,000	100,000,000
Less:		
FY2022-23	2,271,316	45,173,113
FY2023-24		
FY2024-25		
Ending Funding Balance	**97,728,684**	**54,826,887**

Summary of Homeless Health Initiatives and Allocated Funds
As of October 31, 2022

			Amount
Program Commitment		**$**	**100,000,000**
Funds Allocation, approved initiatives:			
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000		
Recuperative Care	8,250,000		
Medical Respite	250,000		
Day Habilitation (County for HomeKey)	2,500,000		
Clinical Field Team (CFT) Start-up & Federal Qualified Health Center (FQHC)	1,600,000		
CalOptima Homeless Response Team	6,000,000		
Homeless Coordination at Hospitals	10,000,000		
CalOptima Days & QI Program - Homeless Clinic Access Program (HCAP)	1,693,261		
FQHC (Community Health Center) Expansion and HHI Support	570,000		
HCAP Expansion for Telehealth and CFT On Call Days	1,700,000		
Vaccination Intervention and Member Incentive Strategy	400,000		
Street Medicine	8,000,000		
Outreach and Engagement Team	7,000,000		
Funds Allocation Total		**$**	**59,363,261**
Program Commitment Balance, available for new initiatives*		**$**	**40,636,739**

Note: Staff will include the Housing and Homelessness Incentive Program (approved by the Board on September 1, 2022) in the Approved Initiatives list on the November 2022 report.

*Funding sources of the remaining balance are IGT8 and CalOptima's operating income, which must be used for Medi-Cal covered services for the Medi-Cal population

Budget Allocation Changes
Reporting Changes for October 2022

Transfer Month	Line of Business	From	To	Amount	Expense Description	Fiscal Year
July	No budget reallocations for July					2022-23
August	Medi-Cal	Health Reward Incentive Fulfillment	Health Reward Incentive Fulfillment	$75,000	To reallocate funds from Purchased Services – Health Reward Incentive Fulfillment to Incentive Budget for PHM Health Rewards.	2022-23
September	No budget reallocations for September					2022-23
October	Medi-Cal	Quality Improvements - Professional Fees - Consultants for NCQA Accreditation	Quality Improvements - Subscriptions - CAQH Application Subscription - Credentialing Database	$75,000	To reallocate funds from Professional Fees – Consultants for NCQA Accreditation to Subscriptions – CAQH Application Subscription – Credentialing Database to provide additional funding for expanding scope of services.	2022-23

This report summarizes budget transfers between general ledger classes that are greater than $10,000 and less than $100,000.
This is the result of Board Resolution No. 12-0301-01 which permits the CEO to make budget allocation changes within certain parameters.

Board of Directors Meeting
December 1, 2022

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 Audit & Oversight department, regulatory audits, privacy updates, fraud, waste, and abuse (FWA) updates, and any notices of non-compliance or enforcement action issued by regulators.

A. Updates on Regulatory Audits

1. OneCare and OneCare Connect

- 2021 Centers for Medicare & Medicaid Services (CMS) Program Audit/Independent Validation Audit (IVA) *(applicable to OneCare and OneCare Connect)*:

  - ***CalOptima Health is pending CMS' review and feedback on the IVA report.***
    - CMS provided feedback on the IVA report on September 12, 2022
      - Inquiries/feedback were not substantial
    - Responses were submitted to CMS on September 30, 2022
    - CalOptima Health is currently awaiting a response from CMS

- Compliance Program Effectiveness (CPE) Audit (*applicable to OneCare*):

  - CMS (Medicare) requires CalOptima Health to undergo an independent audit of the effectiveness of its Compliance program on an annual basis.
  - As per the Medicare requirements, the results must be shared with the CalOptima Health Board of Directors.
  - The virtual audit was conducted by the BluePeak October 11-17, 2022.
  - BluePeak provided the draft audit report on 10/26/22 for review.
    - CalOptima Health is currently reviewing the feedback and will provide a response by November 11, 2022.

- 2022 Timeliness Monitoring Project (TMP) (*applicable to OneCare*):

  - CalOptima Health participated in TMP audit webinars with a CMS contractor on September 26 and 29, 2022.
  - The CMS contractor validated the two reconsideration universes and has submitted the results to CMS.
  - CalOptima Health is awaiting timeliness results from CMS.

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Background – FYI Only
CMS conducts an annual industry-wide appeals timeliness monitoring project. The 2022 TMP will include a retrospective collection and review of CY 2022 Q1 data.

- 2023 CMS Readiness Checklist (applicable to OneCare):

  - A routine readiness checklist is released annually by CMS in anticipation of the upcoming calendar year.
  - On 10/17/22, CMS released the 2023 Readiness Checklist.
  - CalOptima Health is expected to fulfill ongoing key operational requirements summarized in the readiness checklist for the 2023 benefit year.
  - Regulatory Affairs and Compliance (RAC) is leading the 2023 Readiness Checklist activities with all departments to ensure compliance for requirements impacting their respective operational area(s).
  - The validation audit activities are expected to conclude by end of 2022.

2. Medi-Cal

- 2024 Managed Care Plan (MCP) Operational Readiness Contract:

Update:

As of October 31, 2022, CalOptima Health has submitted a total of 61 deliverables for 2024 MCP operational readiness. To date, CalOptima Health has received approval for 51 of the 61 items. The remaining deliverables are awaiting response from DHCS or under review by CalOptima Health as part of an additional information request made by DHCS.

- Phase 1: Deliverable due dates vary from August 12, 2022 – December 15, 2022
  - 12/15/22 deliverables – on-track
  - 10/3/22 deliverables – submitted early on 9/29/22
  - 9/12/22 deliverables – submitted timely
  - 8/12/22 deliverables – submitted timely
- Phase 2: Deliverables due December 15, 2022 – March 31, 2023
- Phase 3: Deliverables due April 20, 2023 – July 31, 2023

On-track for all remaining deliverables. Each phase must be completed and approved by DHCS prior to the initiation of the next phase.

Background – FYI Only

Throughout CY 2022 and CY 2023, MCPs, including CalOptima Health will be required to submit a series of contract readiness deliverables to the Department of Health Care Services (DHCS) for review and approval. Staff will implement the broad operational changes and contractual requirements outlined in the Operational Readiness agreement to ensure compliance with all requirements by the January 1, 2024, contract effective date.

- 2021 DHCS Medical Audit:

  Update: CalOptima Health awaits the final report and formal request for corrective action. Internal stakeholders have proactively taken steps to mitigate and remediate issues identified in the draft findings report. The Office of Compliance expects to have a documented corrective action plan by the time the final report is received.

  Draft findings were received on September 22, 2022, and an Exit Conference was hosted by DHCS on September 27, 2022, to review the draft audit report.

  CalOptima Health received 2 audit reports based on audit scopes. Draft audit results are as follows:

  - DHCS Medical Audit - 9 findings
    - Findings were not a surprise, and most have already been remediated.
  - State Supported Services audit: no findings
  - CalOptima Health has until October 13, 2022, to review and respond to the draft findings prior to DHCS' formal issuance of the corrective action plan.
  - CalOptima Health does not plan to rebut any of the findings.
  - Once the corrective action plan request is issued, CalOptima Health will have 30 days to respond.

  Background – FYI Only
  - Audit engagement notice received on October 7, 2021.
  - Review period was February 1, 2020, through December 31,2021.
  - Scope:
    - Non-Seniors and Persons with Disabilities and Seniors and Persons with Disabilities (SPD) members.
    - Utilization management, case management and coordination of care, member's rights, quality management, access & availability, and administrative and organizational capacity.
    - DHCS selected Kaiser, Prospect, and Family Choice Medical Group (FCMG) to participate in various capacities.
  - Audit close-out: February 4, 2022. DHCS discussed preliminary observations.
    - ***In partnership with the business areas, the Office of Compliance has worked to address preliminary observations, as appropriate***.

- 2022 Managed Care Entity (MCE) Program Integrity (PI) Review:

  Update: On 10/27/22, CalOptima Health met virtually with CMS & DHCS to discuss the internal PI efforts in place to ensure adequate oversight, as well as to deter and address fraud, waste, and abuse. Three separate meetings were originally planned, however, after the first meeting, no additional sessions were determined to be necessary. CalOptima Health has been asked to submit a number of supporting documents and narrative responses by 11/10/22.

Background – FYI Only

- April 13, 2022, the DHCS notified CalOptima Health that it had been selected to provide feedback to CMS in respect to CalOptima Health's internal PI efforts that are in place to ensure adequate oversight as well as to deter and address FWA.
- Review period was the preceding 3 Federal Fiscal Year (FFYs).
- Focused on CalOptima Health's Medi-Cal program. DHCS requested that CalOptima Health respond to a series of questions within the CMS Template and submit responses and supporting documentation to DHCS, which DHCS would then submit to CMS.
- May 4, 2022, CalOptima Health provided its timely response to DHCS.

B. Regulatory Notices of Non-Compliance

- On 10/25/22, CMS issued four Notices of Non-Compliance to CalOptima Health's OneCare Connect (H8016) and OneCare (H5433) Plans, for failing to meet accuracy and accessibility standards for calendar year 2022.
- This was for both Part C and D beneficiary customer service phone lines.
- CMS notices of non-compliance and the results are as follows:

  - TTY Functionality (TTY):

    - Requires 80% of incoming calls requiring TTY services to be connected to a TTY operator within 7 minutes.
    - CalOptima Health's results Part C are out of compliance of the CMS' requirement.

CMS Notices of Non-Compliance	Part C	Part D
OC (H5433)	64.71%	82.35%
OCC (H8016)	60%	86.67%

  - Interpreter Availability - Limited English Proficient (LEP):

    - Requires interpreters to be available for 80% of incoming calls requiring an interpreter within 8 minutes.
    - CalOptima Health's results Part C and D are out of compliance of the CMS' requirement.

CMS Notices of Non-Compliance	Part C	Part D
OC (H5433)	14.89%	15.56%
OCC (H8016)	14.63%	15.38%

- The accuracy and accessibility study results were issued by CMS in the 7/13/22 HPMS Memo, available via the memo below. Prior to receiving the official CMS Notices of Non-Compliance, RAC (Medicare) proceeded to issue a corrective action plan to Customer Service department in response to the results on 8/11/22. The CAP was accepted and upon successful completion of the monitoring results, has been closed out on 10/26/22.

C. Updates on Internal and Health Network Monitoring and Audits

- Health Network Audits:

  - CalOptima Health's Audit and Oversight (A&O) department completed annual audits on the following delegated health networks to assess their capabilities and performance with delegated activities:

    - Optum Care Talbert– July 1, 2021 – June 30, 2022
    - Noble Mid-Orange County– July 1, 2021-June 30, 2022

  - Audit tools and elements were derived from accrediting, regulatory and CalOptima Health contractual standards. For areas that scored below the 100% threshold, A&O issued a corrective action plan (CAP) request and is actively working with each health network to remediate findings.

Non-Clinical Policy Review

Delegated Entity	Access Availability	Claims	Compliance	Cultural & Linguistics	Customer Service	Provider Network Contracting	Provider Relations	Sub-Contractual
Optum Care Talbert	100%	100%	100%	100%	100%	98%	100%	100%
Noble Mid-Orange County	100%	100%	100%	100%	100%	100%	100%	100%

Non-Clinical File Review

Delegated Entity	Claims, Approved	Claims, Denied	PDRs	Customer Service	Initial Provider Training		Annual Provider Training		Initial Staff Training		Annual Staff Training	
					TAT	CT	TAT	CT	TAT	CT	TAT	CT
Optum Care Talbert	90.33%	95.66%	83.33%	61.33%	70%	100%	100%	100%	0%	60%	60%	60%
Noble Mid-Orange County	89.66%	90.33%	None Reported	90%	30%	20%	0%	0%	17%	67%	70%	70%

TAT* Turnaround Time
CT* Completed Training

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Clinical Policy Review

Delegated Entity	Case Management	Case Management, Whole Child Model	Medi-Cal Addendum	Utilization Management
Optum Care Talbert	100%	100%	100%	100%
Noble Mid-Orange County	100%	100%	100%	100%

Clinical File Review

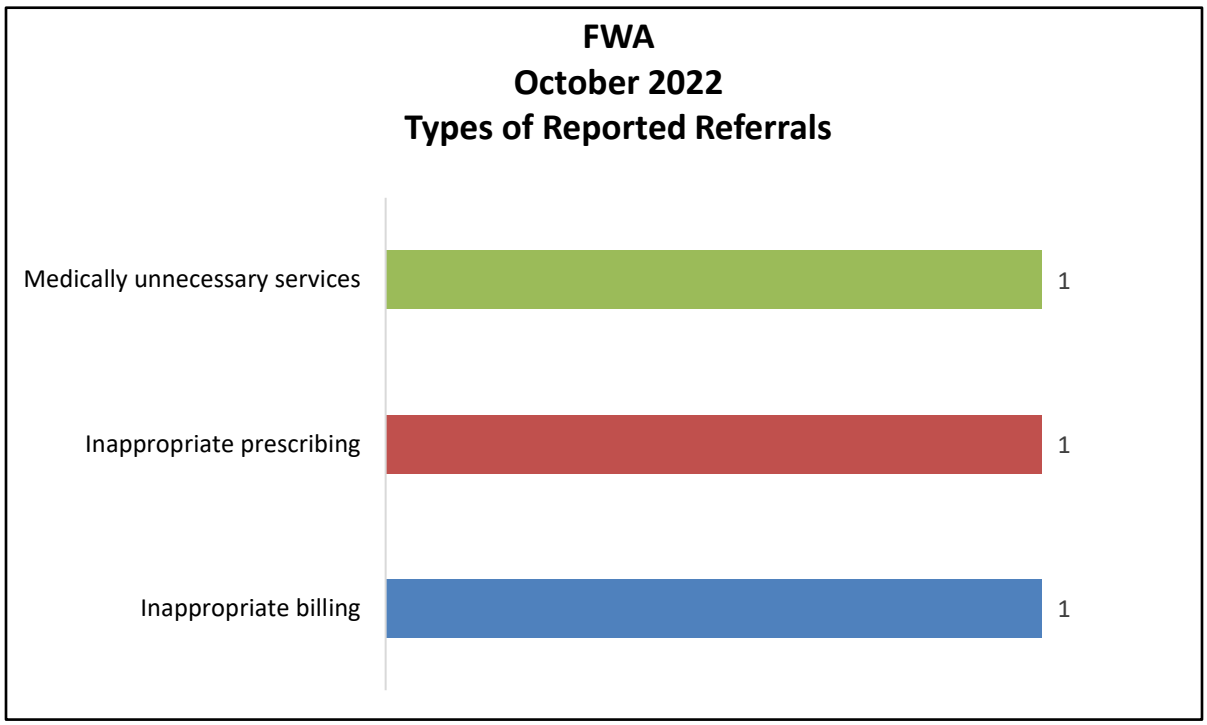
Delegated Entity	Blood Lead Screening (MC)	Case Management	Community Support(s) (MC)	Whole Child Model (MC)	Expedited (MC)	NEMT (MC)	PSA (MC)	Retrospective Denials (MC	Standard (MC)	(NOMNC) (OC)	Pre-Service ODAG	MMP SARAG
Optum Care Talbert	72%	100%	100%	100%	100%	100%	97%	None Reported	100%	100%	99%	94%
Noble Mid-Orange County	55%	95.66%	100%	None Reported	100%	None Reported	0%	100%	99%	30%	93%	97%

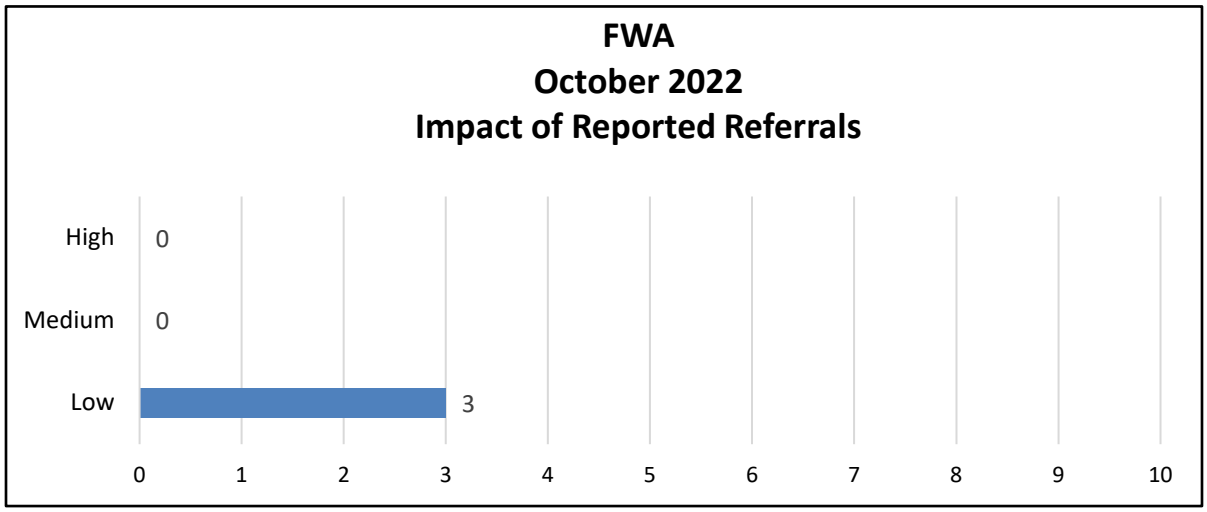
Credentialing and Recredentialing Policy

Delegated Entity	Policy Review
Optum Care Talbert	100%
Noble Mid-Orange County	100%

Delegated Entity	Initial Credentialing File Review	Recredentialing File Review
Optum Care Talbert	100%	100%
Noble Mid-Orange County	100%	100%

D. Fraud, Waste & Abuse (FWA) Investigations (October 2022)

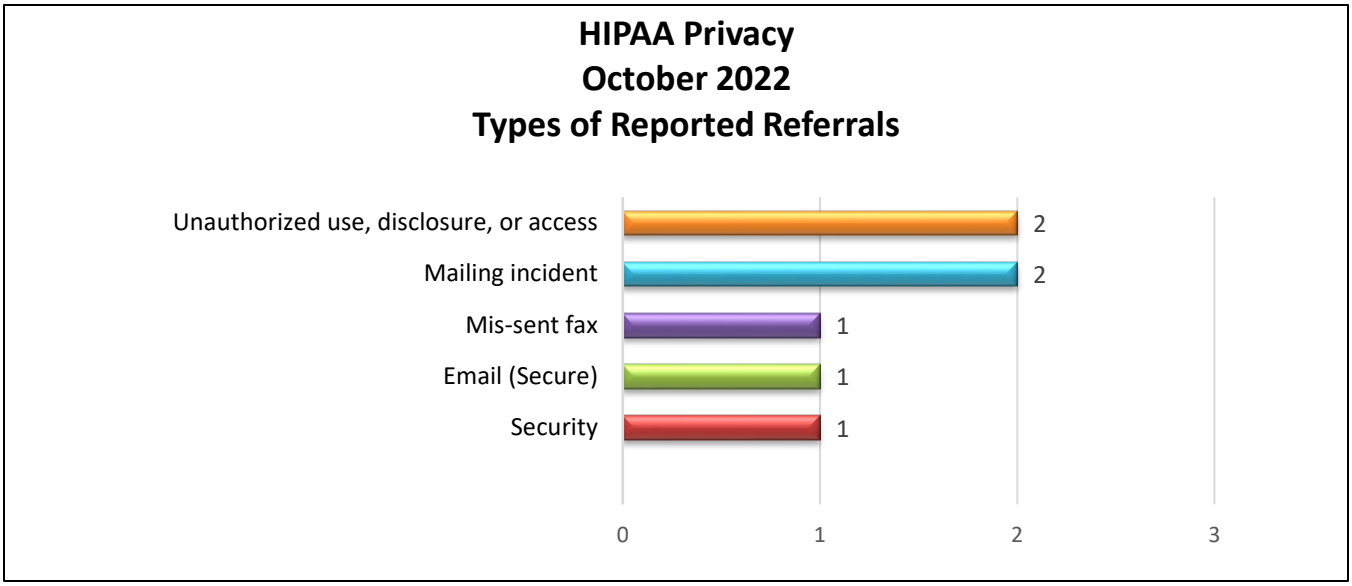


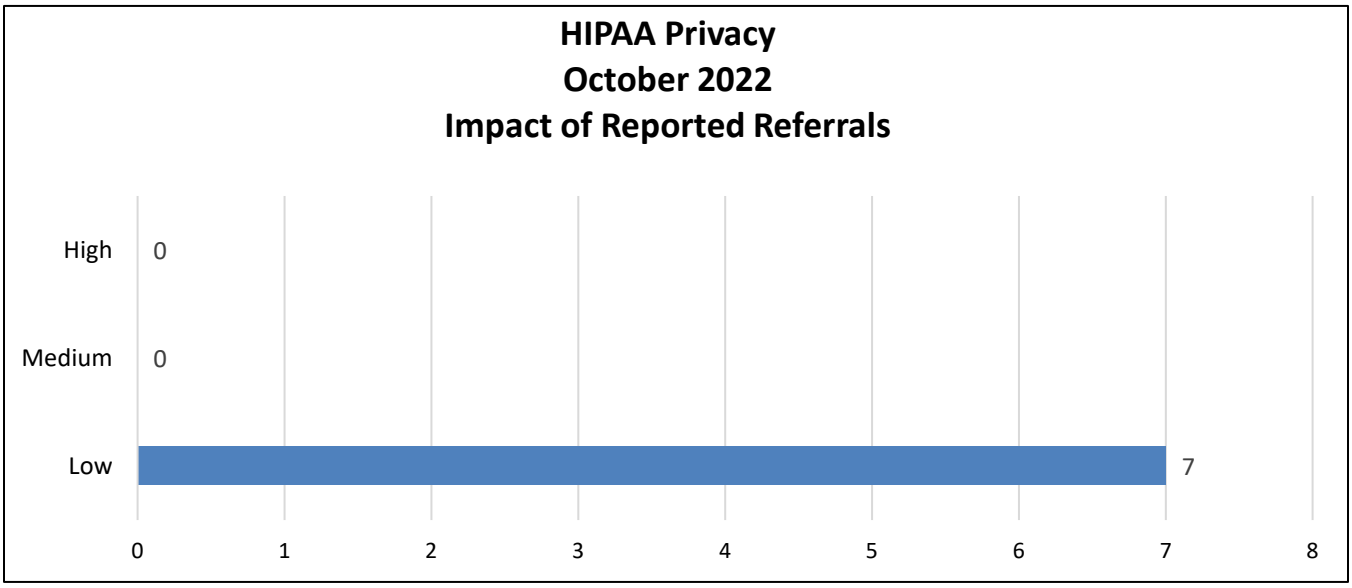


Total Number of New Cases Referred to DHCS (State)	3
Total Number of New Cases Referred to DHCS and CMS*	1
Total Number of Referrals (Subjects) Reported to Regulatory Agencies	**3**

*Effective January 1, 2022, CMS implemented a new portal to report suspicious FWA. Any potential FWA *with impact to Medicare* is reported to both DHCS and CMS at the start of an investigation.

E. Privacy Update: (October 2022)





PRIVACY STATISTICS

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

POTOMAC PARTNERS DC

STRATEGIC HEALTH CARE

M E M O R A N D U M

November 18, 2022

To: CalOptima Health

From: Potomac Partners DC & Strategic Health Care

Re: November Board of Directors Report

MIDTERM ELECTIONS

The 2022 Midterm elections were held on Tuesday, November 8th. A third of the Senate (35 seats) and all 435 House seats were up for elections. Senator Alex Padilla was reelected to a full term with initial counts putting the Democratic Senator at 61.4% of the vote. For the House of Representatives, some of the close races have not yet been called, but Republicans are projected to have a slim majority. Democrats will keep control of the Senate, and depending on the December 6th runoff in Georgia, will increase their margin to 51 seats or maintain 50 seats for an evenly divided Senate, with Vice President Kamala Harris serving as the tie-breaking vote on simple-majority items like budget reconciliation and judicial nominations. The new 118th Congress will be sworn in on January 3rd. A breakdown of the U.S. House races in Orange County (at the time of this writing) is included below:

DISTRICT	DEMOCRAT	REPUBLICAN	% VOTES REPORTED	RESULT
CA District 38	**Linda Sánchez 58.1**	Eric Ching 41.9	(98%)	Dem Hold
CA District 40	Asif Mahmood 43.1	**Young Kim 56.9**	(97%)	GOP Hold
CA District 45	Jay Chen 47.5	**Michelle Steel 52.5**	(97%)	GOP Hold
CA District 46	**Lou Correa 61.6**	Chris Gonzales 38.4	(97%)	Dem Hold
CA District 47	**Katie Porter 51.6**	Scott Baugh 48.4	(97%)	Dem Hold
CA District 49	**Mike Levin 52.6**	Brian Maryott 47.4	(98%)	Dem Hold

House Committee Leadership Outlook

When Republicans take control of the House, they will also take control of all House Committees. A well-made breakdown of likely committee leadership positions that can be expected in the next session of Congress are outlined here. All leadership positions are pending the final party makeup and caucus elections in each chamber. As a result, all projections for committee leadership are not final until each caucus votes on final approval.

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Fiscal Year 2023 Appropriations

Congress returned to Washington, DC on November 15th, and the House and Senate have approximately three working weeks to finish the Fiscal Year 2023 (FY23) appropriations bills to fund the government. The federal government is currently being funded at FY22 levels by a Continuing Resolution that expires on December 16th. Up until this point, leaders from both parties have expressed a desire to pass an omnibus spending package that will include all 12 annual appropriations bills once a few details have been negotiated. If Congress is unable to negotiate a final package before December 16th, they will need to pass another Continuing Resolution (CR) to extend government funding. Historically, a second CR could last a few days, weeks, or months depending on negotiations.

Community Mental Health Services Block Grant

This month, the Department of Health and Human Services (HHS) awarded $59.4 million to states and territories through the *Community Mental Health Services Block Grant (MHBG)* program. The primary objective of this program is to expand comprehensive community mental health services. A full list of awards can be found here.

HHS also announced the availability of another $50 million in supplemental grant funding to help states and territories expand and enhance 988 Suicide & Crisis Lifeline services. The HHS Substance Abuse and Mental Health Services Administration (SAMHSA) expects 988 state and territorial grantees to use the supplemental funding to improve response capacity, including the ability to respond to calls in languages other than English spoken by state and territory residents; to improve and enhance collaboration between 988 and 911 services; and to help with hiring, retention, marketing, and communications to improve awareness of the 988 Lifeline.

Centers for Medicare and Medicaid Services (CMS) Issues Updated Medicare Eligibility Rule

On October 28th, CMS issued a final rule that updates Medicare enrollment and eligibility rules to expand coverage for people with Medicare and advance health equity. The final rule, which implements changes made by the *Consolidated Appropriations Act, 2021*, makes it easier for people to enroll in Medicare and eliminates delays in coverage. Among these changes, individuals will now have Medicare coverage the month immediately after their enrollment, thereby reducing any delays in coverage. In addition, the rule expands access through Medicare special enrollment periods and allows certain eligible beneficiaries to receive Medicare Part B coverage without a late enrollment penalty. Click here for details. Click here to see the rule.

MEDICAID ADVANTAGE ADVERTISING COMPLAINTS LEAD TO REGULATORY CHANGES

After reviewing thousands of complaints about "confusing, misleading, and/or inaccurate" Medicare Advantage ads, and using "secret shoppers" to document deceptive telephone sales pitches, CMS announced it is changing advertising requirements. The director of the agency's Medicare Drug and Health Plan Contract Administration Group said in a three-page letter that CMS is immediately enhancing its review of marketing materials, which must be submitted under its regulatory authority for Medicare Advantage and Part D drug plans, and "may exercise its authority to prohibit" their use. Click here for the letter.

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2022 General Election Update
CalOptima Health
November 18, 2022

Election day is an outdated term as voters can vote weeks earlier in person or by mail. Further, with ballots continuing to be received by county election offices for seven days following the election, the winner in closely contested races is not certain for weeks following the election. Therefore, election day has become election month.

While there are a handful of individual races where neither candidate has declared victory nor conceded, there are certain things about this election that are known now.

Democrats Continue One-Party Control
The California Democratic Party continued its dominance in state elective politics by easily winning all five statewide offices, including Governor, while also continuing to pick up new seats in the Legislature. The partisan makeup of the State Senate will likely be unchanged from 2022 with Democrats holding a 31-9 advantage. The Assembly, on the other hand, will see a decline in its Republican membership, with at least three fewer members from the previous year, with a couple of races that are still too close to call.

The decline in Republican representation is not necessarily a surprise given the overwhelming 2:1 voter registration advantage of the Democrats. However, the continued loss of seats that were once Republican or lean Republican is indicative of a greater voter dissatisfaction with the Republican Party brand in California.

With some Democrat vs. Democrat races yet to be determined, it is too early to say whether this election favored the Progressive Democrats or the Moderate Democrats. At this point, it seems that those contested races were split in their outcomes.

Proposition 1 Helped Drive Voter Participation
Going into the election, we questioned whether voter turnout would suffer due to the lack of a compelling race at the top of the ticket for Governor. With overall voter turnout still not determined, it is still too early to answer that question. However, we believe Proposition 1 to place access to abortion and contraception in the State Constitution did compel people to vote, especially in areas that favor Democrats. Proposition 1 received more yes votes than any other statewide ballot measure or candidate. We further know that individual legislative and congressional campaigns, especially those with competitive partisan elections, incorporated reproductive rights and Proposition 1 into their campaigns.

Governor Newsom "Won"
Unsurprisingly, Governor Newsom won easily against Republican State Senator Brian Dahle. What is surprising is that the Governor did not spend his campaign money on his campaign for Governor. Instead, he focused his time and money on two initiatives - in support of Proposition

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1 and in opposition to Proposition 30. As noted above, the abortion rights initiative was popular with voters in California. However, it was also popular with voters in other states, and being aligned with Proposition 1 could prove useful to the Governor should he decide that he has national ambitions. Proposition 30 would have raised taxes on the super-rich for the dual purposes of subsidizing electric vehicle purchases and combating wildfires. Proposition 30 was polling well prior to the Governor's engagement. The Governor risked his reputation by vigorously working to defeat the measure. He was joined in opposition by the California Republican Party and California Teachers Association, while the supporters included the Democratic Party, firefighters, Lyft, and environmentalists. Had this initiative passed, many would question the Governor's role in the campaign against it. However, with it failing, the Governor emerges victorious on everything he touched in this campaign cycle.

New Legislators/New Leadership

Much has already been made about the number of new people elected to the Legislature, with nine new members in the Senate and 22 in the Assembly from the November election. Combined with those who served only a portion of the 2022 legislative session, we then inch closer to a third of the Legislature being new. This has already had an impact on legislative leadership, with the Assembly Democrats convening two days after the election to hammer out a transition plan for Speaker. The current Speaker, Anthony Rendon, will continue to serve as Speaker until June 30, 2023, at which time the new Speaker will be Robert Rivas from the Salinas area. How this plan plays out remains to be seen. Will the current Speaker appoint committee chairs only to be replaced in June? Or will Chairs be appointed based on consultation with Rivas? How will staff be allocated? Will the existing staff of Speaker Rendon stay on board for the new Speaker?

CalOptima Health Legislative Delegation

The Orange County legislative delegation saw significant change in its membership in this election cycle, most notably with longtime Senator Pat Bates terming out of office. Pending no major changes in uncounted ballots, the new Orange County Delegation for the 2023-24 legislative session is:

	Assembly		*Senate*
AD 59	Phillip Chen (R)	SD 29	Josh Newman (D)
AD 64	Blanca Pacheco (D)	SD 30	Bob Archuleta (D)
AD 67	Sharon Quirk-Silva (D)	SD 32	Kelly Seyarto (R)
AD 68	Avelino Valencia (D)	SD 34	Tom Umberg (D)
AD 70	Tri Ta (R)	SD 36	Janet Nguyen (R)
AD 71	Kate Sanchez (R)	SD 37	Dave Min (D)
AD 72	Diane Dixon (R)	SD 38	Catherine Blakespear (D)
AD 73	Cottie Petrie-Norris (D)		
AD 74	Laurie Davies (R)		

A Significant Budget Deficit

On November 17, the non-partisan Legislative Analyst's Office (LAO) estimated a budget deficit of $25 billion for the 2023-24 budget year, followed by smaller budget deficits of $17 billion, $12

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billion, and $8 billion in the subsequent three budget years. This follows a massive budget surplus of approximately $95 billion in the current 2022-23 budget year. Moreover, the LAO's estimate assumes California's economy will not fall into recession. If a recession does occur, the LAO estimate balloons to $30 to $50 billion for the 2023-24 budget year.

Conclusion

Since there are still many ballots to be counted and not all races are finalized, it is too early to have final conclusions for this election. Most members, including the newly elected and those with more experience, have not had to pass budgets during hard economic times. It will be interesting to see how these legislators grapple with a $25-$50 billion budget deficit. Some questions will be answered by the actions of the Legislature after it takes office. For example, does the defeat of Proposition 30 dampen the desire to seek tax increases to make up for declining state revenues? With overwhelming failure of both sports wagering initiatives, will the Legislature step up to legalize and regulate sports wagering or will this rollover to another statewide ballot?

The new Legislature will take office on December 5.

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2021–22 Legislative Tracking Matrix

Bill Number Author	Bill Summary	Bill Status	Position/Notes
COVID-19 (Coronavirus)			
H.R. 4735 Axne (IA) **S. 2493** Bennet (CO)	**Provider Relief Fund Deadline Extension Act:** Would delay the deadline by which providers must spend any funds received from the Provider Relief Fund (PRF) — created in response to the COVID-19 pandemic — until the end of 2021 or the end of the COVID-19 public health emergency (PHE), whichever occurs later. Funds that are unspent by any deadline must be repaid to the U.S. Department of Health and Human Services (HHS). ***Potential CalOptima Health Impact:*** Increased financial stability for CalOptima Health's contracted providers.	**07/28/2021** Introduced; referred to committees	CalOptima Health: Watch
H.R. 5963 Spanberger (VA) **S. 3611** Shaheen (NH)	**Provider Relief Fund Improvement Act**: Would delay the deadline by which providers must spend any funds received from the PRF until the end of the COVID-19 PHE. Would also direct HHS to distribute any funds remaining in the PRF by March 31, 2022. Finally, would allow workplace safety improvements as an allowable use of PRF dollars. ***Potential CalOptima Health Impact:*** Increased financial stability for CalOptima Health's contracted providers.	**11/12/2021** Introduced; referred to committees	CalOptima Health: Watch
SB 1473 Pan	**COVID-19 Therapeutics Coverage:** Effective immediately, requires a health plan to cover COVID-19 therapeutics provided by an in-network or out-of-network provider, without cost sharing or prior authorization requirements. Out-of-network claims must be reimbursed at the prevailing market rate, as set by future guidance. ***Potential CalOptima Health Impact:*** Reimbursement for all in-network and out-of-network medical claims for COVID-19 therapeutics without utilization management (UM) controls.	**09/25/2022** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Behavioral Health			
H.R. 7780 DeSaulnier (CA)	**Mental Health Matters Act:** Would direct federal departments to award grants for the following purposes: • Build, recruit and retain a school-based mental health provider workforce at high-need elementary and secondary schools • Improve behavioral health interventions provided by Head Start agencies to both participating children and staff • Increase student access to trauma support services through innovative partnerships with local mental health systems In addition, would require institutions of higher education to allow incoming students with existing documentation of a disability to access disability accommodations. ***Potential CalOptima Health Impact:*** Increased access to mental health services for school-aged CalOptima Health members.	**09/29/2022** Passed House floor; referred to Senate Committee on Health, Education, Labor, and Pensions	CalOptima Health: Watch
H.R. 8542 Porter (CA) **S. 515** Warren (MA)	**Mental Health Justice Act:** Would require HHS to award grants to state, tribal and local governments to hire, train and dispatch mental health professionals instead of law enforcement personnel to respond to behavioral health crises. ***Potential CalOptima Health Impact:*** Increased access to behavioral health services for CalOptima Health members; decreased rates of arrest and incarceration.	**02/25/2021** Introduced; referred to committees	CalOptima Health: Watch County of Orange: Support
H.R. 1914 DeFazio (OR) **S. 764** Wyden (OR)	**Crisis Assistance Helping Out On The Streets (CAHOOTS) Act:** Would increase the Federal Medical Assistance Percentage (FMAP) for states to cover 24/7 community-based mobile crisis intervention services for those experiencing a mental health or substance use disorder (SUD) crisis from 85% to 95% for three years. Would also require HHS to issue an additional $25 million in planning and evaluation grants to states. ***Potential CalOptima Health Impact:*** Increased behavioral health and SUD services to CalOptima Health Medi-Cal members.	**03/16/2021** Introduced; referred to committees	**08/05/2021** CalOptima Health: Support

Bill Number Author	Bill Summary	Bill Status	Position/Notes
S. 2938 Rubio (FL)	**Bipartisan Safer Communities Act:** Enacts several gun safety measures as well as provisions to improve access to mental health services for children and families. Specifically, allocates federal funding for the following health care initiatives: • Additional Medicaid telehealth flexibilities to expand access to mental health services • Flexible grants to provide comprehensive community mental health services • Increased number of mental health providers in school-based settings • Partnerships between universities and school districts to prepare a pipeline of mental health providers for employment in high-need schools • Support for implementation of the 988 Suicide and Crisis Lifeline to provide free and confidential 24/7 support to individuals in suicidal crisis or emotional distress • Support for pediatric primary care providers to rapidly access mental health specialists • Training for first responders, school personnel, primary care providers and other adults who interact with school-aged youth to detect and appropriately respond to mental health issues ***Potential CalOptima Health Impact:*** Increased access to behavioral health services for CalOptima Health members; increased training for CalOptima Health providers.	**06/25/2022** Signed into law	CalOptima Health: Watch
AB 552 Quirk-Silva	**Integrated School-Based Behavioral Health Partnership Program:** Would have established the Integrated School-Based Behavioral Health Partnership Program to expand prevention and early intervention behavioral health services for students. This would have allowed a county mental health agency and local education agency to develop a formal partnership whereby county mental health professionals could have delivered brief school-based services to any student who has, or is at risk of developing, a behavioral health condition or SUD. ***Potential CalOptima Health Impact*:** Increased coordination with the Orange County Health Care Agency and school districts to ensure non-duplication of other school-based behavioral health services and initiatives.	**09/19/2022** Vetoed	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 1019 Gonzalez	**Medi-Cal Mental Health Benefit Outreach:** Starting no later than January 1, 2025, requires a Medi-Cal managed care plan (MCP) to conduct annual outreach and education to beneficiaries and primary care physicians regarding covered mental health benefits while incorporating best practices in stigma reduction. The California Department of Health Care Services (DHCS) must review an MCP's outreach and engagement plan for approval. Every three years, DHCS will conduct an assessment of Medi-Cal beneficiaries' experience with mental health services. ***Potential CalOptima Health Impact:*** Additional member and provider outreach activities by CalOptima Health staff.	**09/30/2022** Signed into law	CalOptima Health: Watch
SB 1338 Umberg	**Community Assistance, Recovery, and Empowerment (CARE) Court Program:** No later than October 1, 2023, in Orange County, establishes the CARE Court Program to facilitate delivery of mental health and SUD services to individuals with schizophrenia spectrum or other psychotic disorders who are unable to survive safely in the community. The program will connect a person in crisis with a court-ordered care plan for up to 12 months, with the option to extend an additional 12 months, as a diversion from homelessness, incarceration or conservatorship. Care plans may include court-ordered stabilization medications, wellness and recovery supports, and connection to social services and housing resources. Eligible individuals may be referred by family members, counties, behavioral health providers or first responders among others. ***Potential CalOptima Health Impact:*** Increased behavioral health and SUD services for eligible CalOptima Health members.	**09/14/2022** Signed into law	CalOptima Health: Watch CAHP: Concern

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Budget			
H.R. 2471 DeLauro (CT)	**Consolidated Appropriations Act, 2022**: Appropriates $1.5 trillion to fund the United States federal government for Fiscal Year (FY) 2022 through September 30, 2022, including earmarks for the following projects in Orange County: • Children's Hospital of Orange County: $325,000 to expand capacity for mental health treatment services and programs in response to the COVID-19 pandemic • City of Huntington Beach: $500,000 to establish a mobile crisis response program • County of Orange: $2 million to develop a second Be Well Orange County campus in the City of Irvine • County of Orange: $5 million to develop a Coordinated Reentry Center to help justice-involved individuals with mental health conditions or SUDs reintegrate into the community • North Orange County Public Safety Task Force: $5 million to expand homeless outreach and housing placement services In addition, extends all current telehealth flexibilities in the Medicare program until approximately five months following the termination of the COVID-19 PHE. ***Potential CalOptima Health Impact:*** Increased coordination with the County of Orange and other community partners to support implementation of projects that benefit CalOptima Health members; continuation of all current telehealth flexibilities for CalOptima Health OneCare, OneCare Connect and Program of All-Inclusive Care for the Elderly (PACE).	**03/15/2022** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 6833 Craig (MN)	**Continuing Appropriations and Ukraine Supplemental Appropriations Act, 2023:** Extends FY 2022 federal spending levels from September 30, 2022, through December 16, 2022. In addition, includes the following supplemental provisions: • $18.8 billion for domestic disaster recovery efforts • $12.4 billion for military and diplomatic assistance to Ukraine • $1 billion increase for the current Low Income Home Energy Assistance Program (LIHEAP) • Reauthorization of the Medicare-Dependent Hospital (MDH) program and the Medicare hospital payment low-volume adjustment through December 16, 2022 • Reauthorization of the U.S. Food and Drug Administration (FDA) user fee program for prescription drugs, devices and biosimilars through September 30, 2027 ***Potential CalOptima Health Impact**:* Continuation of current federal spending and Medicare programs; increased financial stability of CalOptima Health members.	**09/30/2022** Signed into law	CalOptima Health: Watch
AB 178 Ting **SB 154** Skinner	**Budget Act of 2022:** Makes appropriations for the government of the State of California for FY 2022–23. Total spending is just over $300 billion, of which $234.4 billion is from the General Fund. ***Potential CalOptima Health Impact:*** Impacts are discussed in the enclosed Analysis of the Enacted Budget.	**06/30/2022** Signed into law	CalOptima Health: Watch
AB 186 Committee on Budget	**Skilled Nursing Facility (SNF) Financing Reform Trailer Bill:** Enacts policy changes needed to implement FY 2022–23 budget expenditures regarding SNF financing. ***Potential CalOptima Health Impact:*** Impacts are discussed in the enclosed Analysis of the Enacted Budget.	**06/30/2022** Signed into law	CalOptima Health: Watch
AB 204 Committee on Budget	**Health Trailer Bill II:** Requires DHCS to issue retention payments of up to $1,000 each to employees of Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC) and other qualified community clinics. ***Potential CalOptima Health Impact:*** Increased workforce stabilization and less employee turnover at contracted FQHCs and other community clinics.	**09/29/2022** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 184 Committee on Budget and Fiscal Review	**Health Trailer Bill I:** Consolidates and enacts policy changes needed to implement most health-related expenditures in the FY 2022–23 state budget. ***Potential CalOptima Health Impact:*** Impacts are discussed in the enclosed Analysis of the Enacted Budget.	**06/30/2022** Signed into law	CalOptima Health: Watch
Covered Benefits			
H.R. 56 Biggs (AZ)	**Patient Access to Medical Foods Act:** Would expand the federal definition of medical foods to include food prescribed as a therapeutic option when traditional therapies have been exhausted or may cause adverse outcomes. Effective January 1, 2022, medical foods, as defined, would be covered by private health insurance providers and federal public health programs, including Medicare, TRICARE, Children's Health Insurance Program (CHIP) and Medicaid, as a mandatory benefit. ***Potential CalOptima Health Impact:*** New covered benefit for CalOptima Health's lines of business.	**01/04/2021** Introduced; referred to committees	CalOptima Health: Watch
H.R. 1118 Dingell (MI)	**Medicare Hearing Aid Coverage Act of 2021:** Effective January 1, 2022, would require Medicare Part B coverage of hearing aids and related examinations. ***Potential CalOptima Health Impact:*** New covered benefit for CalOptima Health OneCare, OneCare Connect and PACE.	**02/18/2021** Introduced; referred to committees	CalOptima Health: Watch
H.R. 4187 Schrier (WA)	**Medicare Vision Act of 2021:** Effective January 1, 2024, would require Medicare Part B coverage of vision services, including eyeglasses, contact lenses, routine eye examinations and fittings. ***Potential CalOptima Health Impact:*** New covered benefits for CalOptima Health OneCare and PACE.	**06/25/2021** Introduced; referred to committees	CalOptima Health: Watch
H.R. 4311 Doggett (TX) **S. 2618** Casey (PA)	**Medicare Dental, Vision, and Hearing Benefit Act of 2021:** Effective no sooner than January 1, 2022, would require Medicare Part B coverage of the following benefits: • Dental: Routine dental cleanings and examinations, basic and major dental services, emergency dental care, and dentures • Vision: Routine eye examinations, eyeglasses, contact lenses and low vision devices • Hearing: Routine hearing examinations, hearing aids and related examinations The Senate version would also increase the Medicaid FMAP for hearing, vision and dental services to 90%. ***Potential CalOptima Health Impact:*** New covered benefits for CalOptima Health OneCare, OneCare Connect and PACE; higher federal funding rate for current Medi-Cal benefits.	**07/01/2021** Introduced; referred to committees	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 4650 Kelly (IL)	**Medicare Dental Coverage Act of 2021**: Effective January 1, 2025, would require Medicare Part B coverage of dental and oral health services, including routine dental cleanings and examinations, basic and major dental treatments, and dentures. ***Potential CalOptima Health Impact:*** New covered benefits for CalOptima Health OneCare and PACE.	**07/22/2021** Introduced; referred to committees	CalOptima Health: Watch
AB 1929 Gabriel	**Medi-Cal Violence Prevention Services:** Adds violence prevention services as a Medi-Cal-covered benefit to reduce the rate of violent injury and trauma as well as promote recovery, stabilization and improved health outcomes. ***Potential CalOptima Health Impact:*** New covered benefit for CalOptima Health Medi-Cal members.	**08/22/2022** Signed into law	CalOptima Health: Watch
AB 1930 Arambula	**Medi-Cal Perinatal Services:** Would have required Medi-Cal coverage of additional perinatal assessments and services, as developed by the California Department of Public Health and additional stakeholders, for beneficiaries up to one year postpartum. A nonlicensed perinatal worker could have delivered such services if supervised by an enrolled Medi-Cal provider or a non-enrolled community-based organization (CBO) if a Medi-Cal provider was available for billing. ***Potential CalOptima Health Impact:*** New covered benefit for CalOptima Health Medi-Cal members up to one-year postpartum.	**09/27/2022** Vetoed	CalOptima Health: Watch
AB 2697 Aguiar-Curry	**Medi-Cal Community Health Workers (CHWs) and Promotores:** Adds preventive services provided by CHWs and promotores as a Medi-Cal-covered benefit with the goal of preventing disease, prolonging life and promoting physical and behavioral health. Requires Medi-Cal MCPs to conduct outreach and education to beneficiaries regarding the CHW benefit, eligibility and lists of referral sources and authorized providers. MCPs must also notify all providers about the CHW benefit. ***Potential CalOptima Health Impact:*** New covered benefit for CalOptima Health Medi-Cal members; additional member and provider outreach activities.	**09/23/2022** Signed into law	CalOptima Health: Watch
SB 245 Gonzalez	**Medi-Cal Abortion Services:** Prohibits a health plan from imposing Medi-Cal cost-sharing on all abortion services, including any pre-abortion or follow-up care, no sooner than January 1, 2023. In addition, a health plan and its delegated entities may not require a prior authorization or impose an annual or lifetime limit on such coverage. ***Potential CalOptima Health Impact:*** Modified UM procedures for a Medi-Cal-covered benefit.	**03/22/2022** Signed into law	CalOptima Health: Watch CAHP: Oppose

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 912 Limón	**Medi-Cal Biomarker Testing:** No later than July 1, 2023, would have added biomarker testing, including whole genome sequencing, as a Medi-Cal-covered benefit to diagnose, treat or monitor a disease. ***Potential CalOptima Health Impact:*** New covered benefit for CalOptima Health Medi-Cal members.	**09/29/2022** Vetoed	CalOptima Health: Watch CAHP: Oppose Unless Amended
Medi-Cal Eligibility and Enrollment			
H.R. 1738 Dingell (MI) **S. 646** Brown (OH)	**Stabilize Medicaid and CHIP Coverage Act of 2021:** Would provide 12 months of continuous eligibility and coverage for any Medicaid or CHIP beneficiary. ***Potential CalOptima Health Impact:*** Increased number of CalOptima Health Medi-Cal members.	**03/10/2021** Introduced; referred to committees	CalOptima Health: Watch ACAP: Support
H.R. 5610 Bera (CA) **S. 3001** Van Hollen (MD)	**Easy Enrollment in Health Care Act:** To streamline and increase enrollment into public health insurance programs, would allow taxpayers to request their federal income tax returns include a determination of eligibility for Medicaid, CHIP or advance premium tax credits to purchase insurance through a health plan exchange. Taxpayers could also consent to be automatically enrolled into any such program or plan if they would be subject to a zero net premium. ***Potential CalOptima Health Impact:*** Increased number of CalOptima Health Medi-Cal members.	**10/19/2021** Introduced; referred to committees	CalOptima Health: Watch ACAP: Support
H.R. 6636 Trone (MD) **S. 2697** Cassidy (LA)	**Due Process Continuity of Care Act:** Would allow states to extend Medicaid coverage to inmates who are awaiting trial and have not been convicted of a crime. ***Potential CalOptima Health Impact*:** If DHCS exercises option and requires enrollment into managed care, increased number of CalOptima Health Medi-Cal members.	**08/10/2021** Introduced; referred to committees	CalOptima Health: Watch
AB 2680 Arambula	**Community Health Navigator Program:** Would require DHCS to create the Community Health Navigator Program, starting January 1, 2023, to issue direct grants to qualified CBOs to conduct targeted outreach, enrollment and access activities for Medi-Cal-eligible individuals and families. ***Potential CalOptima Health Impact:*** Increased number of CalOptima Health Medi-Cal members.	**08/31/2022** Died on Senate floor	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Medi-Cal Operations and Administration			
AB 498 Quirk-Silva	**CalOptima Health Board of Directors:** Makes permanent the current structure of the CalOptima Health Board of Directors (Board), including all designated seats. In addition, effective January 1, 2023, enacts the following prohibitions for one year following a Director's term: • Prohibits Directors in all seats from lobbying CalOptima Health • Prohibits Directors in the Supervisorial and accounting/legal seats from being employed by CalOptima Health or any third-party entity that has received funds from CalOptima Health within the previous five years (not including routine administrative expenses) • Prohibits Directors in a Supervisorial seat from being appointed to any other Board seat ***Potential CalOptima Health Impact:*** Permanent continuation of the current Board structure; new employment restrictions for one year following a Director's Board term.	**09/19/2022** Signed into law	CalOptima Health: Watch
AB 1400 Kalra, Lee, Santiago	**California Guaranteed Health Care for All:** Would create the California Guaranteed Health Care for All program (CalCare) to provide a comprehensive universal single-payer health care benefit for all California residents. Would require CalCare cover a wide range of medical benefits and other services and would incorporate the health care benefits and standards of CHIP, Medi-Cal, Medicare, the Knox-Keene Act, and ancillary health care or social services covered by regional centers for people with developmental disabilities. ***Potential CalOptima Health Impact***: Unknown but potentially significant impacts to the Medi-Cal delivery system and MCPs, including changes to administration, covered benefits, eligibility, enrollment, financing and organization.	**01/31/2022** Died on Assembly floor	CalOptima Health: Watch CAHP: Oppose
AB 1937 Patterson	**Out-of-Pocket Pregnancy Costs:** No later than July 1, 2023, would require DHCS to reimburse pregnant Medi-Cal beneficiaries up to $1,250 for out-of-pocket pregnancy costs, including birth and infant care classes, midwife and doula services, lactation support, prenatal vitamins, lab tests or screenings, prenatal acupuncture or acupressure, and medical transportation. ***Potential CalOptima Health Impact:*** Increased financial stability for CalOptima Health Medi-Cal members who are currently or were recently pregnant.	**04/29/2022** Died in Assembly Health Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 1944 Lee	**Brown Act Flexibilities:** Would extend certain Brown Act flexibilities, temporarily enacted in response to the COVID-19 PHE, until January 1, 2030, regardless of the existence of a PHE. Specifically, teleconferencing locations for any members of a legislative body would not need to be identified or publicly accessible. If exercising these flexibilities, a legislative body must comply with the following requirements: • A quorum of members must participate in person at a single location identified on the agenda and publicly accessible. • The agenda must identify which members are teleconferencing. • Members of the public must have access to a video stream of the primary meeting location. • Members of the public must be able to provide public comment via in-person, audio-visual or call-in options. ***Potential CalOptima Health Impact:*** Continued ability for members of the Board and advisory committees to participate in meetings by teleconference; modified posting and noticing requirements for the Clerk of the Board.	**07/01/2022** Died in Senate Governance and Finance Committee	CalOptima Health: Watch
AB 1995 Arambula	**Medi-Cal Premium and Copayment Elimination:** Would eliminate Medi-Cal premiums for low-income children whose family income exceeds 160% federal poverty level (FPL), working disabled persons with incomes less than 250% FPL and pregnant women and infants enrolled in the Medi-Cal Access Program. Would also eliminate copayments for all Medi-Cal beneficiaries. ***Potential CalOptima Health Impact:*** Increased financial stability for CalOptima Health Medi-Cal members.	**08/12/2022** Died in Senate Appropriations Committee	CalOptima Health: Watch LHPC: Support
AB 2077 Calderon	**Medi-Cal Personal Needs Allowance:** No later than July 1, 2024, would have increased the monthly income that a Medi-Cal beneficiary residing in a long-term care (LTC) facility or receiving PACE services could retain from $35 to $80. Consistent with current law, beneficiaries would have contributed remaining income as a share of cost to the facility before Medi-Cal paid remaining expenses. ***Potential CalOptima Health Impact:*** Increased financial stability for CalOptima Health PACE participants and CalOptima Health Medi-Cal members residing in LTC facilities with a share of cost.	**09/27/2022** Vetoed	CalOptima Health: Watch CalPACE: Support LHPC: Support

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 2449 Rubio, B.	**Brown Act Flexibilities:** Extends and modifies current Brown Act flexibilities *after* the termination of the COVID-19 PHE until January 1, 2026. Specifically, teleconferencing locations for any members of a local legislative body will still not need to be publicly accessible or identified on the meeting agenda. However, if exercising these flexibilities after the COVID-19 PHE, the legislative body must comply with the following requirements: • A quorum of members must participate in person at a single location identified on the agenda and publicly accessible. • Teleconferencing members must participate through audio and visual technology. • Members of the public must be able to provide public comment via in-person, two-way audiovisual platform or two-way telephonic service with a live meeting webcast. • Members may only teleconference due to a medical emergency for themselves or their family, or, at no more than two meetings per calendar year, another "just cause" for remote participation, such as a caregiving need, contagious illness, disability or travel while on official business. Does not impact current Brown Act flexibilities while the COVID-19 PHE remains in effect. ***Potential CalOptima Health Impact:*** Continued ability for Board and advisory committee members to participate in meetings by teleconference after the COVID-19 PHE; modified meeting streaming capabilities by Information Technology Services; modified recordkeeping by the Clerk of the Board.	**09/13/2022** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 2724 Arambula	**Alternate Health Care Service Plan**: No sooner than January 1, 2024, authorizes DHCS to contract directly with an Alternate Health Care Service Plan (AHCSP) as a Medi-Cal MCP in any county. An AHCSP is a nonprofit health plan with at least four million enrollees statewide that owns or operates pharmacies and provides medical services through an exclusive contract with a single medical group in each region. Currently, Kaiser Permanente (Kaiser) is the only AHCSP. Enrollment into Kaiser will be limited to the following Medi-Cal beneficiaries: • Previous AHCSP enrollees and their immediate family members • Dually eligible for Medi-Cal and Medicare benefits • Foster youth • A share of default enrollments when a Medi-Cal MCP is not selected ***Potential CalOptima Health Impact:*** *De facto* termination of the COHS model; Kaiser as an additional Medi-Cal MCP in Orange County; increased coordination with Kaiser on various Medi-Cal and community initiatives; decreased number of CalOptima Health Medi-Cal members; increased percentage of CalOptima Health members who are high-risk.	**06/30/2022** Signed into law	**04/07/2022** CalOptima Health: Oppose Unless Amended LHPC: Oppose
SB 250 Pan	**Prior Authorization "Deemed Approved" Status:** Beginning January 1, 2024, would require a health plan to review a provider's prior authorization requests to determine eligibility for "deemed approved" status, which would exempt the provider from prior authorization requirements for any plan benefit for one year. A provider would qualify if the health plan approved at least 90% of their prior authorization requests for the same service within the past year. ***Potential CalOptima Health Impact:*** Implementation of new UM procedures to assess provider appeals rates and exempt certain providers from UM requirements.	**08/12/2022** Died in Assembly Appropriations Committee	CalOptima Health: Watch CAHP: Oppose
SB 858 Wiener	**Health Plan Civil Penalties:** Increases the civil penalty amount that the California Department of Managed Health Care (DMHC) can levy on a health plan from no more than $2,500 per violation to no more than $25,000 per violation. Also increases several administrative penalty amounts. All amounts will be adjusted every five years, beginning January 1, 2028. ***Potential CalOptima Health Impact:*** Increased financial penalties for CalOptima Health OneCare and PACE.	**09/30/2022** Signed into law	CalOptima Health: Watch CAHP: Oppose

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 923 Wiener	**TGI Inclusive Care Act:** No later than March 1, 2025, requires Medi-Cal MCP, PACE organization and delegated entity staff in direct contact with beneficiaries to complete cultural competency training to help provide inclusive health care services for individuals who identify as transgender, gender diverse or intersex (TGI). In addition, requires a Medi-Cal MCP and PACE organization to identify in its provider directory any in-network providers who share that they offer gender-affirming services. Finally, no later than March 1, 2024, requires the California Health and Human Services Agency to implement a quality standard that measures patient experience with TGI cultural competency. ***Potential CalOptima Health Impact:*** Additional training requirement for member-facing CalOptima Health employees; additional requirement for provider directory publication.	**09/29/2022** Signed into law	CalOptima Health: Watch
Older Adult Services			
H.R. 3173 DelBene (WA) **S. 3018** Marshall (KS)	**Improving Seniors' Timely Access to Care Act:** Would require Medicare Advantage (MA) plans to issue real-time decisions for routine prior authorization requests. HHS would determine and biennially update the definitions of "real-time" and "routine." In addition, HHS would establish electronic prior authorization transmission standards for MA plans. ***Potential CalOptima Health Impact:*** Modified UM procedures and timelines for CalOptima Health OneCare.	**09/14/2022** Passed House floor; referred to Senate	CalOptima Health: Watch
H.R. 4131 Dingell (MI) **S. 2210** Casey (PA)	**Better Care Better Jobs Act:** Would make permanent the enhanced 10% FMAP for Medicaid home- and community-based services (HCBS) enacted by the American Rescue Plan Act of 2021. Would also provide states with $100 million in planning grants to develop HCBS infrastructure and workforces. Additionally, would make permanent spousal impoverishment protections for those receiving HCBS. ***Potential CalOptima Health Impact:*** Continuation of current federal funding rate for HCBS; expansion of HCBS opportunities.	**06/24/2021** Introduced; referred to committees	CalOptima Health: Watch NPA: Support
H.R. 4941 Blumenauer (OR) **S. 5106** Carper (DE)	**PACE Part D Choice Act of 2021:** Would allow a Medicare-only PACE participant to opt out of drug coverage provided by the PACE program and instead enroll in a standalone Medicare Part D prescription drug plan that results in equal or lesser out-of-pocket costs. PACE programs would be required to educate their participants about this option. ***Potential CalOptima Health Impact****:* Increased enrollment into CalOptima Health PACE by Medicare-only beneficiaries due to decreased out-of-pocket costs.	**08/06/2021** Introduced; referred to committees	CalOptima Health: Watch NPA: Support

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 6770 Dingell (MI) **S. 1162** Casey (PA)	**PACE Plus Act:** Would increase the number of PACE programs nationally by making it easier for states to adopt PACE as a model of care and providing grants to organizations to start PACE centers or expand existing PACE centers. Would incentivize states to expand the number of seniors and people with disabilities eligible to receive PACE services beyond those deemed to require a nursing home level of care. Would provide states a 90% FMAP to cover the expanded eligibility. ***Potential CalOptima Health Impact:*** Subject to further DHCS authorization, expanded eligibility for CalOptima Health PACE; additional federal funding to expand the size and/or service area of a current PACE center or to establish a new PACE center(s).	**04/15/2021** Introduced; referred to committees	CalOptima Health: Watch NPA: Support
H.R. 6823 Brownley (CA) **S. 3854** Moran (KS)	**Elizabeth Dole Home and Community Based Services for Veterans and Caregivers Act:** Would require Veterans Affairs (VA) medical centers to establish partnerships with PACE organizations to enable veterans to access PACE services through their VA benefits. ***Potential CalOptima Health Impact:*** Increased number of CalOptima Health PACE participants; increased care coordination for CalOptima Health PACE participants who are veterans.	**07/19/2022** Passed House Committee on Veterans' Affairs; referred to House floor	CalOptima Health: Watch NPA: Support
H.R. 9209 Dingell (MI) **S. 3626** Casey	**PACE Expanded Act:** To increase access to and the affordability of PACE, would allow PACE organizations to set premiums individually for Medicare-only beneficiaries consistent with their health status. Would also allow individuals to enroll in PACE at any time during the month. In addition, would simplify and expedite the process for organizations to apply for the following: • New PACE program • New centers for an existing PACE program • Expanded service area for an existing PACE center Finally, would allow pilot programs to test the PACE model of care with new populations not currently eligible to participate in PACE. ***Potential CalOptima Health Impact****:* Increased number of CalOptima Health PACE participants; expanded eligibility criteria; new premium development procedure; simplified process to establish new PACE centers.	**02/10/2022** Introduced; referred to committee	CalOptima Health: Watch NPA: Support

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 1342 Bates	**Older Adult Care Coordination:** Allows a county and/or an Area Agency on Aging to create a multi-disciplinary team (MDT) for county departments and aging service providers to exchange information about older adults to better address their health and social needs. By eliminating data silos, MDTs can develop coordinated case plans for wraparound services, provide support to caregivers and improve service delivery. ***Potential CalOptima Health Impact:*** Participation in Orange County's MDT; improved care coordination for CalOptima Health's older adult members.	**09/27/2022** Signed into law	**03/29/2022** CalOptima Health: Support County of Orange: Sponsor/Support
Pharmacy			
H.R. 5376 Yarmuth (KY)	**Inflation Reduction Act of 2022:** Modifies federal policies and appropriates significant investments related to climate change, energy, health care and taxation. Notably, requires the U.S. Centers for Medicare and Medicaid Services (CMS) to negotiate lower prices for certain high-cost drugs in Medicare Parts B and D, starting in 2026. In addition, reduces Part D out-of-pocket costs and increases Part D plan costs for catastrophic coverage. Lastly, extends current enhanced levels of advanced premium tax credits for individuals purchasing health coverage through an exchange/marketplace through 2025. ***Potential CalOptima Health Impact:*** Decreased prescription drug costs for CalOptima Health OneCare members; increased costs for CalOptima Health OneCare program.	**08/16/2022** Signed into law	CalOptima Health: Watch
SB 853 Wiener	**Medication Access Act:** Effective January 1, 2023, would require a health plan to cover a prescribed medication for the duration of any internal and external appeals if the drug was previously covered for the beneficiary by any health plan. ***Potential CalOptima Health Impact:*** Modified UM and Grievance and Appeals requirements for prescribed drugs covered by CalOptima Health; increased CalOptima Health costs for drug coverage.	**08/12/2022** Died in Assembly Appropriations Committee	CalOptima Health: Watch CAHP: Oppose

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 958 Limón	**Medication and Patient Safety Act of 2022:** Would prohibit health plans from arranging for "brown bagging" or "white bagging," as follows, except under certain limited conditions: • "Brown bagging" involves specialty pharmacies dispensing an infused or injected medication directly to a patient who transports it to a provider for administration. • "White bagging" involves specialty pharmacies distributing such medications to a provider ahead of a patient's visit. ***Potential CalOptima Health Impacts:*** Increased CalOptima Health costs and decreased member access for certain physician-administered drugs covered by CalOptima Health.	**07/01/2022** Died in Assembly Health Committee	CalOptima Health: Watch CAHP: Oppose LHPC: Oppose Unless Amended
Providers			
AB 2581 Salas	**Behavioral Health Provider Credentialing:** Effective January 1, 2023, requires health plans to process credentialing applications from mental health and SUD providers within 60 days of receipt. ***Potential CalOptima Health Impact:*** Modified provider credentialing processes for Quality Improvement staff.	**09/25/2022** Signed into law	CalOptima Health: Watch
AB 2659 Patterson	**Midwife Access:** Would require a Medi-Cal MCP to include at least one licensed midwife (LM), certified-nurse midwife (CNM) and alternative birth center specialty clinic in each county within its provider network. An MCP would be exempt if such providers or centers are not located within the county or do not accept Medi-Cal payments. An MCP must reimburse an out-of-network provider who accepts the Medi-Cal fee-for-service rate. ***Potential CalOptima Health Impact:*** Additional provider contracting and credentialing; increased access to midwifery services for CalOptima Health Medi-Cal members.	**04/29/2022** Died in Assembly Health Committee	CalOptima Health: Watch
SB 966 Limón	**FQHC Provider Types:** Permanently allows FQHCs and RHCs to be reimbursed for visits with an *associate* clinical social worker or an *associate* marriage and family therapist when supervised by a licensed behavioral health practitioner. Currently, such reimbursements are temporary flexibilities allowable only during the COVID-19 PHE. ***Potential CalOptima Health Impact:*** Increased member access to behavioral health providers at contracted FQHCs.	**09/27/2022** Signed into law	CalOptima Health: Watch LHPC: Support

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 987 Portantino	**California Cancer Care Equity Act**: Requires a Medi-Cal MCP to make a good faith effort to contract directly with at least one National Cancer Institute (NCI)-Designated Cancer Center in each county — where one exists — within the MCP's service area. In addition, an MCP must inform a beneficiary with a complex cancer diagnosis of their right to request a referral to a Cancer Center. An MCP must refrain from arbitrarily denying such referrals. ***Potential CalOptima Health Impact:*** Modified UM procedures for CalOptima Health Medi-Cal members referred to contracted NCI-Designated Cancer Centers in Orange County; increased access to cancer care.	**09/27/2022** Signed into law	CalOptima Health: Watch
Reimbursement Rates			
AB 1892 Flora	**California Orthotic and Prosthetic Patient Access and Fairness Act:** Would require reimbursement for prosthetic and orthotic appliances and durable medical equipment (DME) to be at least 80% of the lowest maximum allowance for California established by the federal Medicare program. ***Potential CalOptima Health Impact***: Increased cost to CalOptima Health Medi-Cal due to higher reimbursement to DME providers; adjustment to DHCS capitation rates.	**08/12/2022** Died in Senate Appropriations Committee	CalOptima Health: Watch
AB 2458 Weber	**Whole Child Model (WCM) Reimbursement Rates:** Effective January 1, 2023, would increase provider reimbursement rates for WCM services by 25% if provided at a medical practice in which at least 30% of pediatric patients are Medi-Cal beneficiaries. ***Potential CalOptima Health Impact:*** Increased cost to CalOptima Health Medi-Cal due to higher reimbursement to WCM providers; adjustment to DHCS capitation rates.	**05/20/2022** Died in Assembly Appropriations Committee	CalOptima Health: Watch
Social Determinants of Health			
H.R. 379 Barragan (CA) **S. 104** Smith (MN)	**Improving Social Determinants of Health Act of 2021:** Would require the Centers for Disease Control and Prevention (CDC) to establish a social determinants of health (SDOH) program to coordinate activities to improve health outcomes and reduce health inequities. CDC would be required to consider SDOH in all relevant grant awards and other activities as well as issue new grants of up to $50 million to health agencies, nonprofit organizations and/or institutions of higher education to address or study SDOH. ***Potential CalOptima Health Impact:*** Increased availability of federal grants to address SDOH.	**01/21/2021** Introduced; referred to committees	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 943 McBath (GA) **S. 851** Blumenthal (CT)	**Social Determinants for Moms Act:** Would require HHS to convene a task force to coordinate federal efforts on social determinants of maternal health as well as award grants to address SDOH, eliminate disparities in maternal health and expand access to free childcare during pregnancy-related appointments. Would also extend postpartum eligibility for the Special Supplemental Nutrition Program for Women, Infants, and Children from six months postpartum to two years postpartum. ***Potential CalOptima Health Impact:*** Additional federal guidance or requirements as well as increased availability of federal grants to address social factors affecting maternal health.	**02/08/2021** Introduced; referred to committees	CalOptima Health: Watch
H.R. 2503 Bustos (IL) **S. 3039** Young (IN)	**Social Determinants Accelerator Act of 2021:** Would establish the Social Determinants Accelerator Interagency Council to award state and local health agencies up to 25 competitive grants totaling no more than $25 million (House version) or $10 million (Senate version) as well as provide technical assistance to improve coordination of medical and non-medical services to a targeted population of high-need Medicaid beneficiaries. ***Potential CalOptima Health Impact:*** Increased availability of federal grants to address the SDOH of members with complex needs.	**07/15/2021** Passed Subcommittee on Health of the House Committee on Energy and Commerce; referred to full Committee	CalOptima Health: Watch
H.R. 3894 Blunt Rochester (DE)	**Collecting and Analyzing Resources Integral and Necessary for Guidance (CARING) for Social Determinants Act of 2021:** Would require CMS to update guidance at least once every three years to help states address SDOH in Medicaid and CHIP programs. ***Potential CalOptima Health Impact:*** Increased opportunities for CalOptima Health to address SDOH.	**12/08/2021** Passed House floor; referred to Senate Committee on Finance	CalOptima Health: Watch
H.R. 4026 Burgess (TX)	**Social Determinants of Health Data Analysis Act of 2021:** Would require the Comptroller General of the United States to submit a report to Congress outlining the actions taken by HHS to address SDOH. The report would include an analysis of interagency efforts, barriers and potential duplication of efforts as well as recommendations on how to foster private-public partnerships to address SDOH. ***Potential CalOptima Health Impact:*** Increased opportunities for CalOptima Health to address SDOH.	**11/30/2021** Passed House floor; referred to Senate Committee on Health, Education, Labor, and Pensions	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 17 Pan	**Racial Equity Advisory and Accountability Commission:** Would establish the Racial Equity Commission (REC) to develop a Racial Equity Framework containing resources, best practices and tools for advancing racial equity across the state government by April 1, 2025.The REC would also provide technical assistance upon request by state and local agencies as well as issue annual reports, starting December 1, 2025, with recommendations to address issues related to racial equity. ***Potential CalOptima Health Impact:*** Increased reporting requirements to DHCS.	**08/31/2022** Died on Assembly floor	CalOptima Health: Watch
Telehealth			
H.R. 366 Thompson (CA)	**Protecting Access to Post-COVID-19 Telehealth Act of 2021:** Would allow HHS to waive or modify any telehealth service requirements in the Medicare program during a national disaster or PHE and for 90 days after one is terminated. Would also permit Medicare reimbursement for telehealth services provided by an FQHC or RHC as well as allow patients to receive telehealth services in the home without restrictions. ***Potential CalOptima Health Impact:*** Continuation and expansion of certain telehealth flexibilities allowed during the COVID-19 pandemic for CalOptima Health OneCare, OneCare Connect and PACE.	**01/19/2021** Introduced; referred to committees	CalOptima Health: Watch
H.R. 1332 Carter (GA) **S. 368** Scott (SC)	**Telehealth Modernization Act of 2021:** Would permanently extend certain current Medicare telehealth flexibilities enacted temporarily in response to the COVID-19 pandemic. Specifically, would permanently allow the following: • FQHCs and RHCs may serve as the site of a telehealth provider • Beneficiaries may receive all telehealth services at any location, including their own homes • CMS may retain and expand the list of covered telehealth services • CMS may expand the types of providers eligible to provide telehealth services ***Potential CalOptima Health Impact:*** Continuation of certain telehealth flexibilities allowed during the COVID-19 pandemic for CalOptima Health OneCare, OneCare Connect and PACE.	**02/23/2021** Introduced; referred to committees	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 2166 Sewell (AL)	**Ensuring Parity in MA and PACE for Audio-Only Telehealth Act of 2021:** Would require CMS to include audio-only telehealth diagnoses in the determination of risk adjustment payments for MA and PACE plans during the COVID-19 PHE. ***Potential CalOptima Health Impact:*** For CalOptima Health OneCare, OneCare Connect and PACE, members' risk scores and risk adjustment payments would accurately reflect diagnoses.	**03/23/2021** Introduced; referred to committees	**08/05/2021** CalOptima Health: Support ACAP: Support NPA: Support
H.R. 2903 Thompson (CA) **S. 1512** Schatz (HI)	**Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act of 2021:** Would expand telehealth services for those receiving Medicare benefits and remove restrictions in the Medicare program that prevent physicians from using telehealth technology. Specifically, would: • Remove all geographic restrictions for telehealth services • Allow beneficiaries to receive telehealth in their own homes, in addition to other locations determined by HHS • Remove restrictions on the use of telehealth in emergency medical care • Allow FQHCs and RHCs to provide telehealth services ***Potential CalOptima Health Impact:*** Continuation and expansion of telehealth flexibilities for CalOptima Health OneCare, OneCare Connect and PACE.	**04/28/2021** Introduced; referred to committees	CalOptima Health: Watch
H.R. 3447 Smith (MO)	**Permanency for Audio-Only Telehealth Act:** Would permanently extend the following current flexibilities, which have been temporarily authorized by CMS during the COVID-19 PHE: • Medicare providers may be reimbursed for providing certain services via audio-only telehealth, including evaluation and management, behavioral health and SUD services, or any other service specified by HHS. • Medicare beneficiaries may receive telehealth services at any location, including their homes. ***Potential CalOptima Health Impact:*** Permanent continuation of certain telehealth flexibilities for CalOptima Health OneCare, OneCare Connect and PACE.	**05/20/2021** Introduced; referred to committees	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 4058 Matsui (CA) **S. 2061** Cassidy (LA)	**Telemental Health Care Access Act of 2021:** Would remove the requirement that Medicare beneficiaries be seen in-person within six months of being treated for behavioral health services via telehealth. ***Potential CalOptima Health Impact:*** For CalOptima Health OneCare and OneCare Connect, decreased in-person behavioral health encounters and increased telehealth behavioral health encounters.	**06/22/2021** Introduced; referred to committees	CalOptima Health: Watch
H.R. 7573 Axne (IA) **S. 3593** Cortez Masto (NV)	**Telehealth Extension and Evaluation Act**: Would extend current Medicare telehealth payments authorized temporarily in response to the COVID-19 pandemic for two additional years following the termination of the PHE. Would require HHS to study the impact of telehealth flexibilities and report its recommendations for permanent telehealth policies to Congress. ***Potential CalOptima Health Impact:*** Continuation of telehealth flexibilities for CalOptima Health OneCare, OneCare Connect and PACE.	**02/08/2022** Introduced; referred to committee	CalOptima Health: Watch
S. 150 Cortez Masto (NV)	**Ensuring Parity in MA for Audio-Only Telehealth Act of 2021:** Would require CMS to include audio-only telehealth diagnoses in the determination of risk adjustment payments for MA plans during the COVID-19 PHE. ***Potential CalOptima Health Impact:*** For CalOptima Health OneCare and OneCare Connect, members' risk scores and risk adjustment payments would accurately reflect diagnoses.	**02/02/2021** Introduced; referred to committee	CalOptima Health: Watch ACAP: Support NPA: Support
AB 32 Aguiar-Curry	**Medi-Cal Telehealth Flexibilities:** Modifies the permanent Medi-Cal telehealth policy recently implemented by SB 184, the Health Trailer Bill for the FY 2022–23 Enacted State Budget, effective after the termination of COVID-19 PHE flexibilities. Specifically, Medi-Cal providers, including FQHCs and RHCs, may establish a new patient using audio-only telehealth when the visit is related to sensitive services or when the patient requests audio-only telehealth or does not have access to video. ***Potential CalOptima Health Impact:*** Continuation and modification of certain telehealth flexibilities for CalOptima Health Medi-Cal and PACE.	**09/25/2022** Signed into law	CalOptima Health: Watch CAHP: Concern

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Youth Services			
H.R. 66 Buchanan (FL)	**Comprehensive Access to Robust Insurance Now Guaranteed (CARING) for Kids Act:** Would permanently extend authorization and funding of CHIP and associated programs, including the Medicaid and CHIP express lane eligibility option, which enables states to expedite eligibility determinations by referencing enrollment in other public programs. ***Potential CalOptima Health Impact:*** Continuation of current federal funding and eligibility requirements for CalOptima Health Medi-Cal members eligible under CHIP.	**01/04/2021** Introduced; referred to committee	CalOptima Health: Watch
H.R. 1390 Wild (PA) **S. 453** Casey (PA)	**Children's Health Insurance Program Pandemic Enhancement and Relief (CHIPPER) Act:** Would retroactively extend CHIP's temporary 11.5% FMAP increase, enacted by the HEALTHY KIDS Act (2018), from September 30, 2020, until September 30, 2022, to meet increased health care needs during the COVID-19 PHE. ***Potential CalOptima Health Impact:*** Increased federal funds for CalOptima Health Medi-Cal members eligible under CHIP.	**02/25/2021** Introduced; referred to committees	CalOptima Health: Watch

2021 Signed Bills

- H.R. 1868 (Yarmuth [KY])
- AB 128 (Ting)
- AB 133 (Committee on Budget)
- AB 161 (Ting)
- AB 164 (Ting)
- AB 361 (Rivas)
- AB 1082 (Waldron)
- SB 48 (Limón)
- SB 65 (Skinner)
- SB 129 (Skinner)
- SB 171 (Committee on Budget and Fiscal Review)
- SB 221 (Wiener)
- SB 306 (Pan)
- SB 510 (Pan)

2021 Vetoed Bills

- AB 369 (Kamlager)
- AB 523 (Nazarian)
- SB 365 (Caballero)
- SB 682 (Rubio)

Information in this document is subject to change as bills proceed through the legislative process.

ACAP: Association for Community Affiliated Plans
CAHP: California Association of Health Plans
CalPACE: California PACE Association
LHPC: Local Health Plans of California
NPA: National PACE Association

Last Updated: November 17, 2022

2022 Federal Legislative Dates

January 3	117th Congress, Second Session convenes
April 11–2	Spring recess
August 1–12	Summer recess for House
August 8–September 5	Summer recess for Senate
December 10	Second Session adjourns

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

2022 State Legislative Dates

January 3	Legislature reconvenes
January 14	Last day for policy committees to hear and report to fiscal committees any fiscal bills introduced in that house in 2021
January 21	Last day for any committee to hear and report to the floor any bill introduced in that house in 2021
January 31	Last day for each house to pass bills introduced in that house in 2021
February 18	Last day for legislation to be introduced
April 7–18	Spring recess
April 29	Last day for policy committees to hear and report to fiscal committees any fiscal bills introduced in that house in 2022
May 6	Last day for policy committees to hear and report to the floor any non-fiscal bills introduced in that house in 2022
May 20	Last day for fiscal committees to hear and report to the floor any bills introduced in that house in 2022
May 23–27	Floor session only
May 27	Last day for each house to pass bills introduced in that house in 2022
June 15	Budget bill must be passed by midnight
July 1	Last day for policy committees to hear and report bills in their second house to fiscal committees or the floor
July 1–August 1	Summer recess
August 12	Last day for fiscal committees to report bills in their second house to the floor
August 15–31	Floor session only
August 25	Last day to amend bills on the floor
August 31	Last day for each house to pass bills; final recess begins upon adjournment
September 30	Last day for Governor to sign or veto bills passed by the Legislature

Source: 2022 State Legislative Deadlines, California State Assembly: http://assembly.ca.gov/legislativedeadlines

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 four major programs: Medi-Cal, OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan), OneCare (Medicare Advantage Special Needs Plan) and the Program of All-Inclusive Care for the Elderly (PACE).

FY 2022–23 California State Budget: Analysis of the Enacted Budget

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Background

On January 10, 2022, Gov. Gavin Newsom released the Fiscal Year (FY) 2022–23 Proposed State Budget with total spending at $286.4 billion, including $213.1 billion General Fund (GF). The proposed budget also estimated a $45.7 billion surplus and proposed $34.6 billion in budget reserves, which could be attributed to federal COVID-19 stimulus funding and higher than expected tax receipts.

On May 13, 2022, Gov. Newsom released the FY 2022–23 Revised Budget Proposal (May Revise) at a total of $300.7 billion, including $227.4 billion in GF spending, representing an increase of $14.3 billion compared to the January Proposed Budget due to further revenue growth. The May Revise included an even larger $49.2 billion discretionary surplus and $37.1 billion in budget reserves.

To meet the constitutionally obligated deadline to pass a balanced budget, on June 14, 2022, the Senate and Assembly passed Senate Bill (SB) 154, the Budget Act of 2022, a preliminary state budget representing the Legislature's counterproposal to the May Revise. The Legislature's Budget included a spending plan of $300 billion, including $235.5 billion GF.

Following negotiations with the Legislature, Gov. Newsom signed into law the preliminary state budget (SB 154) on June 27 and the final budget revisions (Assembly Bill [AB] 178) on June 30. On the same day, he signed the consolidated Health Trailer Bill (SB 184) and the Skilled Nursing Facility (SNF) Financing Reform Trailer Bill (AB 186) containing the statutory policy changes needed to implement health-related budget expenditures. Together, these bills represent the Enacted Budget for FY 2022–23, effective July 1, 2022.

Overview

In summary, the enacted budget appropriates a total of just over $300 billion, of which $234.4 billion is from the GF. This represents an increase of $37.4 billion compared with the FY 2021–22 enacted budget. Specifically, the budget includes $135.5 billion ($36.6 billion GF) in Medi-Cal spending, an 11.2% increase from the current FY, with an assumption that Medi-Cal caseload will increase by 0.6% to 14.5 million beneficiaries as redeterminations resume this FY following termination of the COVID-19 public health emergency (PHE). Based on a record-high budget surplus, the budget allocates 93% towards one-time spending initiatives and $37.2 billion for reserves. Major components included in the enacted budget that may impact CalOptima are discussed below.

Behavioral Health

The Enacted Budget includes significant investments in behavioral health, particularly for children and youth. As expected, there is ongoing funding towards implementing the Children and Youth Behavioral Health Initiative (CYBHI), including the following components in FY 2022–23:

- Dyadic services as a new Medi-Cal benefit, as discussed later
- Evidence-based behavioral health practices
- School behavioral health partnerships and capacity
- Statewide behavioral health services platform and related e-consult service and provider training

While some CYBHI initiatives are directly managed by DHCS, CalOptima's Behavioral Health Integration department may still be involved in guiding certain programs or coordinating member access.

In addition, the budget includes an extra $290 million in one-time funding over three years to address urgent needs and emergent issues in children's behavioral health through the following initiatives:

- Wellness and mindfulness programs
- Parent training and education
- Digital supports for remote assessment and intervention
- School-based crisis response pilots to prevent youth suicide
- Peer-to-peer support programs

A total of $8 million in one-time finding is also allocated for National Suicide Prevention Lifeline crisis centers to prepare for the implementation of the 9-8-8 calling code on July 16, 2022.

Finally, to address the immediate housing and treatment needs of those with serious behavioral health conditions, the budget also includes $1.5 billion over two years to purchase and install tiny homes for immediate behavioral health bridge housing.

California Advancing and Innovating Medi-Cal (CalAIM)

The Enacted Budget includes $3.1 billion ($1.2 billion GF) in FY 2022–23 to implement CalAIM. CalAIM initiatives being implemented in FY 2022–23 continue to include:

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

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

In addition to $1.8 billion of previously allocated PATH funding, the budget provides an additional $50 million ($16 million GF) for counties and correctional entities to support capacity building, technical assistance, collaboration and planning. While plans are not eligible for this funding, CalOptima is expected to coordinate PATH and CalAIM Incentive Payment Program investments with the County of Orange.

COVID-19

As the COVID-19 pandemic enters its endemic phase, the budget allocates $1.9 billion to ensure ongoing pandemic response and preparedness for potential future surges of additional COVID-19 variants. This includes investments towards vaccinations (including boosters), rapid and school-based testing, enhanced surveillance, test to treat therapeutics and medical surge staffing.

In addition, with the PHE expected to terminate in the coming months, the budget includes funding to ensure continuity of Medi-Cal coverage as eligibility redeterminations resume. Funding supports additional county workloads, Health Enrollment Navigators expansion and media and outreach campaigns to collect updated member contact information. CalOptima is separately executing its own member communication strategies.

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

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

Housing and Homelessness

Building off a $12 billion multiyear investment to address homelessness as part of last year's enacted budget, this year's budget includes an additional $2 billion multiyear affordable housing package, including investments in the Multifamily Housing Program, Housing Accelerator Program, Farmworker Housing Program, Accessory Dwelling Unit financing and Veterans Housing and Homelessness Prevention Program. The budget also includes $700 million over two years for local jurisdictions to address encampments through short- and long-term rehousing strategies.

Contingent on passage of implementing legislation (SB 1338), the budget sets aside funding for the governor's proposed Community Assistance, Recovery, and Empowerment (CARE) Court. CARE Court would facilitate delivery of mental health and substance use disorder services to individuals with schizophrenia spectrum or other psychotic disorders who lack medical decision-making capabilities. The program would connect a person in crisis with a court-ordered care plan for up to 24 months as a diversion from homelessness, incarceration or conservatorship. Care plans could include court-ordered stabilization medications, wellness and recovery supports, and connection to social services and a housing plan. It is not yet known how Medi-Cal managed care plans (MCPs) may be involved in the delivery or coordination of care to their members.

Inflation Relief

In an effort to provide direct relief for rising costs due to inflation, the budget includes a $17 billion relief package, which includes the following elements:

- $1.3 billion for retention payments of up to $1,500 each for hospital and SNF workers
- Permanent extension of the State Premium Subsidy Program to provide financial assistance for individuals purchasing health care coverage through Covered California

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

Kaiser Medi-Cal Contract

As part of the budget packet, Gov. Newsom also signed into law AB 2724, which authorizes DHCS to enter into a direct, statewide contract with Kaiser Permanente to provide Medi-Cal services in any county, starting January 1, 2024. If the Centers for Medicare and Medicaid Services approves DHCS' waiver request, the contract is expected to result in significant negative impacts to CalOptima and its members and providers as well as the broader safety net health system. CalOptima and the County of Orange adopted positions of Oppose Unless Amended to prohibit a direct contract in counties with County Organized Health Systems (COHS), but the final bill still applies to COHS counties.

Medi-Cal Benefits

The Enacted Budget includes additional funding for several new Medi-Cal benefits.

As referenced earlier, the budget funds the implementation of dyadic services, effective January 1, 2023. Similar to Parent-Child Interaction Therapy, currently managed by the Orange County Health Care Agency (HCA), dyadic care provides integrated physical and behavioral health screening and services to the whole family. The goal of providing dyadic care is to improve access to preventive and coordinated care for children, rates of immunization completion, social-emotional health services, developmentally appropriate parenting and maternal mental health.

In addition, 24/7 mobile crisis intervention services will become a Medi-Cal benefit implemented through county behavioral health systems as soon as January 1, 2023. It is expected that HCA may operate this benefit out of the Be Well OC campus. While not provided by MCPs, this new benefit may still require increased coordination and follow-up care by CalOptima and its contracted providers.

The budget also delays implementation of the doula benefit from July 1, 2022, until January 1, 2023, and provides funding to increase the maximum reimbursement rate from an average of $450 to $1,094 per birth for doula services. Lastly, effective July 1, 2022, annual cognitive health assessments become a Medi-Cal benefit for beneficiaries ages 65 years and older if they are ineligible under Medicare.

Medi-Cal Eligibility

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

The budget also continues to include $53 million ($19 million GF) funding to eliminate Medi-Cal premiums for approximately 500,000 higher-income pregnant women,

children and disabled working adults covered under the Children's Health Insurance Program (CHIP), Medi-Cal Access Program (MCAP) and 250% Working Disabled Program.

Additionally, trailer bill language authorizes continuous Medi-Cal eligibility for children up to 5 years of age, beginning January 1, 2025, preventing disenrollment regardless of changes in family income. DHCS will also expand the Children's Presumptive Eligibility Program by allowing all Medi-Cal providers to enroll children under 19 years of age into Medi-Cal through the presumptive eligibility process.

No sooner than January 1, 2025, seniors and persons with disabilities who qualify for Medi-Cal under Medically Needy criteria will have reduced share of cost requirements by increasing the Medi-Cal Maintenance Need Income Level to match the income eligibility limit for Medi-Cal without a share of cost. As a result of CalAIM, these share of cost beneficiaries are currently covered under Medi-Cal FFS, as of January 1, 2022.

Provider Payments

The Enacted Budget includes $700 million over five years for Equity and Practice Transformation Payments, which are one-time provider payments focused on advancing equity, reducing COVID-19-driven care gaps, supporting upstream interventions to address social determinants of health and improving quality in maternity, children's preventive and integrated behavioral health care. It is anticipated that some if not all of these payments will flow through Medi-Cal MCPs, though key details on implementation have not been shared.

A new Workforce and Quality Incentive Program will provide $280 million in directed payments to SNFs that meet quality benchmarks or who have demonstrated substantial improvement. Medi-Cal MCPs will coordinate program implementation and issue payments. Other changes to SNF payments include:

- New reimbursement rate structure, beginning January 1, 2023
- Average 4% annual rate increase
- One-year extension of the temporary 10% rate increase effective during the COVID-19 PHE

The budget continues nearly all Proposition 56 supplemental payment programs, with several transferring to the GF to allow for ongoing funding regardless of fluctuations in Proposition 56 revenues. However, the Value Based Payment program still sunsetted on June 30, 2022, and the Behavioral Health Integration program is still set to sunset on December 31, 2022. The budget made permanent the Medi-Cal Physician and Dentist Loan Repayment Program, also funded through Proposition 56, and provided additional funds from the GF for FY 2022–23.

The Enacted Budget also eliminates most remaining Great Recession-era ("AB 97") Medi-Cal rate cuts for 35 additional provider types and services, effective either July 1, 2022, or January 1, 2023.

Telehealth

To build off telehealth flexibilities adopted during the COVID-19 pandemic, the budget authorizes a permanent telehealth policy that allows Medi-Cal providers, including FQHCs, to be reimbursed for both video and audio-only telehealth encounters at the same rate as an in-person visit. Providers must still provide an option for in-person visits. However, a new Medi-Cal patient relationship may not be established via audio-only telehealth.

Miscellaneous

The Enacted Budget also includes the following provisions that may impact CalOptima:

- $351.6 million over four years for workforce development, including:
  - $200 million for the behavioral health workforce
  - $76 million for the primary care, clinic and reproductive health workforce
  - $75.6 million for the public health workforce
- $350 million over three years to recruit, train and certify 25,000 new community health workers by 2025, with specialized training to work with those who are justice-involved, unhoused, older adults or disabled
- $200 million to improve access to reproductive health services
- $101 million to expand medication-assisted treatment to help address the opioid crisis
- $100 million for the CalRX Biosimilar Insulin Initiative to create public-private partnerships to increase generic insulin manufacturing and lower insulin costs
- $50 million over two years for technical assistance grants and capacity development programs for small and under-resourced providers to improve data exchange capabilities
- Development of an Alternative Payment Model for FQHCs, optionally allowing them to transition from a volume-based to value-based reimbursement methodology, no sooner than January 1, 2024
- Reclassification of diabetic products, including continuous glucose monitors, as pharmacy benefits covered under Medi-Cal Rx, effective July 1, 2022

Next Steps

The Legislature will continue to advance budget trailer bills and policy bills through the legislative process. Bills with funding allocated in the Enacted Budget are likely to be passed and signed into law. The Legislature has until August 31 to pass legislation, and Gov. Newsom has until September 30 to either sign or veto that legislation. Additionally, state agencies will begin implementing the policies enacted through the budget. Staff will continue to monitor these polices and provide updates regarding issues that have a significant impact to CalOptima.

About CalOptima

CalOptima, a county organized health system (COHS), is the single plan providing guaranteed access to Medi-Cal for all eligible individuals in Orange County and is responsible for almost all medical acute services, including custodial long-term care. CalOptima is governed by a locally appointed Board of Directors, which represents the diverse interests that impact Medi-Cal.

If you have any questions, please contact GA@caloptima.org.

Board of Directors Meeting
December 1, 2022

CalOptima Health Community Outreach Summary — November and December 2022

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 and supports our community partners' public activities.

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

We continue to participate in public activities virtually in most instances, with limited in-person attendance. Participation includes providing Medi-Cal educational materials and, if criteria are met, financial support and/or CalOptima Health-branded items.

Community Outreach Highlight

CalOptima Health has been hosting CalFresh enrollment events to increase awareness and enrollment in the CalFresh program as well as address food insecurity for our members and the community at large. The most recent event took place at Murdy Park in the City of Huntington Beach. The County of Orange Social Services Agency was onsite to enroll members in CalFresh and educate the community about the program. The event also distributed food and diapers as well as offered a resource fair to share information about programs for basic needs, mental health, early education, and services for older adults. The event was designed to celebrate health and wellness and included family activities, such as a magic show, face painting, and balloon artists. As of September, nearly 29,000 CalOptima Health members have enrolled in CalFresh, more than 193,000 CalFresh collateral materials have been distributed in the community and CalFresh has been featured in several media outlets, including KABC, KTLA, KCBS, Telemundo, and the Orange County Register.

Summary of Public Activities

As of November 4, CalOptima Health plans to participate in, organize or convene 40 public activities in November and December. In November, there will be 27 public activities, including 12 virtual community/collaborative meetings, three community-based presentations, 11 community events, and one Health Network Forum. In December, there will be 13 public activities, including 10 virtual community/collaborative meetings, one community event, one Health Network Forum, and one Cafecito. A summary of the agency's participation in community events throughout Orange County is attached.

Endorsements

CalOptima Health provided two 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.

1. Letter of support for Anaheim Union High School District for the California Department of Education's grant to contract a technical team to maximize reimbursement and increase services on school campuses.
2. Provided use of CalOptima Health name or logo to the Institute for Healthcare Advancement to include collaborative partners in support of organizational health literacy as a path to health equity.

For additional information or questions, contact CalOptima Health Community Relations Manager Tiffany Kaaiakamanu at 657-235-6872 or tkaaiakamanu@caloptima.org.

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Community events hosted by CalOptima Health and community partners in November and December 2022:

November 2022			
11/2 10–11 a.m.	**CalOptima Health Medi-Cal Overview Presentation in English for Laura's House** Virtual	At least one staff member presented.	• Community-based organization presentation • Open to members only
11/2 10–11 a.m.	**CalOptima Health Medi-Cal Overview Presentation in English for Waymakers** Virtual	At least one staff member presented.	• Community-based organization presentation • Open to members only
11/3 9 a.m.–Noon	**In-Home Supportive Services (IHSS) Provider Appreciation Lunch hosted by the United Domestic Workers†** UFCW Union 8530 Stanton Ave., Buena Park	At least one staff member attended (in person).	• Health/resource fair • Open to the public
11/4 11 a.m.–2 p.m.	**Community Resource Fair hosted by Garden Grove Adult Education†** Lincoln Education Center 11261 Garden Grove Blvd., Garden Grove	At least one staff member attended (in person).	• Health/resource fair • Open to the public
11/5 1–9 p.m.	**Noche De Altares (Day of the Dead) hosted by El Centro Cultural de Mexico †** Birch Park 400 W. 3rd St., Santa Ana	At least four staff members attended (in person). Sponsorship fee: $1,000; included resource booth, sponsorship listed on event website and social media, shoutout on stage to all sponsors, and thank you follow-up to all sponsors.	• Health/resource fair • Open to the public
11/10 Noon–1 p.m.	**CalOptima Health Medi-Cal Overview Presentation in English** Fullerton Community Center 340 W. Commonwealth Ave., Fullerton	At least one staff member presented (in person).	• Community-based organization presentation • Open to members only
11/12 8 a.m.–2 p.m.	**Anaheim Health Fair hosted by the City of Anaheim†** Anaheim Convention Center 800 W. Katella Ave., Anaheim	At least one staff member attended (in person). Sponsorship fee: $1,000; included an opportunity to have name and link to website on the event web page, name and logo on the event banner and in press releases, and a resource table at the event.	• Health/resource fair • Open to the public
11/12 9 a.m.–Noon	**Annual Turkey Giveaway hosted by the United Domestic Workers †** UFCW Union 8530 Stanton Ave., Buena Park	At least one staff member attended (in person).	• Health/resource fair • Open to the public
11/15 1:30–3 p.m.	**InfoSeries: Equity for A Healthy Orange County*** Virtual	At least four staff members attended.	• Forum • Open to community stakeholders

* CalOptima Health-hosted
† Exhibitor/Attendee

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			registration required prior to event
11/17 9–11 a.m.	**Health Network Forum*** Virtual	At least 10 staff members attended.	• Forum • Open to health and human service providers
11/18 9 a.m.–Noon	**Senior and Caregiver Health Fair hosted by the Institute for Healthcare Advancement†** La Habra Community Center 101 W. La Habra Blvd., La Habra	At least one staff member attended (in person).	• Health/resource fair • Open to the public
11/19 9 a.m.–1 p.m.	**CalFresh Enrollment Event and Resource Fair*** Murdy Park 7000 Norma Dr., Huntington Beach	At least 10 staff members attended (in person).	• Health/resource fair • Open to the public
11/20 10:30 a.m.–2:30 p.m.	**Health Fair hosted by Vietnamese Community Health at UCLA†** Delhi Center 505 E. Central Ave., Santa Ana	At least four staff members attended (in person).	• Health/resource fair • Open to the public
11/24 8–11 a.m.	**9th Annual Turkey Trot OC hosted by the Orange County Rescue Mission†** Orange County Rescue Mission 1 Hope Dr., Tustin	At least one staff member attended (in person). Sponsorship fee: $1,500; included resource table at event; featured in all event promotion and registration materials, including an event press release with an approximate reach of 32 million readers each month; company logo on racer t-shirt and event results page; and registration for number of racers.	• Health/resource fair • Open to the public
11/28 5–6 p.m.	**Resource Fair hosted by the Garden Grove Unified School District †** Rancho Alamitos High School 11351 Dale St., Garden Grove	At least one staff member attended (in person).	• Health/resource fair • Open to the public
December 2022			
12/6 9–10:30 a.m.	**Cafecito Meeting*** Virtual	At least four staff members to attend.	• Steering committee meeting • Open to collaborative members
12/8 9a.m– Noon	**Be Well Older Adult Mental Health Training†** Behavioral Health Training Center 750 The City Dr. South, Orange	At least three staff members to attend (in person).	• Health/resource fair • Open to the public
12/15 9–11 a.m.	**Health Network Forum*** Virtual	At least 10 staff members to attend.	• Forum • Open to health and human service providers

* CalOptima Health-hosted
† Exhibitor/Attendee

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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 December 1, 2022
Regular Meeting of the CalOptima Health Board of Directors

Report Item

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

Contacts

Kelly Bruno Nelson, Executive Director, Medi-Cal and CalAIM, (657) 550-4741
Yunkyung Kim, Chief Operating Officer, (714) 923-8834

Recommended Actions

1. Authorize CalOptima Health staff to develop and administer direct contracts or grants to the following entities:
    a. Orange County Office of Care Coordination (as administrative entity for the Orange County Continuum of Care) for the Orange County point in time count and coordinated entry system evolution and CalAIM collaboration.
    b. Pulse For Good to launch a kiosk-based member engagement and feedback system in local shelters (and other provider locations) for people experiencing homelessness.
2. Authorize CalOptima Health staff to develop scopes of work to be used in a request for proposal or notice of funding opportunity process for the following projects:
    a. Equity Grants for Programs Serving Underrepresented Populations;
    b. Capital and Infrastructure Projects; and
    c. The county-wide homeless continuum mapping and visualization project.

Background/Discussion

The Department of Health Care Services (DHCS) established the Housing and Homelessness Incentive Program (HHIP) to be implemented from January 1, 2022, to December 31, 2023. HHIP is a voluntary program that aims to improve health outcomes and access to whole person care services by addressing housing insecurity and instability as a social determinant of health for the Medi-Cal population. CalOptima Health is eligible to receive up to $83,755,557 in incentive payments over a two-year period. The HHIP incentive payments are based on Medi-Cal managed care plan performance and demonstrated progress in tackling housing and homelessness needs.

To date, CalOptima Health staff has completed the following submissions to DHCS:

- April 2022 – Letter of intent to participate in HHIP.
- June 30, 2022 – Local homelessness plan that included a brief community needs assessment.
- September 30, 2022 – Investment plan outlining proposed strategies that CalOptima Health would fund in support of achieving program metrics and goals submitted to DHCS.

In September 2022, CalOptima Health's Board of Directors (Board) approved staff's request to reallocate $40.1 million from the Homeless Health Initiative (HHI) reserves to fund the HHIP Investment Plan, which was largely informed by community stakeholder input.

With consideration of the broad investment strategies presented to the Board in September and with submission of the final investment plan to DHCS, staff requests Board approval to proceed with

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implementing direct contracts for specified investments (up to $3.6 million) and preparations for the competitive bid process, through requests for proposals (RFPs) or notices of funding opportunities (NOFO), for the remaining funding (up to $36.5 million), as identified in the below table.

Staff proposes that CalOptima Health move forward with operationalization of the following targeted investments, which coincide with the September Board-approved investment plan and identified priority areas.

Priority 1: Delivery of services and member engagement (investment level approved on 9/1/2022: $3.6M)				
Entity/Activity	Project Description	Rationale	Amount	Method
Office of Care Coordination (administrator of the Continuum of Care)	Funding to support administration of annual Point in Time (PIT), stipends for lived experience committee participants and other capacity building.	Bolster activities with county-wide reach; could include staffing to support data entry and evolution of the Coordinated Entry System (CES) (currently unfunded).	$2.2 million	Contract
Pulse For Good	Establish a feedback process for members who receive homeless services to share their experience; pilot in shelters.	No mechanism exists to collect feedback on member experience with homeless services.	$0.8 million	Contract
Consultant	Contract with a specified vendor, with unique expertise in visual mapping of complex government systems, to map out the OC homeless service continuum to move closer to a county-wide system of care for the unhoused, with gaps and barriers collectively identified and understood.	Often overly complex systems and service duplication make it challenging to understand the consumer experience.	$0.6 million	RFP
Priority 2. Infrastructure to coordinate and meet member housing needs (investment level approved on 9/1/2022: $15.5M)				
Equity Grants for Programs Serving Underrepresented Populations	To ensure members with unique, diverse needs (e.g. transition-age youth, LGBTQIA) are connected to supportive housing services that reflect their experiences. Community grants to be administered to support	Efforts will be taken to ensure funds are distributed equitably across the three SPAs and populations of focus.	$5 million	NOFO

	HHIP goals to prevent and address homelessness in the county and increase access to quality care and services.			

Infrastructure Projects	Building infrastructure to meet member housing needs by providing supported, direct placement into permanent housing. Distributions for trauma-informed, dignified, sustainable, inclusive, non-residency restricted and low barrier projects.	Housing, medical, and behavioral health services are historically siloed. Services are often scattered, disjointed, underfunded, and there continues to be a lack of bed capacity.	$10.5M	NOFO
Priority 3. Partnerships and capacity to support referrals for services (Investment level approved on 9/1/2022: $21M)				
Capital Projects	Increasing the capacity of permanent housing beds across the county to support increase in referrals for service and housing placement. Distributions for trauma-informed, dignified, sustainable, inclusive, non-residency restricted and low-barrier projects.	Housing, medical, and behavioral health services are historically siloed. Services are often scattered, disjointed, underfunded, and there continues to be a lack of bed capacity.	$21 million	NOFO
		Running Total:	**$40.1 million**	

Fiscal Impact

The recommended actions have no additional fiscal impact. A previous Board action on September 1, 2022, reallocated up to $40.1 million within the Homeless Health Initiatives Reserve to provide investment funding related to the homeless initiatives included in the HHIP.

Rationale for Recommendation

CalOptima Health staff recommend proceeding with development of key contracts as soon as administratively feasible so that operationalization of critical housing and homeless healthcare activities can commence. For those activities that require a competitive bid process through RFP or NOFO, the preliminary approval for staff to begin working on developing those materials will enable these funds to get out in the community as quickly as possible. As planning continues and additional HHIP incentive funds are earned, CalOptima Health staff will bring additional funding recommendations to the Board for consideration in 2023.

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Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Entities Covered by this Recommended Action

/s/ Michael Hunn *11/23/2022*
Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Pule for Good, L3c	467 South 850 E	Logan	UT	84321
County of Orange	601 N. Ross Street, 5th Floor	Santa Ana	CA	92701

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CalOptima Health Board Action Agenda Referral

Action To Be Taken December 1, 2022
Regular Meeting of the CalOptima Health Board of Directors

Report Item

22. Approve Actions Related to the National Alliance for Mental Illness Orange County Peer Support 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

1. Authorize the CalOptima Health Chief Executive Officer to develop and execute a grant agreement with the National Alliance for Mental Illness (NAMI) Orange County to administer a peer support program no earlier than January 1, 2023, for a five-year term; and
2. Authorize expenditures in an amount up to $5 million from existing reserves to fund the grant agreement with NAMI Orange County.

Background/Discussion

With the rollout of CalAIM, and the overall evolution of the health care system, expectations of managed care plans increasingly include efforts to design programs to support whole-person, integrated care. Additional expectations include moving the administration of Medi-Cal behavioral health to a more consistent and seamless system by reducing complexity and increasing flexibility; and improving quality outcomes, reducing health disparities, and driving delivery system transformation and innovation through improvements to behavioral health policies and the launch of behavioral health payment reform.

In an effort to improve behavioral health integration for its members, CalOptima Health proposes to contract with NAMI Orange County to launch a peer support program for members identified as having a mental health or behavioral health diagnosis. The peer support program would prioritize individuals recently discharged from a psychiatric inpatient hospital stay or emergency room visit.

NAMI Orange County would pair trained peer support mentors with CalOptima Health members to provide tailored, social support and resource navigation. The peer support would begin during a hospital inpatient stay or emergency room visit and last for up to six months post-discharge, based on members' needs. Specifically, peer support mentors would support members in scheduling and attending follow-up primary care physician or other physician appointments (especially post-discharge), connect the member to their enhanced case management (ECM) provider (or make a referral to one), help members build a social support network that includes family members and provide training, and connect members to other social and behavioral support services.

The overall program goals include: (1) Facilitating behavioral health transitions from hospital to home/community; (2) supporting behavioral health integration through peer facilitating member connection to ECM; (3) improving CalOptima Health's HEDIS Follow-Up after Emergency Department Visit for Mental Illness measure; and (4) reducing readmissions at psychiatric hospitals through family and resource connection.

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CalOptima Health would support the project through collaboration with Orange County Health Care Agency and local hospitals and emergency departments. Furthermore, this program would also be used as a resource for members calling into CalOptima Health's Behavioral Health Call Center.

The program will launch no earlier than January 1, 2023, with a planning phase for NAMI Orange County to create internal capacity to establish and grow the NAMI Orange County Peer Support Program to meet the needs of CalOptima Health members. The program will run for five consecutive years.

Objectives of the planning phase would focus on NAMI Orange County hiring the right staff; training initial cohort of peer supporters; establishing a relationship with CalOptima Health to accept referrals from CalOptima Health's behavioral health call center; and establishing memorandums of understanding, as needed. After the planning phase, NAMI Orange County will launch the first cohort of peer supporters and serve at least 100 CalOptima Health members with comprehensive peer support within the first year of program implementation. It is anticipated that NAMI Orange County will serve 1,000 individuals in the first five years of service.

NAMI Orange County will use funding to hire staffing to implement the program at both the administrative level and the direct service level (e.g. peer support mentors). Funding will also be used to train initial and future peer support mentor cohorts, to track member interactions through charting software, to support the program's operations, and to outreach and engage with CalOptima Health members.

Finally, during the implementation period, NAMI Orange County will work to create sustainability for the program by identifying a path to integrate community health workers (CHW) into this program. By doing this, NAMI Orange County could access the CHW benefit as a sustainable source of program revenue.

Fiscal Impact

An appropriation of up to $5 million from existing reserves will fund the grant agreement for the five (5) year period.

Rationale for Recommendation

CalOptima Health staff recommend proceeding with development of the grant agreement as soon as administratively feasible so that critical behavioral health integration activities can commence. NAMI Orange County has been identified as a successful, reliable program administrator in this space. Research shows that people with lived mental health experiences can function as peer mentors and provide support unlike traditional providers. NAMI Orange County provides incredible access to that cohort of individuals with lived experience and has a long-standing program that engages that population to assist others in finding mental and behavioral health support.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

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Attachment

1. Entities Covered by this Recommended Action

/s/ Michael Hunn *11/23/2022*
Authorized Signature **Date**

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
NAMI Orange County	1810 17th St.	Santa Ana	CA	92705

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 1, 2022
Regular Meeting of the CalOptima Health Board of Directors

Report Item

23. Approve CalOptima Health's Measurement Year 2023 Medi-Cal and OneCare Quality Pay for Value Programs

Contacts

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

Recommended Actions

1. Approve modification of the measurement year 2023 Health Network Medi-Cal Pay for Value Performance Program for the measurement period effective January 1, 2023, through December 31, 2023; and
2. Approve Measurement Year 2023 OneCare Pay for Value for the measurement period effective January 1, 2023, through December 31, 2023.

Background

CalOptima Health's Pay for Value (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. CalOptima Health currently has P4V programs for Medi-Cal and OneCare Connect (OCC). Health networks and CalOptima Health Community Network (CCN) 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 health networks and their physicians for demonstrating quality performance;
2. Provide comparative performance information for members, providers, and the public on CalOptima Health's performance; and
3. Provide industry benchmarks and data-driven feedback to health networks and physicians on their quality improvement efforts.

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 OCC P4V program will be retired since OCC sunsets on December 31, 2022, and OCC members transition into OneCare effective January 1, 2023. OneCare does not have an existing P4V program.

In December 2021, CalOptima Health's Board of Directors approved the health network Medi-Cal P4V Performance Program for Calendar Years (CYs) 2022 and 2023 with the measurement period effective January 1, 2022, through December 31, 2023. For MY 2022-2023, CalOptima Health's Board of

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Directors also approved supporting HNs in achieving the Medi-Cal P4V goals by excluding HEDIS/CAHPS measures with small denominators of less than 30 from HN score calculation and continued use of the HN Quality Rating (HNQR) methodology to establish an overall quality rating score for each HN.

For MY 2023, CalOptima Health will maintain all elements of the MY 2022 Medi-Cal P4V to sustain improvements and leverage resources that the HNs have allocated towards quality improvement. CalOptima Health recommends modifying MY 2023 Medi-Cal P4V program to align with DHCS's targeted focus on children preventive, behavioral health integration, and maternity care and improve the quality of care being provided to members.

Additionally, CalOptima Health recommends establishing a OneCare P4V Program for MY 2023 to incentivize HNs and CCN primary care physicians for quality care (effective January 2023). MY 2023 OneCare P4V will align with the Centers for Medicare and Medicaid Services (CMS) Star program and focus on areas with the greatest opportunity for improvement.

Discussion

Medi-Cal Pay for Value Program

Staff recommends the following modifications to the MY 2023 Medi-Cal P4V program:

1. Maintain all 12 measures from MY 2022 P4V and add the following six new measures:
    - Comprehensive Diabetes Care – Blood Pressure Control <140/90;
    - Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents;
    - Prenatal Immunization Status;
    - Follow-up After ER Visit for Substance use – within 7 days;
    - Follow Up Care for Children Prescribed ADHD Medications; and
    - Diabetes Screening for People with Schizophrenia or bipolar disorder who are using Antipsychotic medications.

    MY 2023 Medi-Cal P4V will have a total of 18 HEDIS measures. There are no changes to CAHPS member experience measures.

2. Continued use of the National Committee for Quality Assurance (NCQA) Quality Compass National Medicaid percentiles as benchmarks.

3. Revise the program funding methodology from $5 per member per month (PMPM) to ten percent (10%) of professional capitation (base rate only), to support the HNs in improving member quality of care.

OneCare Pay for Value Program

Staff recommends implementing MY 2023 OneCare P4V Program with the following:

1. Leverage CMS Star measures and thresholds as benchmarks:
    - Part C – Staying Healthy and Managing Chronic Conditions.
    - Part D – Pharmacy.
    - CAHPS – Member experience measures.

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2. Establish an overall quality rating score for each HN using the HNQR methodology and CMS Star thresholds for measure rating (1-5 Stars).

   The HNQR methodology was approved in 2020 by CalOptima Health's Board of Directors for Medi-Cal.

3. Apply a program funding methodology of $20 PMPM.

CalOptima Health staff calculates the quality rating score for each HN and CCN providers using the HNQR methodology annually. For MY 2023, staff will use the HNQR methodology for both Medi-Cal and OneCare and improve efficiencies by using one standard quality rating methodology. The HNQR score is derived from the most recently available audited, plan level HEDIS results. HNs and CCN providers must achieve a minimum score of 2.5 to be eligible to receive performance incentive dollars. HNs and CCN providers that score below 2.5 will be required to submit an improvement plan to CalOptima Health.

Performance incentive payments are distributed upon final calculation and validation of each measurement rate. To qualify for payments, a HN or CCN provider must be contracted with CalOptima during the entire measurement period (January 1, 2023, through December 31, 2023) and the calculation period (July 1, 2023, through June 30, 2024), and in good standing with CalOptima, as determined by the Audit and Oversight Department, at the time of disbursement of payment.

Fiscal Impact

Medi-Cal P4V Performance Program

Staff estimates that the fiscal impact for the measurement period of January 1, 2023, through December 31, 2023, will be no more than ten percent (10%) of the professional capitation (base rate only) or approximately $60.0 million. Since incentive distributions will occur after the close of the MY, Management will include related expenses in the CalOptima Health Fiscal Year (FY) 2023-24 Operating Budget.

OneCare P4V Program

Staff estimates that the fiscal impact for the measurement period of January 1, 2023, through December 31, 2023, will be no more than $20 PMPM or approximately $4.5 million. Since incentive distributions will occur after the close of the MY, management will include related expenses in the CalOptima Health FY 2023-24 Operating Budget.

Rationale for Recommendation

Implementing a OneCare P4V program in addition to the Medi-Cal P4V program will improve the quality of care and outcomes for all members. In addition, CalOptima Health is committed to demonstrating breakthrough improvement in all quality measures, maintaining high performing Medi-Cal managed care plan status and achieving 5-Star status.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

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Attachment

1. CalOptima Health's Measurement Year 2023 Quality Incentive Programs

/s/ Michael Hunn *11/23/2022*
Authorized Signature **Date**

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Attachment 1

CalOptima Health Measurement Year (MY) 2023
Medi-Cal and OneCare Pay for Value Programs

MY 2023 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.

CalOptima Health recommends modifications to MY 2023 Medi-Cal P4V program to align with DHCS's targeted focus on children preventive, behavioral health integration, and maternity care and improve the quality of care being provided to members.

Recommended modifications for MY 2023 Medi-Cal P4V

1. Maintain all 12 measures for MY 2022 P4V and add six measures that aligns with DHCS's targeted focus on children preventive, behavioral health integration, and maternity care and improve the quality of care being provided to members.

MY 2023 Pay for Value Measures	
HEDIS	CAHPS: Member Experience
Breast Cancer Screening	Care Coordination
Cervical Cancer Screening	Customer Service
Child and Adolescent Well-Care Visits: Total	Getting Care Quickly
Childhood Immunization Status: Combo 10	Getting Needed Care
Chlamydia Screening in Women: Total	Rating of Health Care
Comprehensive Diabetes Care: HbA1c > 9	Rating of Health Network
Controlling High Blood Pressure	Rating of PCP
Follow-Up After ED Visit for Mental Illness: 30 Days	Rating of PCP
Immunizations for Adolescents: Combo 2	Rating of Specialist
Lead Screening in Children	
Prenatal and Postpartum Care: Prenatal	
Well-Child Visits (WCV) in the First 30 Months of Life: • WCV in the First 15 Months (W30) • WCV for Age 15 Months – 30 Months (W30)	
Add - Comprehensive Diabetes Care – Blood Pressure Control <140/90	
Add - Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	
Add - Prenatal Immunization Status	
Add - Follow-up After ER Visit for Substance use – within 7 days	
Add - Follow Up Care for Children Prescribed ADHD Medications - Initiation phase and Continuation/ maintenance phase	
Add - Diabetes Screening for People with Schizophrenia or bipolar disorder who are using Antipsychotic medications	

2. Revise program funding methodology from $5 per member per month (PMPM) to ten percent (10%) of professional capitation (base rate only).

3. Continue to use the HN Quality Rating (HNQR) methodology to assess overall quality rating score based on performance for each HN
    - National Committee for Quality Assurance (NCQA) Quality Compass National Medicaid percentiles used as benchmarks
    - Health networks assigned an HNQR performance score from 1-5 based on HEDIS and CAHPS measure results
        - HEDIS measures weighted 1.0
        - CAHPS measures weighted 1.5
    - The overall rating is the weighted average of HN's measure ratings
        - Health networks must achieve a minimum score of 2.5 to be eligible to receive performance incentive dollars
    - Performance incentive allocations will be distributed upon final calculation and validation of and each health network's HNQR

Health Network Quality Rating Score	Percent of Performance Incentive
≥ 4.5	100%
≥ 4.0	80%
≥ 3.5	60%
≥ 3.0	40%
≥ 2.5	20%
< 2.5	0%

Attachment 1

CalOptima Health Measurement Year (MY) 2023
Medi-Cal and OneCare Pay for Value Programs

OneCare Pay for Value Program (P4V)

CalOptima Health recommends establishing a new OneCare P4V program to focus on areas with the greatest opportunity for improvement and incentivize 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, Consumer Assessment of Healthcare Providers and Systems (CAHPS) member experience, and Pharmacy Quality Alliance. Health networks (HNs) and CalOptima Community Network (CCN) primary care physicians (PCPs) are eligible to participate in the OneCare P4V program.

Recommended for MY 2023 OneCare P4V

Alignment with the CMS Star program and the following components:

4. Utilize the following CMS Star Part C and Part D measures, measure weights, and Star thresholds as benchmark:

MY 2023 OneCare Pay for Value Program		
Measure Category	Measure	Measure Weights
Staying Healthy and Managing Chronic Conditions (Part C)	Breast Cancer Screening (BCS)	1
	Colorectal Cancer Screening – Total	1
	Diabetes Care - Eye Exam	1
	Diabetes Care - Hemoglobin A1c Control	3
	Controlling Blood Pressure	1
Pharmacy (Part D)	Medication Adherence for Diabetes	3
	Medication Adherence for Hypertension	3
	Medication Adherence for Cholesterol	3
	Statin Use in Persons with Diabetes	1
Member Experience (Part C)	Care Coordination	4
	Getting Care Quickly	4
	Getting Needed Care	4

5. Establish an overall quality rating score based on performance for each HN using the HN Quality Rating (HNQR) methodology
    - The overall rating is the weighted average of HN's measure ratings
        - Health networks will be assigned an HNQR performance score from 1-5
        - Health networks must achieve a minimum score of 2.5 to be eligible to receive performance incentive dollars
    - Performance incentive allocations will be distributed upon final calculation and validation of and each health network's HNQR

Health Network Quality Rating Score	Percent of Performance Incentive
≥ 4.5	100%
≥ 4.0	80%
≥ 3.5	60%
≥ 3.0	40%
≥ 2.5	20%
< 2.5	0%

6. Apply a program funding methodology of $20 PMPM

CalOptima Health Board Action Agenda Referral

Action To Be Taken December 1, 2022
Regular Meeting of the CalOptima Health Board of Directors

Report Item

24. Approve CalOptima Health's Five-Year Hospital Quality Program Beginning Measurement Year 2023

Contacts

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

Recommended Actions

1. Authorize CalOptima Health staff to implement the Hospital Quality Program for measurement years 2023 through 2027;
2. Authorize appropriation of funds in an amount up to $150 million from existing reserves to fund the hospital incentive quality pool over the five (5)-year period;
3. Authorize appropriation of funds in an amount up to $3.5 million from existing reserves to fund the hospital reporting incentive payments for calendar years 2023 through 2025; and
4. Authorize the Chief Executive Officer to execute hospital contract amendments to include the Hospital Quality Program.

Background

CalOptima Health's hospitals and their affiliated physicians are integral components of the delivery of health services to members and play critical role in the delivery of care to CalOptima Health's members. For many years, CalOptima Health has been providing quality incentive payments to its Health Networks to drive improvement in quality outcomes and member satisfaction. Staff recommends establishing a Hospital Quality Program for CalOptima Health's contracted hospitals to improve quality of care to members through increased patient safety efforts and performance-driven processes. Hospital performance measures would serve to:

- Support hospital quality standards for Orange County in support of CalOptima Health's mission;
- Provide industry benchmarks and data-driven feedback to hospitals on their quality improvement efforts;
- Recognize hospitals demonstrating quality performance;
- Provide comparative information on CalOptima Health hospital performance; and
- Identify areas for improvement and for working collaboratively with these hospitals to ensure the provision of quality care for CalOptima Health members.

Discussion

Staff recommends a five (5)-year Hospital Quality Program beginning on January 1, 2023, through December 31, 2027. The program is comprised of two (2) initiatives: Hospital Incentive Quality Pool and Hospital Reporting Incentive Payments.

Hospital Incentive Quality Pool (Measurement Year (MY) 2023 through MY 2027)
This initiative will include the following principles:

1. Leverage publicly available, industry-standard measures from the Centers for Medicare &

Medicaid Services (CMS) and the Leapfrog Group including:
    - CMS Quality;
    - CMS Patient Experience;
    - Leapfrog Hospital and Surgery Center Rating; and
    - Leapfrog Hospital Safety Grade.
2. Require contracted hospital participation in CMS quality reporting programs (hospital inpatient, hospital outpatient, prospective payment systems-exempt cancer, or inpatient psychiatric) or Leapfrog Group Hospital and Surgery Center Rating for measurement as follows:
    - Contracted hospitals will be assessed on CMS quality reporting programs as reported on CMS Care Compare;
    - Contracted hospitals not listed on CMS Care Compare for quality and patient experience will be assessed using the Leapfrog Hospital and Surgery Center Rating; and
    - Contracted hospitals not listed on either CMS Care Compare or Leapfrog Hospital and Surgery Center Rating will not qualify for incentive payments.
3. Require contracted hospital participation in Leapfrog Hospital Safety Grade reporting
4. Allocate a maximum amount of $150 million for a five (5)-year period from 2023-2027 to fund the hospital incentive pool. The annual calendar year budget is $30 million. The amount that each hospital may earn will be based on their proportion of services provided to CalOptima Health members, i.e. proportion of total bed days. Funding will be used to reward performance and unearned incentive dollars will be forfeited.

Beginning in Calendar Year (CY) 2023 and annually thereafter, staff will monitor and evaluate hospital performance as measure performance results are made publicly available. The measurement period will be the period ending the year prior to public reporting. For example, calendar year public report 2024 reflects the measurement period ending 2023. As of this writing, staff anticipates MY 2023 data will be published in October 2024, with payments made to eligible hospitals in December 2024. Payments will be issued within twelve (12) months following the measurement period and will be limited to those hospitals holding a direct Medi-Cal contract with CalOptima Health, contracted during the calculation period, and in good standing with CalOptima Health.

Incentive awards will be based on performance compared to quality thresholds and allocated based on the sum of claims and encounter inpatient days gathered six months after the end of the measurement period, to allow for data lag.

<u>Hospital Reporting Incentive Payments (CY 2023 through CY 2025)</u>
CalOptima Health recognizes that hospitals may not currently participate in CMS/Leapfrog public reporting programs. To promote hospital participation, CalOptima Health will provide a ramp-up period to allow hospitals to participate in CMS/Leapfrog reporting. During the ramp-up period, CalOptima Health will provide hospital reporting incentive payments in an amount of $150,000 per eligible hospital per calendar year.

CalOptima Health will provide hospital reporting incentive payments to eligible hospitals that have submitted a written agreement to participate in CMS/Leapfrog reporting in CY 2023. Eligible hospitals will receive payments in CY 2024 and CY 2025 upon submission of an action plan to CalOptima Health. Eligible hospitals will be required to make timely submissions by quarter 1 of the corresponding CY. CalOptima Health will provide payments in quarter 2 of the same year. Hospitals that fail to

demonstrate reasonable efforts will be subject to recoupment of reporting incentive payments at CalOptima Health's discretion.

Staff projects six (6) hospitals will be eligible for payments in CY 2023, eight (8) hospitals will be eligible for payments in CY 2024, and nine (9) hospitals will be eligible for payments in CY 2025.

Fiscal Impact
An appropriation of up to $153.5 million from existing reserves will fund the Hospital Incentive Quality Pool for MY 2023 through MY 2027 and the Hospital Reporting Incentive Payments for CY 2023 through CY 2025. Management will include expenses in current and future operating budgets.

Rationale for Recommendation
A Hospital Quality Program will create a process to measure performance and incentivize contracted hospitals for quality member care. In addition, CalOptima Health is committed to demonstrating breakthrough improvement in all quality measures.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachment
1. CalOptima Health's Hospital Quality Program 2023-2027

/s/ Michael Hunn *11/23/2022*
Authorized Signature **Date**

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Attachment 1
CalOptima Health's Hospital Quality Program 2023-2027

Hospital Quality Program

CalOptima Health recommends establishing a new Hospital Quality Program for CalOptima Health contracted hospitals to improve quality of care to our members through increased patient safety efforts and performance-driven processes. Additionally, staff recommends approving the Hospital Quality Program for five years to promote ongoing quality improvement. Hospitals holding a direct Medi-Cal contract with CalOptima Health are eligible to participate in the Hospital Quality Program. The Hospital Quality Program will establish a process to measure performance and incentivize contracted hospitals quality care delivered in the hospital setting.

Recommended for Hospital Quality Program Measurement Years 2023-2027

1. Leverage publicly available hospital data and performance listed on CMS Care Compare and the Leapfrog Group to minimize hospital burden
2. Require contracted hospital participation in CMS Care Compare (for hospital inpatient, hospital outpatient, PPS-exempt cancer, or inpatient psychiatric measures) and/or Leapfrog Group Hospital Rating
    - Contracted hospitals not listed on CMS Care Compare for quality and patient experience will be assessed using the Leapfrog Hospital Rating.
    - Contracted hospitals not listed on either CMS Care Compare or Leapfrog will not qualify for incentive payments.
3. Allocate a maximum amount of $30 million per year for five years
4. Hospital incentive payments distribution
    - Incentive awards will be based on performance compared to quality thresholds and allocated based on the sum of claims and encounter inpatient days gathered six months after the end of the measurement period, to allow for data lag.

Measurement Area	Data Source	Percent of Incentive Pool	Performance Range	Incentive
Quality	CMS Care Compare or Leapfrog Hospital Rating	40%	5 stars 4 stars 3 stars 1 – 2 stars	100% of incentive 75% of incentive 50% of incentive 0% of incentive
Patient Experience	CMS Care Compare or Leapfrog Hospital Rating	40%	5 stars 4 stars 3 stars 1 – 2 stars	100% of incentive 75% of incentive 50% of incentive 0% of incentive
Hospital Safety	Leapfrog Hospital Safety Grade	20%	Grade A Grade B Grade C Grade D or F	100% of incentive 75% of incentive 50% of incentive 0% of incentive

CalOptima Health recognizes that hospitals may not currently participate in these public reporting programs. To promote hospital participation, CalOptima Health will provide a ramp-up period to allow hospitals to participate in CMS/Leapfrog reporting. During this time, CalOptima Health will provide hospital reporting incentive payments in an amount of $150,000 per eligible hospital per calendar year.

CalOptima Health Board Action Agenda Referral

Action To Be Taken December 1, 2022
Regular Meeting of the CalOptima Health Board of Directors

Report Item

25. Approve Actions Related to the Medi-Cal Annual Wellness Visit Initiative

Contacts

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

Recommended Actions

1. Authorize the Chief Executive Officer to establish a Medi-Cal Annual Wellness Visit Initiative for Medi-Cal members ages 45 years or older; and
2. Authorize unbudgeted expenditures and appropriate funds in an amount up to $3.75 million from existing reserves to support the Medi-Cal Annual Wellness Visit Initiative from April 1, 2023, through June 30, 2023.

Background and Discussion

First introduced as part of the Affordable Care Act of 2010, the Medicare Annual Wellness Visit (AWV) was established to promote health and early disease detection by encouraging beneficiaries to utilize preventive services. The Medicare AWV is an annual appointment with a beneficiary's primary care provider to develop or update a personalized prevention plan to coordinate care based on a person's health care needs.

The Primary Care Engagement and Clinical Documentation Integrity Program (PCE-CDIP) is an attestation program that gives providers incentives to identify and address chronic conditions, review preventive care, and ensure accurate clinical documentation and completeness of medical records. CalOptima Health's current OneCare Connect (OCC) PCE-CDIP attestation is completed during the member's Medicare AWV and includes a form detailing chronic conditions and upcoming screenings, specific to each member. Providers are required to confirm condition diagnosis codes and review preventive care needs for each OCC member.

Staff recommends that CalOptima Health implement a Medi-Cal AWV initiative, inclusive of a documentation attestation program and member incentive for CalOptima Health's Medi-Cal only members aged 45 years or older. Based on the Medicare AWV, this population will greatly benefit from the comprehensive care that is provided through the AWV, which prioritizes preventive services and improving overall health outcomes for members. The attestation form will include member-specific information on screenings, diagnostic conditions, and social determinants of health (SDOH) codes, which will help providers improve member engagement, ensure accurate clinical documentation, and qualify for supplemental payment for completed attestations conducted during validated AWVs. The recommended Medi-Cal AWV Initiative would provide a visit rate of $125 per visit, a provider incentive rate of $100 per completed and reviewed attestation, and a member incentive up to $50 (non-monetary gift card) per eligible member per calendar year pending Department of Health Care Services approval.

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Implementing the Medi-Cal AWV Initiative will allow approximately 165,000 eligible members to receive a beneficial service that would otherwise only be available to Medicare beneficiaries. This would include aged Medi-Cal members who are not eligible for Medicare, providing an equitable opportunity to receive comprehensive care and preventive services.

By incentivizing providers to submit timely and accurate data on screening measures and SDOH, CalOptima Health will be able to gain a greater understanding of the eligible members' medical and social care needs and develop an action plan to improve their quality of care. In addition, with the planned implementation of regional rate setting for Medi-Cal managed care plans, CalOptima Health's revenue from the State will be subject to quality and risk adjustment. Medi-Cal managed care plans can increase or decrease revenue based on quality and risk performance in comparison to other plans included in the regional rate setting. The Medi-Cal AWV Initiative will offer CalOptima Health an opportunity to improve overall quality and risk scores ahead of these revenue adjustments.

As of this writing, staff projects an annual estimated cost of $15.0 million with estimated annual costs as provided in the table below. To maintain and improve coding accuracy and quality for the sizeable Medi-Cal only population, the staffing needs will range between three (3) to ten (10) additional full-time coding employees dependent on the AWV completion rate. Initially, CalOptima Health would need three (3) full-time employees at the start of the Medi-Cal AWV Initiative and additional FTEs will be added based on increases in program participation, with a total annual staffing costs not to exceed $1.0 million.

Initiative Component	Estimated Annual Costs
AWV Visits	$7.1 million
Provider Incentive Payments	$4.0 million
Member Incentives	$2.9 million
Staffing Costs	$1.0 million
Total	**$15.0 million**

Note: All figures are estimates as of this Board action. Final allocations may vary based on AWV uptake rates by providers and members.

The Medi-Cal AWV Initiative will operate on a calendar year (CY) basis. Staff anticipates a tentative start date in Spring 2023, and requests funding of up to $3.75 million for the current fiscal year (through June 30, 2023). Management will include the second half of funding for CY 2023 and the first half of funding for CY 2024 in the CalOptima Health fiscal year (FY) 2023-24 Operating Budget.

Staff will develop a policy and procedure for Medi-Cal AWV and include this initiative in the next Quality Improvement Program (QIP) to be reviewed and approved by the Board. The progress and outcomes will be reported to the CalOptima Health Quality Improvement Committee as part of the normal QIP quarterly reporting process.

Fiscal Impact

The recommended action is unbudgeted. The annual estimated cost for the Medi-Cal AWV Initiative is $15.0 million. An allocation of up to $3.75 million from existing reserves will fund this action for FY 2022-23. Management will include additional expenses in future operating budgets.

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Rationale for Recommendation

CalOptima Health staff recommends authorizing the recommended actions to improve member access to annual visits, comprehensive care and preventive services to improve member quality of care and health outcomes.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Medi-Cal Attestation Form (Draft Sample)

Board Actions

Board Meeting Dates	Action	Term	Not to Exceed Amount
May 7, 2020	Consider Actions Related to CalOptima Health's Primary Care Engagement and Clinical Documentation Integrity Program for Qualified Providers Contracted with the CalOptima Community Network for the OneCare Connect Program	Fiscal year 2020–21	$307,000 for the fiscal year
February 3, 2022	Approve Modifications to CalOptima Health Policy CMC.2001: Primary Care Engagement and Clinical Documentation Integrity Program for CalOptima Community Network Contracted Providers to Require a Medicare Annual Wellness Visit to be Completed	Not applicable	Not applicable

/s/ Michael Hunn *11/23/2022*
Authorized Signature **Date**

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Medi-Cal
CalOptima Health

Primary Care Engagement and Clinical Documentation Integrity Program

Please submit completed form with supporting clinical documentation to fax # 714-571-2491.

Provider Information:	**Check box to confirm the provider completing the assessment. Enter the provider name and NPI if not populated.**
☐ Provider:	**Last, First** **505 City Parkway West Orange CA 92868**
☐ Provider:	

Patient Name:	**Last, First**		
Member ID:	**33333333T**	DOB:	**3/18/1952**
Date(s) of Service:			

Preventative Health Screening(s)

Screening to Consider	**Date Completed**	**Member Refused**	**Not Applicable**
A1c Test	_____	☐	☐
Breast Cancer Screening	_____	☐	☐
Colorectal Cancer Screening	_____	☐	☐
Diabetic Eye Exam	_____	☐	☐

Additional Comments:

_____

Year Over Year Chronic Conditions

Potential Diagnosis	**Diagnosis Code**	**Risk Factor**	**Present**	**Not Present**	**Unable to Determine**
Type 2 diabetes mellitus with hyperglycemia	E11.65	Diabetes with Chronic Complications	☐	☐	☐
Type 2 diabetes mellitus without complications	E11.9	Diabetes without Complication	☐	☐	☐
Paranoid schizophrenia	F20.0	Schizophrenia	☐	☐	☐
Delusional disorders	F22	Major Depressive, Bipolar, and Paranoid Disorders	☐	☐	☐
Schizoaffective disorder, unspecified	F25.9	Schizophrenia	☐	☐	☐
Unspecified psychosis not due to a substance or known physiological condition	F29	Reactive and Unspecified Psychosis	☐	☐	☐

Year Over Year Non-Chronic Conditions

Potential Diagnosis	**Diagnosis Code**	**Risk Factor**	**Present**	**Not Present**	**Unable to Determine**
Acute kidney failure with tubular necrosis	N17.0	Acute Renal Failure	☐	☐	☐
Acute kidney failure, unspecified	N17.9	Acute Renal Failure	☐	☐	☐

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_____ _____

Signature **Date**

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CalOptima Health Board Action Agenda Referral

Action To Be Taken December 1, 2022
Regular Meeting of the CalOptima Health Board of Directors

Report Item

26. Authorize Actions Related to Improving Member Quality and Experience of Care Through Better Access to Skilled Nursing Facilities

Contacts

Richard Pitts, D.O., Ph.D., Chief Medical Officer, (714) 246-8491
Yunkyung Kim, Chief Operating Officer, (714) 923-8834

Recommended Actions

1. Authorize the Chief Executive Officer to develop and execute a three (3)-year skilled nursing facility Access Program, from July 1, 2023, through June 30, 2026;
2. Authorize the Chief Executive Officer to amend contracts to implement the Skilled Nursing Facility Access Program;
3. Authorize appropriation of funds in the amount of up to $10 million from existing reserves to fund the Skilled Nursing Facility Access Program over the three (3)-year period; and
4. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima Health's mission and purpose.

Background and Discussion

CalOptima Health proposes to launch a three (3) year, up to $10 million-dollar program with Skilled Nursing Facilities (SNFs) to enhance quality through better access and further strengthen the safety net system across Orange County for individuals who require SNF post hospitalization care.

Placing a CalOptima Health member in a SNF can incur significant delay, from weeks to months, due to the inability to secure a SNF bed. SNFs form the bridge for members who no longer require acute care in a hospital setting, but still require skilled care and services. SNFs are often the only option for continued medical care for these complex members. SNFs contribute to the safety net system by creating a path to lower levels of care for members who may still need close monitoring and supervision for medical treatment, personal, and behavioral care. Further, moving members from the hospital setting to a SNF frees up needed hospital beds for more acute patients for the entire Orange County community. These complex members often present with few social supports and require additional, intense case manager coordination, and oversight to assist members to effectively transition to a SNF. CalOptima Health's complex members often have significant behavioral health issues making SNF placement very difficult. In summary, these factors have resulted in substantial issues delaying timely discharge from emergency departments, hospitals, acute rehabs, and long-term acute health care (LTAC) facilities all of which impacts upstream bed resources.

CalOptima Health staff propose a three (3)-year program with CalOptima Health contracted SNF's. The program will assist acute care facilities with safe discharges to SNFs by:

1. Improving timely transitions from acute settings to SNF level of care by improving bed availability at SNF's.

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2. Enhancing and strengthening safety net placement options for members with complex and behavioral health needs.
3. Enhance quality through better access to SNF's.

The initiative will be structured to provide up to $10 million over a three (3)-year period. Funding distribution over the period will be focused on improving system throughput and bed availability.

Fiscal Impact
An appropriation of up to $10 million from existing reserves will fund the SNF Access Program from July 1, 2023, through June 30, 2026. Management will include expenses in future operating budgets.

Rationale for Recommendation
SNF bed unavailability creates a challenge for hospitals, emergency departments, and LTACs to ensure members receive the right care at the right level at the right time. Working with CalOptima Health's SNF providers will enhance the safety net for these complex members who require timely SNF placement and continued medical care. Through the SNF Access Program, CalOptima Health seeks to ensure that the SNFs remain strong quality partners in care for all CalOptima Health members.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
None

/s/ Michael Hunn *11/23/2022*
Authorized Signature **Date**

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CalOptima Health Board Action Agenda Referral

Action To Be Taken December 1, 2022
Regular Meeting of the CalOptima Health Board of Directors

Report Item

27. Authorize In-Home Care Pilot Program with the University of California Irvine Family Health Center

Contact

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

Recommended Actions

1. Authorize the Chief Executive Officer to develop and execute an agreement with the Regents of the University of California, on behalf of the University of California Irvine (UCI) Family Health Center, to conduct a twenty-four (24) month home-based care pilot to improve quality and cost effectiveness of care to CalOptima Health members; and
2. Authorize unbudgeted expenditures and appropriate funds in an amount up to $2 million from existing reserves to fund the pilot program.

Background

The UCI Family Health Center is a Federally Qualified Health Center that services nearly 28,000 CalOptima Health direct and delegated members and provided over 100,000 patient care visits in 2021.

Earlier this year, UCI Health, including the Family Health Center, launched a program to provide home-based care for patients. Under this program, patients are offered same-day, high-acuity medical care in the home for illnesses, injuries, and for complex medical conditions. In-home care can be a valuable option for:

- Patients who are high utilizers of the emergency room;
- Patients who cannot use health care options during the day due to work schedules, leading to unnecessary emergency room use;
- Patients who cannot be seen by providers due to lack of same day access in busy practices, or when patients need to be seen after-hours, on weekends, or on holidays;
- Patients who have difficulty leaving their home including patients with mobility limitations, memory care diagnoses, or who are too ill to travel; and
- Patients at risk for recidivism or readmissions due to multiple chronic conditions or complex hospital discharges.

UCI Health has partnered with a vendor called DispatchHealth for this program to establish a care continuum that enables appropriate levels of care and promote a value-based care infrastructure. Early outcomes are promising. Since the program's launch, nearly 2,000 patients have accessed this program. The results are 85% avoided emergency room visits, hospital visits, and 911 dispatches.

The program is currently available to approximately one million Orange County residents who have commercial or Medicare coverage, including patients at UCI Family Health Center. It is currently

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unavailable to the UCI Family Health Center's CalOptima Health patients because the UCI Family Health Center is only contracted to provide primary care services.

Discussion

Staff propose a pilot project over twenty-four (24) months to test and evaluate the effectiveness of this home-based program for appropriate CalOptima Health members at the UCI Family Health Center. The pilot will measure the following outcomes:

- Emergency room utilization;
- Urgent care utilization; and
- Inpatient readmission.

The hypothesis of the pilot is that providing home-based care to CalOptima Health's members will:

- Improve member health by providing care in the appropriate setting; and
- Decrease costs by reducing unnecessary emergency room visits and hospital admissions or readmissions.

If approved, staff will develop and execute an agreement, or an amendment to CalOptima Health's current agreement, with UCI Family Health Center (through the Regents of the University of California) to provide home-based services to members assigned to the UCI Family Health Center. Under the agreement or amendment, CalOptima Health will fund the cost of the home-based services on a fee-for-service basis. CalOptima Health will require monthly reporting from UCI Family Health Center and will share quarterly performance outcome data with the Quality Assurance Committee of the CalOptima Health Board.

If successful, the initial investment for the pilot program costs should be offset by savings resulting from avoided emergency room and hospital inpatient costs. Staff request a twenty-four (24) month period, from January 1, 2023, through December 31, 2025, to implement the pilot, collect data, and evaluate success against defined metrics. CalOptima Health will have the ability to terminate the contract after twelve (12) months if the project does not perform.

Fiscal Impact

The recommended action is unbudgeted. An appropriation of up to $2 million from existing reserves will fund this action.

Rationale for Recommendation

The in-home care pilot with UCI Family Health will provide insights into the quality outcomes of a home-based diversion program and will inform expansion of such programs in the future. The pilot will also test the ability to provide access to services that are available to commercially insured members, to CalOptima Health Medi-Cal members.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

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Attachment

1. Entities Covered by this Recommended Action

/s/ Michael Hunn *11/23/2022*

Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Regents of the University of California University of California Irvine Family Health Center	333 City Blvd., West Ste. 200	Orange	CA	92868

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CalOptima Health Board Action Agenda Referral

Action To Be Taken December 1, 2022
Regular Meeting of the CalOptima Health Board of Directors

Report Item

28. Authorize Actions Related to the CalOptima Health Comprehensive Community Cancer Screening and Support Program for Medi-Cal Members

Contacts

Richard Pitts, D.O., Ph.D., Chief Medical Officer, (714) 246-8491
Katie Balderas, Director III, Population Health Management, (657) 235-6907

Recommended Actions

1. Approve the recommended expenditure plan for the CalOptima Health Comprehensive Community Cancer Screening and Support Program for Medi-Cal Members in an amount not to exceed $50.1 million; and
2. Authorize funding the program over the five-year period from:
    a. A reallocation of $19,134,815 from Intergovernmental Transfer (IGT) 9 funds previously allocated for the Whole Child Model (WCM) program and the 24/7 Virtual Urgent Care Services After Hours Initiative; and
    b. An allocation of the remaining IGT 10 funds, estimated at $31.0 million.

Background & Discussion

CalOptima Health strives to be the healthcare exemplar for all Orange County (OC) residents. The goal is for all of Orange County to have the lowest in the nation late-stage cancer incidence rate for breast, cervical, colon, and lung cancer in certain smokers. In other words:

- With rare exception, no one should die from breast cancer.
- With rare exception, no one should die from cancer of the cervix.
- With rare exception, no one should die from cancer of the colon.
- With rare exception, no one should die from lung cancer in certain heavy smokers.

CalOptima Health seeks to create a new OC health ethos with respect to cancer care by going after these four specific cancers that are relatively easy to detect compared to many more occult cancers. Early detection of these specific cancers has an incredible return on investment. CalOptima intends to build this new ethos by leveraging the key cancer centers and community opinion makers to the point where cancer detection for these specific cancers is part of the community's daily discussions. Additionally, having the lowest late-stage cancer detection in the nation will be a source of intense community pride.

CalOptima Health proposes a five year, approximately $50.1 million Comprehensive Community Cancer Screening and Support Program. The program will increase early detection through improved awareness and access to cancer screening, decrease late-stage cancer diagnoses rates and mortality, and improve quality and member experience during cancer screening and treatment procedures among Medi-Cal members.

The proposed Comprehensive Community Cancer Screening and Support Program will create a culture of cancer prevention, early detection and collaboration with partners towards a shared goal of

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dramatically decreasing late-stage cancer incidence and ensuring that all Medi-Cal members have equitable access to high quality care. The Program will use a phased-in approach to invest approximately $10 million per year over the next five years toward the following three pillars:

1) Increasing community and member awareness and engagement;
2) Increasing access to cancer screening; and
3) Improving member experience throughout cancer treatment.

As of November 14, 2022, 3,925 CalOptima Health members were newly diagnosed with cancer. Of these cases, 480 are lung cancer, 565 are breast cancer, 120 are cervical cancer, and 477 are colorectal cancer. The COVID-19 pandemic has significantly disrupted preventive care and cancer screenings, leading to a decrease in early detection and treatment[1]. Between 2019 and 2021, Medi-Cal Healthcare Effectiveness Data and Information Set (HEDIS) rates decreased by approximately 5% for breast and cervical cancer screenings. Currently, more than one-third of eligible members have not received their cervical, breast, or colorectal cancer screenings.

Increasing these cancer screening rates is crucial for the early diagnosis and treatment of cancer, ultimately increasing life expectancy, quality of life, and reducing healthcare costs. For example, the five-year survival rate for colorectal cancer that has spread is only 15 percent, compared to a 90 percent survival rate when detected earlier at a localized stage. Yet every year in Orange County, an average of 1,500 community members are diagnosed with late-stage cancer of the breast, cervix, or colon[2]. Additionally, trends in late-stage colorectal cancer diagnoses significantly increased over the most recent ten-year period in Orange County, and in 2022, colorectal cancer will likely continue to be the second leading cause of cancer-related deaths following lung cancer[1].

Staff plan to collaborate with the Orange County Cancer Coalition, providers, health networks, and community-based organizations to ensure that funds are utilized equitably to address disparities and build sustained capacity in the cancer screening and treatment community infrastructure.

Recommended Funding Source

Staff recommends reallocation of unused IGT 9 funds and allocation of the remaining IGT 10 funds in order to support this program over a five-year period. Specifically, there is $19,134,815 available in two initiatives previously approved by the Board on April 2, 2020 (see table below). After finalizing the state funding and risk corridor settlement for the WCM program with our health networks, the actual need for IGT 9 funds for this purpose was lower than originally anticipated. Additionally, after conducting user research, management directed staff to end the 24/7 Virtual Urgent Care Services After Hours Initiative due to competing priorities and limited value to CalOptima Health members at this time.

CalOptima Health's share of IGT 10 funds is $67.82 million, of which $45.15 million was received in May 2021, $18.42 million was received in December 2021 and $4.25 million was received in March 2022. As of February 3, 2022, the Board has allocated $36.90 million of IGT 10 funds, leaving

[1] https://www.science.org/doi/10.1126/science.abd3377
[2] https://statecancerprofiles.cancer.gov/index.html

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approximately $30.92 million unallocated. More information on IGT 10 is attached. The total program funding requested from IGT funds over five (5) years is approximately $50.1 million.

IGT	Amount
IGT 9: Proposed Reallocation	
• Whole Child Model	$17,134,815
• 24/7 Virtual Urgent Care Services After Hours Initiative	$2,000,000
Subtotal	$19,134,815
IGT 10: Proposed Allocation	$30,916,053
Total	**$50,050,868**

Staff will return with additional recommended actions and a more detailed implementation plan for Board review and approval at a future meeting.

Fiscal Impact

The recommended action to authorize reallocation of $19,134,815 in IGT 9 funds and allocation of the remaining IGT 10 funds, estimated at $31.0 million does not have a net fiscal impact to CalOptima Health's total net assets since the IGT revenue has been or will be recognized in the fiscal year the funds are received.

Rationale for Recommendation

CalOptima Health is committed to improving cancer screening rates and health outcomes for members. The recommended action will improve access to cancer screenings, early cancer diagnosis, and treatment for CalOptima health members.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Previous Board Action February 3, 2022, "Authorize Allocation of Intergovernmental Transfer (IGT) 10 Funds to the Coronavirus (COVID-19) Member Vaccination Incentive Program (VIP)
2. Intergovernmental Transfers (IGT) 10 Summary

/s/ Michael Hunn *11/23/2022*
Authorized Signature **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 3, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

13. Authorize Allocation of Intergovernmental Transfer (IGT) 10 Funds to the Coronavirus (COVID-19) Member Vaccination Incentive Program (VIP)

Contacts

Richard Helmer, Chief Medical Officer (Interim), 714-468-1100
Marie Jeannis, Executive Director, Quality and Population Health Management, 714-246-8591

Recommended Action

Authorize the allocation of Intergovernmental Transfer (IGT) 10 funds in an amount not to exceed $421,200 for staffing resources for the COVID-19 Member VIP.

Background

In 2021, the CalOptima Board of Directors approved CalOptima's COVID-19 Member VIP. The goal of this program was to motivate members to get the required doses of COVID-19 vaccines by providing $25 non-monetary gift card per vaccine and booster. Additionally, on March 4, 2021, the Board approved the use of Intergovernmental Transfer (IGT) 10 funds for two temporary staff in support of administrative assistance for the COVID VIP Program. Although CalOptima has made significant strides in vaccination, the COVID-19 pandemic continues to impact the well-being of our members.

In 2021, CalOptima membership grew from 800,000 to over 860,000. Additionally, the number of CalOptima members eligible for the COVID-19 vaccine increased, from 408,000 to over 810,000, as a result of the Food and Drug Administration approving vaccines for members 5 – 11 years of age and boosters for all individuals 16 years and older. Eligible members can receive up to three $25 non-monetary gift cards (one gift card per dose and one for the booster). Depending on the vaccine dose requirement and member participation, CalOptima may potentially distribute over 1.6 million gift cards.

As of January 14, 2022, CalOptima has distributed more than 578,000 gift cards to eligible members with the assistance of our fulfilment vendor. CalOptima's contracted fulfillment vendor is responsible for mailing gift cards to the largest Medi-Cal threshold language populations (i.e., English, Spanish, and Vietnamese). Of the 578,000 gift cards distributed, Population Health Management (PHM) staff has manually processed over 114,000 mailings to the smaller threshold language populations as well as processing returned mail. The volume of return mail averages 1,500 per month. Staff are also responsible for data entry, tracking and responding to member inquiries. Additionally due to the increase in gift card processing volumes, the ongoing pandemic and additional vaccine booster doses, the PHM Department call center has experienced a significant increase in incoming calls (see Attachment 4). As the number of members eligible for vaccines continues to grow, management anticipates that the volume of calls and returned mail will continue to increase.

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Discussion

To ensure timely and accurate processing for the COVID-19 Member VIP, staff recommends that the Board allocate additional funding for temporary staffing, not to exceed $421,200, for calendar year (CY) 2022 through the end of the first quarter of CY 2023.

CalOptima staff proposes to allocate staffing resources through the utilization of Intergovernmental Transfer (IGT) 10 funds. CalOptima's share of IGT 10 funds is $63.57 million ($45.15 million was received in May 2021 and $18.42 million was received in December 2021). As of December 20, 2021, the CalOptima Board of Directors has allocated $36.48 million of IGT 10 funds, leaving $27.09 million unallocated. More information on IGT 10 is in Attachment 5.

Fiscal Impact

The recommended action to allocate up to $421,200 in IGT 10 funds for staffing resources for the COVID-19 Member VIP has no net fiscal impact to CalOptima's Fiscal Year 2021-22 Operating Budget approved by the Board on June 3, 2021. Expenditure of IGT funds is for covered Medi-Cal services provided to CalOptima members and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

Authorization of the expenditures will allow CalOptima to process and assist members with their COVID-19 Member VIP questions and concerns in a timely manner. The recommended action will support CalOptima's efforts to help achieve community immunity and continue providing access to quality health care for members during the ongoing pandemic.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Previous Board Action January 7, 2021, "Consider Authorizing Coronavirus (COVID-19) Vaccination Member Incentive Program for Calendar Year 2021"
2. Previous Board Action March 4, 2021, "Consider Ratification and Authorization of Additional Unbudgeted Expenditures Related to Coronavirus (COVID-19) Member Vaccination Incentive Program"
3. Previous Board Action December 20, 2021, "Consider Recommending that the Board of Directors Authorize Extension of CalOptima's Coronavirus (COVID-19) Member Vaccination Incentive Program (VIP) for Calendar Year 2022"
4. Population Health Management Weekly Incoming Call Volume Analysis 2020-2021 & Customer Service Incoming Call Volumes
5. Intergovernmental Transfers (IGT) 10 Summary

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Board Actions

Board Meeting Dates	Action	Term	Not to Exceed Amount
January 7, 2021	Consider Authorizing Coronavirus (COVID-19) Vaccination Member Incentive Program for Calendar Year 2021	CY 2021	$35,000,000
March 4, 2021	Consider Ratification and Authorization of Additional Unbudgeted Expenditures Related to Coronavirus (COVID-19) Member Vaccination Incentive Program	CY 2021	$1,179,619
December 20, 2021	Consider Recommending that the Board of Directors Authorize Extension of CalOptima's Coronavirus (COVID-19) Member Vaccination Incentive Program (VIP) for Calendar Year 2022	CY 2022	The original funding level of $35 million

/s/ Michael Hunn *01/27/2022*
Authorized Signature **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken January 7, 2021
Special Meeting of the CalOptima Board of Directors

Report Item

5. Consider Authorizing Coronavirus (COVID-19) Vaccination Member Incentive Program for Calendar Year 2021

Contacts

Emily Fonda, M.D., MMM, CHCQM, Interim Chief Medical Officer, 714-246-8887
Betsy Ha, Executive Director, Quality and Population Health Management, 714-246-8574
Ladan Khamseh, Chief Operating Officer, (714) 246-8866

Recommended Actions

1. Authorize the development and implementation of a COVID-19 Vaccination Incentive Program (VIP) for Calendar Year (CY) 2021, as described below, to increase member participation and ensure community safety amid the COVID-19 pandemic, subject to DHCS approval prior to implementation;
2. Approve the recommended allocation of Intergovernmental Transfer (IGT) 10 funds, not to exceed $20 million, to provide two $25 nonmonetary gift cards to individual Medi-Cal members age 14 and older for receiving the two required doses of the COVID-19 vaccine (one gift card per shot); and
3. Authorize implementation of the VIP prior to CalOptima's receipt of IGT 10 funds from the State of California.
4. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to enter into an Memorandum of Understanding (MOU), and/or contract or contract amendment with the Orange County Health Care Agency (OCHCA) as appropriate for administration and implementation of the VIP.

Background

In late December 2020, the first doses of the COVID-19 vaccines arrived in Orange County. Vaccines will be distributed according to a phased approach, with high-priority groups vaccinated first and eventually the general public as determined by the California Department of Public Health and local health department. The U.S. Food and Drug Administration issued an emergency use authorization (EUA) for the Pfizer-BioNTech and Moderna vaccines, both of which offer more than 94% protection against COVID-19 when two doses are taken. Public health experts recommend that at least 70% of the population needs to get vaccinated to develop herd community, which can bring an end to the pandemic.

As the only Medi-Cal plan serving Orange County's most vulnerable residents, CalOptima is responding in collaboration with the Orange County Health Care Agency (OCHCA) to support the community in achieving herd immunity. The first step is a strategy that promotes COVID-19 vaccination, including tailoring member education on the importance of vaccination, dispelling misconceptions, and providing nonmonetary member incentives to ensure health equity across race, ethnicity and socioeconomic status. To support this effort, CalOptima staff is seeking an allocation of IGT 10 funds.

Intergovernmental Transfers (IGT) are transfers of public funds between eligible government entities, which are used to draw down federal funds for the Medi-Cal program. To date, CalOptima has participated in ten Voluntary Rate Range IGT transactions. Funds from IGTs 1 through 9 have been

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received, and IGT 10 funds will be distributed in two separate installments, which are expected from the state in 2021.

Discussion

Subject to state approval, staff will work with various internal and external partners on a member outreach program that provides COVID-19 vaccine information. The proposed program includes:

1. A mailing to all members with information about the vaccine.
2. A targeted text messaging campaign. When different priority groups are permitted to be vaccinated, CalOptima will send out targeted text messages to these members letting them know the following:
    a. They are now eligible to be vaccinated.
    b. Where they need to go to be vaccinated. (This information is not yet available, but staff continue to work with OCHCA to establish vaccine events in targeted geographic locations within the county. The vaccine events are likely to begin in Spring 2021, but may extend into the fall, depending on the vaccine distribution timeline as established by OCHCA.)
3. A targeted phone call campaign to population segments who are at high risk for not getting vaccinated. This will begin once the vaccine is widely available to at least essential workers, according to the phased approach.

Staff projects that as many as 400,000 members will participate in this program. To encourage members to participate in vaccination, staff proposes to provide two $25 nonmonetary gift cards for Medi-Cal members age 14 and older for receiving each of two doses of the COVID-19 vaccine, for a total of $50. Members will be encouraged to sign up with the OCHCA's app, Othena, at no cost, to receive the gift card incentives, one gift card for each shot received. The app is being developed to help healthcare providers track vaccine recipients to ensure they get a booster shot and to monitor for side effects. Staff is also seeking authority to enter into a Memorandum of Understanding (MOU) and/or contract or contract amendment with the County as necessary to implement the program. If it is subsequently determined that agreements with other entities, organizations or vendors are necessary, staff will return to the Board with further recommendations for consideration at a later date.

The targeted timeframe for the COVID-19 nonmonetary incentive is CY 2021. IGT 10 funds have not yet been received. For the approved and funded IGT transactions to date, the net proceeds have been evenly divided between CalOptima and the respective funding partners, and funds retained by CalOptima have been invested in addressing member's unmet health care needs. It is anticipated that CalOptima's share of IGT 10 funds will be approximately $66 million ($43.3 million in Spring 2021 and $22.7 million in Fall 2021).

Due to timing issues, staff requests that the Board authorize the CEO to implement the COVID-19 Vaccination Incentive Program for CY 2021 prior to CalOptima's receipt of IGT 10 funds from DHCS. Providing the nonmonetary incentive to coincide with the availability of the COVID-19 vaccination to members will support CalOptima's health promotion efforts in our community.

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It should be noted that since IGT 10 funds are accounted for in the same fashion as the Medi-Cal capitation revenue CalOptima receives from DHCS, to the extent that these funds are not expended on covered, medically necessary Medi-Cal services or qualifying quality initiatives, the expenditures would be charged to CalOptima's administrative loss ratio (ALR), rather than the medical loss ratio (MLR).

Fiscal Impact

The recommended action to allocate up to $20 million in IGT 10 funds to support the COVID-19 Vaccination Member Incentive Program has no net fiscal impact to CalOptima's Fiscal Year 2020-21 Operating Budget approved by the Board on June 4, 2020. Staff anticipates any cash expended to implement the program will be replenished when IGT 10 funds are received from DHCS. Expenditure of IGT funds is for restricted one-time purposes for covered Medi-Cal services to CalOptima members and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

Staff recommends adding a COVID-19 vaccination member incentive component to CalOptima's preventive initiatives to educate and encourage member participation. The recommended actions will support CalOptima's efforts to help the community reach herd immunity, address health disparities, and continue providing access to quality health care for members during the COVID-19 public health crisis.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Action
2. CalOptima Board Action dated February 6, 2020, Consider Pursuit of Proposals with Qualifying Funding Partners to Secure Medi-Cal Funds Through the Voluntary Rate Range Intergovernmental Transfer Program for Rating Period 2019-20 (IGT 10)

/s/ Richard Sanchez *12/31/2020*
Authorized Signature **Date**

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CalOptima Board Action Agenda Referral

Action To Be Taken March 4, 2021
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

16 Consider Ratification and Authorization of Additional Unbudgeted Expenditures Related to Coronavirus (COVID-19) Member Vaccination Incentive Program

Contacts

Emily Fonda, M.D., MMM, CHCQM, Interim Chief Medical Officer, (714) 246-8887
Marie Jeannis, Interim Executive Director, Quality and Population Health Management, (714) 246-8591

Recommended Actions

1. Ratify and authorize the unbudgeted expenditures in an amount up to $262,500 from existing reserves for mailing member education materials related to the Coronavirus (COVID-19) vaccination;
2. Authorize unbudgeted expenditures in an amount up to $695,974 from existing reserves for the COVID-19 Member Vaccination Incentive Program (VIP) to include the OneCare and OneCare Connect populations, subject to regulator(s) approval, as necessary;
3. Authorize the allocation of Intergovernmental Transfer (IGT) 10 funds in an amount not to exceed $221,145 for staffing resources for the COVID-19 Member VIP; and
4. Authorize funding for staffing resources for the COVID-19 Member VIP prior to CalOptima's receipt of IGT 10 funds from the State of California.

Background

On January 7, 2021, the CalOptima Board of Directors (Board) approved a COVID-19 Member VIP for calendar year 2021 (see Attachment 1). The goal of this program is to motivate members to get the required doses of COVID-19 vaccination by providing nonmonetary gift cards.

In addition to offering nonmonetary incentives, another essential strategy to promote vaccination is tailoring member education on the importance of vaccination and correcting misconceptions. As discussed at the Board's January 7, 2021 meeting, one element of the member communication plan is to mail information about the vaccine to all members. To provide this information in a timely manner, in February 2021, CalOptima has mailed member educational pieces (e.g., a cover letter addressing the importance of receiving vaccines, information on incentive administration, frequently asked questions, etc.) to all members. In addition, the texting campaign, which is another element of the strategy for member outreach, is currently pending approval by the Department of Health Care Services (DHCS), and staff will seek any additional required approvals as appropriate.

Staff also note that the OneCare (OC) and OneCare Connect (OCC) populations, among CalOptima's most vulnerable populations, were initially excluded from the COVID-19 Member VIP as this initiative is funded by IGT 10 dollars. In order to ensure the safety of these vulnerable populations and promote vaccination, staff recommend that the Board allocate additional funding for outreach and education of the OC and OCC members to align CalOptima's efforts with the County of Orange's COVID-19 Vaccine Equity Pilot Program (VEPP) deployment.

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Discussion

Member Education Mailing

Staff have been working with various internal and external partners on a member outreach program that provides COVID-19 vaccine information. The program includes a mailing to all members with information about the vaccine. Mailing outreach allows members who do not have a mobile phone or access to internet services to receive CalOptima's COVID-19 Member VIP information and other important vaccine-related information.

Staff estimates that the total cost for mailing educational materials, including postage, envelop, and printing and fulfillment, is $250,000. In addition, staff estimates mailing approximately 5,000 to 5,500 gift cards each month from March through June 2021. The total estimated cost for gift card mailing is $12,500.

Expanding the COVID-19 Member VIP to OC and OCC

OC and OCC members are among the highest risk populations that CalOptima serves due to their age and underlying chronic conditions. The OC/OCC populations are not eligible for IGT dollars as Medicare is their primary health insurance coverage; therefore, they were excluded from the COVID-19 Member VIP request that was approved at the Board's January 7, 2021 meeting. In order to promote vaccination among these populations, staff recommends that the Board authorize unbudgeted expenditures to expand the COVID-19 Member VIP to include OC and OCC members, subject to regulator(s) approvals as necessary.

Staff estimates a 70% vaccine take-up rate by OC and OCC members. The total estimated cost for Medicare member incentive gift cards and related gift card activation fees is $64,000 for OC and $631,974 for OCC. Staff note that OC and OCC members residing in long-term care settings and PACE members are excluded from this COVID-19 Member VIP.

Staffing Resources for COVID-19 Member VIP

In order to deploy the COVID-19 Member VIP in a timely and effective manner, staff recommends hiring a dedicated Program Specialist, Int. and two temporary staff under the Population Health Management department. The Program Specialist, Int. will work with various internal and external stakeholders to execute the planned activities, track vaccination status and member incentive distribution status. Staff proposes making this position permanent beyond the pandemic as member incentive programs continue to grow, and permanent staff resources would be beneficial to support coordination and tracking of various member incentives. Temporary staff will support any administrative and data entry related responsibilities.

The estimated salary and benefit expenses for the Program Specialist, Int. is $147,225 for an 18 month period. The estimated cost for 2 temporary staff for a 9 month period or approximately 1,000 work hours is $73,920.

CalOptima staff proposes staffing resources for COVID-19 Member VIP for up to $221,145 through allocation of IGT 10 funds. It is anticipated that CalOptima's share of IGT 10 funds will be

approximately $66 million ($43.3 million in Spring 2021 and $22.7 million in Fall 2021). Due to timing issues, staff requests the Board to authorize the CEO to approve this staff resources request prior to CalOptima's receipt of the IGT 10 funds from DHCS. As of February 1, 2021, the CalOptima Board of Directors has allocated $36.2 million of the anticipated IGT 10 funds, leaving $29.8 million unallocated. IGT 10 funds allocation recommendation requests totaling $221,145, including this one, are being made today. More information on IGT 10 is attached.

Fiscal Impact

The recommended actions to ratify and authorize mailing member education materials related to the COVID-19 vaccination and to include the OC and OCC populations in the COVID-19 Member VIP are unbudgeted items. An allocation of up to $958,474 from existing reserves will fund these actions.

The recommended action to allocate up to $221,145 for staffing resources for the COVID-19 Member VIP has no net fiscal impact to CalOptima's Fiscal Year 2020-21 Operating Budget approved by the Board on June 4, 2020. Staff anticipates any cash expended for this purpose will be replenished when IGT 10 funds are received from DHCS. Expenditure of IGT funds is for restricted, one-time purposes for covered Medi-Cal services to CalOptima members and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

Ratification and authorization of the expenditures will allow CalOptima to promote vaccination for all members regardless of their eligibility program. The recommended actions will support CalOptima's efforts to help the community reach herd immunity and continue providing access to quality health care for members during the COVID-19 public health crisis.

Concurrence

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

Attachments

1. Board Action Dated January 7, 2021, Consider Authorizing Coronavirus (COVID-19) Vaccination Member Incentive Program for Calendar Year 2021
2. Intergovernmental Transfers (IGT) 10 Summary

/s/ Richard Sanchez — *02/24/2021*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 20, 2021
Special Meeting of the CalOptima Board of Directors

Consent Calendar

15. Consider Authorizing an Extension of CalOptima's Coronavirus (COVID-19) Member Vaccination Incentive Program (VIP) for Calendar Year 2022

Contacts

Emily Fonda, MD, MMM, CHCQM, Chief Medical Officer, (714) 246-8887
Marie Jeannis, Executive Director, Quality & Population Health Management, (714) 246-8591

Recommended Actions

1. Recommend Extending CalOptima's Coronavirus (COVID-19) Member Vaccination Incentive Program through Calendar Year 2022 (CY 2022), and authorize the provision of vaccine incentives for Members who receive booster or additional doses of the COVID-19 vaccine; and
2. Authorize use of the previously approved allocation of unspent IGT 10 funds, not to exceed the original funding level of $35 million, to include provision of a $25 non-monetary gift card (one gift card per shot) to individual Medi-Cal members who receive a booster or additional dose of the COVID-19 vaccine.

Background

On January 7, 2021, the CalOptima Board of Directors allocated $35 million in Intergovernmental Transfer (IGT) 10 funds for CalOptima's COVID-19 VIP (CalOptima VIP). Staff notes that the originally recommended request was $20 million; however, during the Board meeting, the Board increased the allocation to $35 million and approved an amended motion to include incentives for all CalOptima Medi-Cal members, subject to DHCS approval, for receiving the two doses of the COVID-19 vaccine, including children under 14 years of age. The program included Member Health Rewards for eligible CalOptima members to receive a $25 gift card per vaccine for a maximum of $50 per individual CalOptima Member. On the same day, the Board also approved $400,000, from the Homeless Health Initiative, to provide Member Health Rewards for members experiencing homelessness.

On March 4, 2021, the Board approved $695,974 from existing reserves to support OneCare and OneCare Connect Member Health Rewards, $262,500 from existing reserves for member education materials and $221,145 from IGT 10 funds for staffing resources.

On August 13, 2021, DHCS released APL 21-010: Medi-Cal COVID-19 VIP (DHCS VIP), to improve Medi-Cal members' vaccination rates across the state of California. DHCS allocated up to $350 million statewide to incentivize COVID-19 vaccination efforts for the period September 1, 2021, through February 28, 2022. As presented at the August Board meeting, a combined total of $250 million can be earned by health plans, including CalOptima, for activities designed to close the vaccination gaps for enrolled Medi-Cal members. The APL included $100 million, to be used by all health plans, for direct member incentives of $50, at maximum, per eligible enrollee. The DHCS VIP includes all unvaccinated CalOptima members, 12 years and older and has also identified populations of focus such as:

- Members who are homebound and unable to travel to vaccination sites
- Members between the ages of 50 and 64 with multiple chronic diseases

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- Members who self-identify as persons of color, and younger members between the ages of 12 and 25.

CalOptima joined the DHCS VIP in September 2021 to increase the rates of vaccinated members. The Food & Drug Administration (FDA) has continued to authorize the COVID-19 vaccine for additional uses and populations after the implementation of the DHCS VIP, such as:

- Pfizer Booster was approved on September 22, 2021;
- Moderna and Johnson & Johnson Boosters were approved on October 20, 2021;
- Vaccine for children 5 – 11 years of age was approved on October 29, 2021.

As such, these populations are not covered under the DHCS VIP for member health rewards. To help ensure that all CalOptima members are fully vaccinated, staff proposes extending the CalOptima VIP through CY 2022 and using the remaining IGT funds to continue providing $25 non-monetary gift cards for Medi-Cal members receiving the two required doses of the COVID-19 vaccine (one gift card per shot) and receiving a single COVID-19 booster shot.

Discussion

To date, with the state's support and collaboration with various community organizations, CalOptima has achieved significant progress in vaccinating its members in CY 2021. As of November 5, 2021:

- 430,950 members, eligible for the vaccine, have been vaccinated;
- 417,857 of vaccinated members are eligible for non-monetary gift cards (371,178 gift cards have been fulfilled [~89%]);
- 65% of members aged 16 years and older received at least one dose of vaccine
- 63% of members aged 12 years and older received at least one dose of vaccine

Although CalOptima has made significant strides in vaccination, staff believes that we must continue outreaching to the community and increase vaccination rates until herd immunity is reached. The targeted timeframe for the approved CalOptima VIP was for CY 2021 (January 1, 2021 – December 31, 2021). Therefore, staff recommends extending the CalOptima VIP through CY 2022, continuing to provide $25 non-monetary gift cards for Medi-Cal members receiving the two required doses of the COVID-19 vaccine, and providing $25 nonmonetary gift cards for Medi-Cal members receiving the single booster shot.

Staff believes these recommended actions will help ensure community safety amid the ongoing COVID-19 pandemic.

Fiscal Impact

The recommended action to authorize the revision to and extension of the CalOptima Member VIP through December 31, 2022, has no net fiscal impact to CalOptima Fiscal Year 2021-22 Operating Budget approved by the Board on June 3, 2021.

As of October 18, 2021, approximately $15.6 million of the $35 million Board allocation has been spent. Staff anticipates the remaining $19.4 million in IGT 10 funds will be sufficient to cover program expenses through December 31, 2022. Expenditure of these IGT funds is for covered Medi-Cal services to CalOptima members and does not commit CalOptima to future budget allocations.

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Rationale for Recommendation

Staff believes that non-monetary gift cards are great tools to motivate members to protect themselves from COVID-19 and increase member participation. The recommended actions will support CalOptima's efforts to continue reaching herd immunity and address health disparities during the COVID-19 public health crisis.

Concurrence

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

Attachments

1. Previous Board Action January 7, 2021: Consider Authorizing Coronavirus (COVID-19) Vaccination Member Incentive Program for Calendar Year 2021
2. Previous Board Action January 7, 2021: Consider Authorizing Homeless Health Initiative Vaccination Intervention and Member Incentive Strategy in Response to the Coronavirus Pandemic
3. Previous Board Action March 4, 2021: Consider Ratification and Authorization of Additional Unbudgeted Expenditures Related to Coronavirus (COVID-19) Member Vaccination Incentive Program
4. Previous Board Action October 7, 2021: Consider Appropriation of Funds and Authorization of Unbudgeted Expenditures and Other Actions as Necessary to Implement the All-Plan Letter (APL) 21-010: Medi-Cal COVID-19 Vaccination Incentive Program

/s/ Michael Hunn *12/15/2021*
Authorized Signature **Date**

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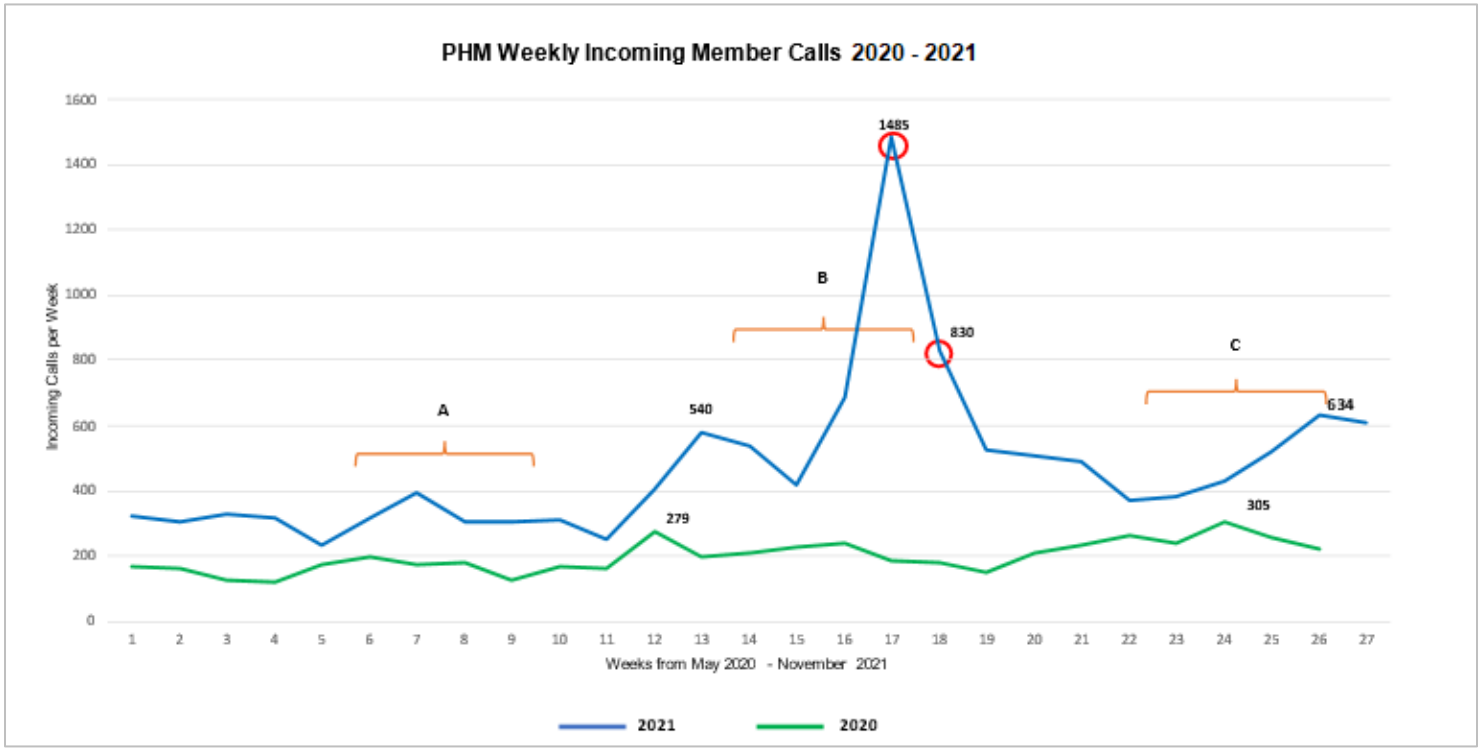
Population Health Management Weekly Incoming Call Volume Analysis 2020-2021



A. Weeks 5-9 represent the time period in the month of June 2021 were 141,000 gift cards were processed. Within a two-week time frame the incoming calls to the Population Health Management (PHM) department jumped from an average of 175 per week to 540 calls per week at the peak level.

B. Weeks 14-17 represent the time period in the month of August in which the internal address and privacy breach occurred. At this point in time 50,000 gift cards were deactivated. Within one week the call volume to the PHM department escalated to almost 1500 calls in one week.

C. Weeks 23-26 represent the time period in which 90,000 gift cards were processed. An increase in incoming calls to the PHM department occurred with the peak point reaching 634 calls in one week.

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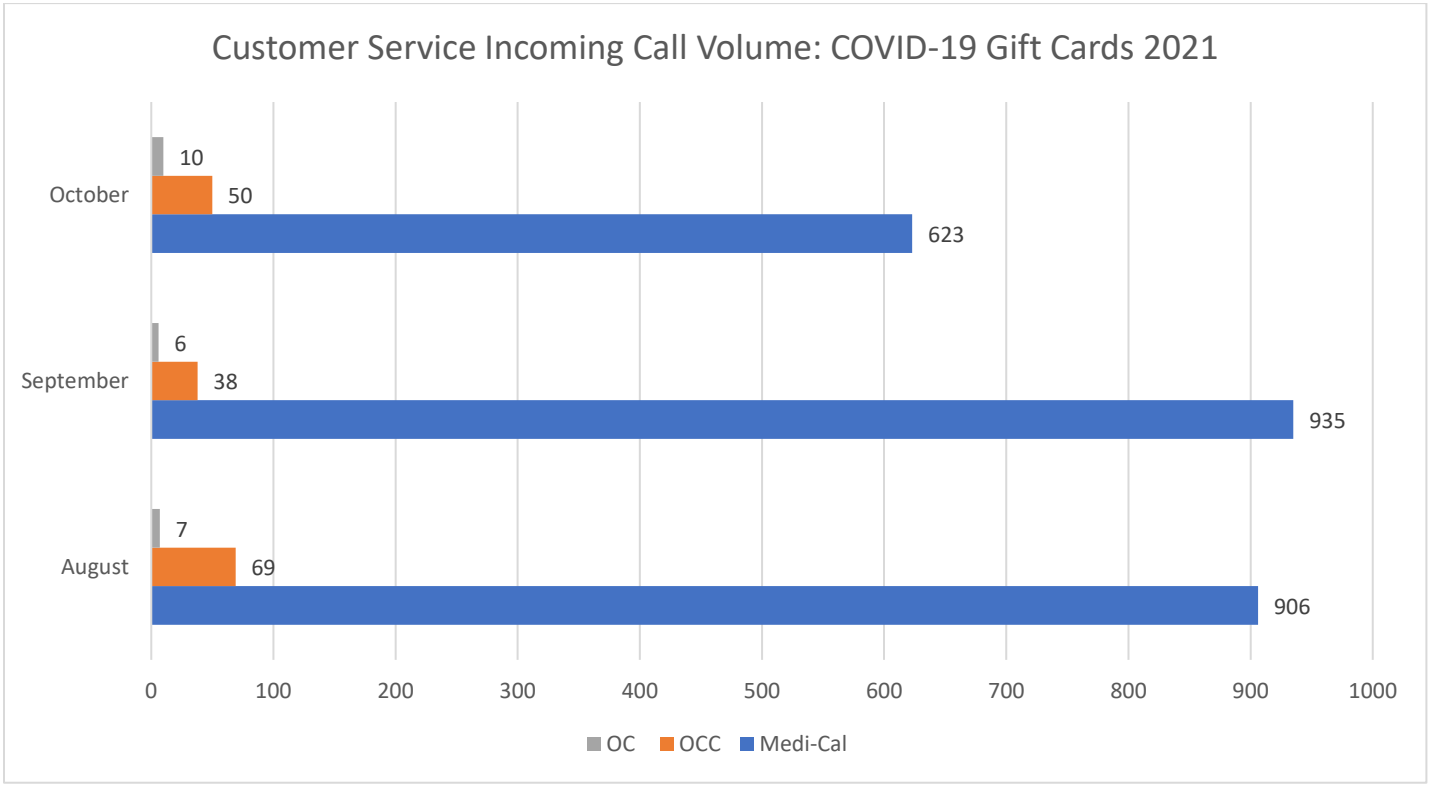
Customer Service Incoming Call Volumes COVID-19 Incentive Related Aug – Oct 2021



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Intergovernmental Transfers (IGT) 10 Summary

Intergovernmental Transfers (IGT) are transfers of public funds between eligible government entities, which are used to draw down federal funds for the Medi-Cal program. To date, CalOptima has participated in ten Voluntary Rate Range IGT transactions.

For the DHCS approved and funded IGT transactions to date, the net proceeds have been evenly divided between CalOptima and the respective funding partners, and funds retained by CalOptima have been invested in addressing member's unmet health care needs. CalOptima's share of IGT 10 funds is $63.57 million ($45.15 million was received in May 2021 and $18.42 million was received in December 2021). As of December 20, 2021, the CalOptima Board of Directors has allocated $36.48 million of IGT 10 funds, leaving $27.09 million unallocated as follows:

Date	Initiative	Amount
	Total Received	**$63.57 million**
1/7/2021	Orange County COVID-19 Nursing Home Prevention Program Grant Extension and Expansion	$1.2 million
1/7/2021	COVID-19 Vaccination Member Incentive Program for Calendar Year 2021- Member Incentive	$35.0 million
3/4/2021	COVID-19 Vaccination Member Incentive Program for Calendar Year 2021- Staffing	$221,145
12/20/2021	Orange County COVID-19 Nursing Home Prevention Program Grant Extension and Expansion CY2021	$61,000
	Total Allocated	**$36.48 million**
	Unallocated	**$27.09 million**
	Allocation Recommended in this Board Action Request	**$421,200**

It should be noted that since IGT 10 funds are accounted for in the same fashion as the Medi-Cal capitation revenue CalOptima receives from DHCS in the year received and thus will have an impact on medical loss ratio (MLR) and administrative loss ratio (ALR), in that year. Similarly, amounts will have an impact on MLR and ALR in the year the funds are spent. To the extent that these funds are not expended on covered, medically necessary Medi-Cal services or qualifying quality initiatives, the expenditures would be charged to CalOptima's ALR.

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For the DHCS approved and funded IGT transactions to date, the net proceeds have been evenly divided between CalOptima and the respective funding partners, and funds retained by CalOptima have been invested in addressing member's unmet health care needs. CalOptima's share of IGT 10 funds is $67.82 million ($45.15 million was received in May 2021, $18.42 million was received in December 2021 and $4.25 million was received in March 2022). As of February 3, 2022, the CalOptima Board of Directors has allocated $36.90 million of IGT 10 funds, leaving $30.92 million unallocated as follows:

Date	Initiative	Amount
	Total Received	**$67.82 million**
1/7/2021	Orange County COVID-19 Nursing Home Prevention Program Grant Extension and Expansion	$1.2 million
1/7/2021	COVID-19 Vaccination Member Incentive Program for Calendar Year 2021- Member Incentive	$35.0 million
3/4/2021	COVID-19 Vaccination Member Incentive Program for Calendar Year 2021- Staffing	$221,145
12/20/2021	Orange County COVID-19 Nursing Home Prevention Program Grant Extension and Expansion CY2021	$61,000
2/3/2022	COVID-19 Member Vaccination Incentive Program Staffing Resources (CY 2022-Q1 CY2023)	$421,200
	Total Allocated	**$36.90 million**
	Unallocated	**$30.92 million**
	Allocation Recommended in this Board Action Request	**$30.92 million**

It should be noted that since IGT 10 funds are accounted for in the same fashion as the Medi-Cal capitation revenue CalOptima receives from DHCS in the year received and thus will have an impact on medical loss ratio (MLR) and administrative loss ratio (ALR), in that year. Similarly, amounts will have an impact on MLR and ALR in the year the funds are spent. To the extent that these funds are not expended on covered, medically necessary Medi-Cal services or qualifying quality initiatives, the expenditures would be charged to CalOptima's ALR.

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Board of Directors Meeting
December 1, 2022

OneCare Connect Cal MediConnect Plan
(Medicare-Medicaid Plan)
Member Advisory Committee Update

On October 27, 2022, the OneCare Connect Member Advisory Committee (OCC MAC) held its regular meeting via teleconference using Zoom Webinar technology.

Michael Hunn, Chief Executive Officer (CEO), started his update by thanking the members of the OCC MAC for their service, input, and advocacy on behalf of the members and the mission of CalOptima Health. Mr. Hunn updated the Committee on several topics, which included the upcoming redetermination process, with the upcoming ending of the public health emergency (PHE). He noted that he has been working closely with An Tran, Director, Social Services Agency (SSA) as this is a major priority. CalOptima Health will coordinate its efforts with SSA, the Health Care Agency, the local Coalition of Community Health Centers including FQHCs and other community providers to get the word out about the process and how to successfully navigate redetermination. CalOptima Health continues to communicate with other associations across the State including the local health plans to make sure that messaging to members was consistent on the redetermination effort throughout the State.

Yunkyung Kim, Chief Operating Officer, echoed Mr. Hunn's comments, thanking the members of the OCC MAC for their service and on the Committee. Ms. Kim provided an update on the transition from OneCare Connect to OneCare and noted that Orange County was one of the few counties that had an existing Special Needs Plan (SNP) for members eligible for both Medicare and Medi-Cal and noted that has made it easier to transition current OneCare Connect members into CalOptima Health's OneCare Program. Ms. Kim reported that CalOptima Health decided to partner with broker agencies to promote and help grow the OneCare program. She noted that CalOptima Health has partnered with one agency now as the enrollment period has started and will partner with additional broker agencies next year.

Richard Pitts, D.O., Ph.D., Chief Medical Officer, provided a verbal update on COVID-19 and noted that there were zero CalOptima Health members in the hospital with COVID-19 at the time of the meeting. Dr. Pitts also discussed the Respiratory Syncytial Virus (RSV) that is affecting many children in the area and had children's hospitals at or close to capacity. He also noted that flu season was approaching and encouraged everyone to get a flu shots and stay up-to-date on their COVID-19 boosters.

OCC MAC heard a presentation from the Orange County Social Services Agency with important updates on the PHE and its redetermination efforts. The OCC MAC also heard a presentation from the Social Security Administration with important updates regarding

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Supplemental Security Income (SSI). In addition, the Committee received an Ombudsman Report and a OneCare Connect transition update.

The OCC MAC appreciates this opportunity to provide the CalOptima Board with input and updates on their final activities.

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Board of Directors Meeting
December 1, 2022

Regular Meeting of the
Whole-Child Model Family Advisory Committee
Report to the Board

On October 25, 2022, the Whole-Child Model Member Family Advisory Committee (WCM FAC) conducted a special meeting via teleconference meeting using Zoom Webinar technology.

Michael Hunn, Chief Executive Officer, provided a comprehensive CEO update that touched upon the Redetermination Initiative being undertaken by the Social Services with the anticipation that the public health emergency is going to end as early as January 2023. Mr. Hunn also discussed the increase in emergency room visits by children with the Respiratory Syncytial Virus (RSV) that had affected many children in the area and had emergency rooms at capacity. Mr. Hunn also discussed the on-going vaccine promotions in conjunction with the community clinics.

Yunkyung Kim, Chief Operating Officer, discussed the changes to the health network minimum and maximum enrollment. Ms. Kim reviewed the policy changes with the members and noted that CalOptima Health was circulating a policy for feedback from all stakeholders and that the committee members would receive the policy via email after the meeting. She asked members to review the policy provide feedback as necessary.

Richard Pitts, D.O., Ph.D., Chief Medical Officer, provided a COVID update and noted that COVID numbers were down across the county which was attributed to the vaccine efforts. Dr. Pitts encouraged everyone to stay current on their vaccinations, including getting a flu shot.

Doris Billings provided a California Children Services (CCS) update on behalf of the Orange County Health Care Agency.

The WCM FAC heard presentations on both Medi-Cal and Supplemental Security Income (SSI) and how both items are important to the redetermination effort underway by the Orange County Social Services Agency in preparation for the end of the public health emergency which was anticipated to end in January 2023.

Kelly Bruno-Nelson, Executive Director, Program Implementation, lead a discuss on Respite Care under CalAIM's Community Supports and listened to the members about their experience in coordinating respite care for the Whole-Child Model members.

The WCM FAC appreciates and thanks the CalOptima Board for the opportunity to present input and updates on the WCM FAC's current activities.