NOTICE OF A REGULAR MEETING OF THE CALOPTIMA BOARD OF DIRECTORS

APRIL 7, 2022
2:00 P.M.

505 CITY PARKWAY WEST, SUITE 108
ORANGE, CALIFORNIA 92868

BOARD OF DIRECTORS

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

Supervisor Katrina Foley, Alternate

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

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

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

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

To ensure public safety and compliance with emergency declarations and orders related to the COVID-19 pandemic, individuals are encouraged not to attend the meeting in person. As an alternative, members of the public may:

1.) **Participate via Zoom Webinar at:**
https://us06web.zoom.us/webinar/register/WN_tT37auKUQUKJIHPXj71E1A and Join the Meeting.
Webinar ID: 949 5127 5797
Passcode: 424801 -- Webinar instructions are provided below.

CALL TO ORDER
Pledge of Allegiance
Establish Quorum

PRESENTATIONS/INTRODUCTIONS

MANAGEMENT REPORTS
1. Chief Executive Officer

2. Annual Legislative Update

3. Introduction to the FY 2022-23 CalOptima Budget: Part 1

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
4. Minutes
   a. Approve Minutes of the March 3, 2022 Regular Meeting of the CalOptima Board of Directors and Minutes of the March 17, 2022 Regular Meeting of the CalOptima Board of Directors
   b. Receive and File Minutes of the December 8, 2021 Regular Meeting of the CalOptima Board of Directors' Quality Assurance Committee

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

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

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

8. Ratify Amendments to Contract with Newmark Knight Frank

9. Retire Policies GG.1331 and GG.1350 for the Health Homes Program

10. Approve Modifications to CalOptima Policy GG.1513: Health Network Utilization Management Reporting and Monitoring Requirements

11. Adopt Resolution No. 22-0407-01, Authorizing Remote Teleconference Meetings for the CalOptima Board of Directors and its Advisory Committees in Accordance with California Government Code section 54953, subdivision (e)

12. Authorize Extension of Contract to Secure Transportation for CalOptima Program of All-Inclusive Care for the Elderly (PACE)

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

REPORTS/DISCUSSION ITEMS

14. Approve CalOptima Position on Proposed Legislation

15. Authorize Appropriation of Funds, Unbudgeted Expenditures and a Grant Agreement with the Coalition of Orange County Community Health Centers for Population Health and Value-Based Care Transformation

16. Authorize Appropriation of Funds from the Homeless Health Initiatives, and a Grant Agreement with the County of Orange to fund the Expansion of the Outreach and Engagement Team to Enhance to Facilitate Identification and Enrollment of Potential Medi-Cal Eligible Members

17. Authorize Actions Related to CalAIM for Community Support Services

18. Ratify Amendments to the Medi-Cal Health Network Contract for Health Care Services and Approve the CalAIM Community Supports Provider Incentive Payment Program Agreement

19. Authorize Extension and Amendments of CalOptima Provider Contracts

20. Authorize the Extension of the Quality Initiative Related to Post-Acute Infection Prevention and Authorize Related Funding for Quality Initiative Payments

21. Adopt Resolution Approving and Adopting Updated CalOptima Policy GA.8042: Supplemental Compensation and Appropriation of Funds and Authorization of Unbudgeted Expenditures

ADVISORY COMMITTEE UPDATES

22. OneCare Connect Member Advisory Committee Update

23. Joint Member Advisory Committee and Provider Advisory Committee Updates

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

ADJOURNMENT

TO JOIN THE MEETING

Please register for the Regular Meeting of the CalOptima Board of Directors on April 7, 2022 at 2:00 p.m. (PST)

https://us06web.zoom.us/webinar/register/WN_tT37auKUQUKJIHPXj71E1A

Or One tap mobile:
+13462487799,,94951275797#,,,,*424801# US (Houston)
+17207072699,,94951275797#,,,,*424801# US (Denver)

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

Webinar ID: 949 5127 5797
Passcode: 424801

International numbers available: https://us06web.zoom.us/u/kcvh2Hj1QR

MEMORANDUM

DATE:	March 31, 2022
TO:	CalOptima Board of Directors
FROM:	Michael Hunn, Chief Executive Officer
SUBJECT:	CEO Report — April 7, 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. Press Conference Generates Significant Media Coverage for New Mission, Vision

On March 18, CalOptima held a press conference to announce your Board-approved new mission and five-year strategic vision, $100 million investment in technology transformation, and $8 million commitment to Street Medicine. The press conference was well attended and, coupled with a press release, resulted in more than a dozen articles and TV and radio segments. The Orange County Register published a story about the announcements, quoting CEO Michael Hunn and Board Member Isabel Becerra. Spanish and Vietnamese newspapers covered the news, including Excelsior and Viet Dong. CalOptima also gained TV, radio and online coverage from KABC, Telemundo, KFI, Nam Quan Trust Media and PhoBolsaTV. Numerous trade publications also picked up the news, including Becker's Healthcare, Healthcare Innovation, Health Plan Weekly and others.

b. CalFresh Campaign Begins in April

CalOptima's CalFresh outreach campaign kicks off in mid-April with billboard ads and a direct mailer to members promoting that an eligible individual can receive up to $250 monthly and an eligible family of four can receive up to $835 monthly in CalFresh food benefits. The mailer will be sent to members who are potentially eligible to enroll and distributed in phases, starting with those who have chronic illnesses and expanding to families. The full CalFresh campaign will run through the fall and includes a toolkit for providers and community-based organizations, community events, media outreach and other forms of advertising.

c. State Prepares for Public Health Emergency (PHE) Termination

As many as 16 million low-income Americans will likely be disenrolled from Medicaid when the COVID-19 PHE ends and states resume eligibility redeterminations. The latest PHE extension runs through April 16, but it is expected to be renewed for another 90 days through mid-July since the Biden administration has guaranteed at least a 60-day notice before termination. CalOptima's federal trade association, the Association for Community Affiliated Plans, and other organizations recently sent a letter to Congressional leaders requesting a 120-day notice instead. Redetermination could take up to 14 months. In California, the Department of Health Care Services (DHCS) is taking multiple steps to prepare for the PHE termination, including the following:

- Sending letters to all 14.4 million Medi-Cal beneficiaries to test whether they reach the intended recipients

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- Providing scripts to county social services departments, which oversee renewals, to answer callers' questions in 19 languages
- Allocating extra money for federally funded "navigators" — community workers who help consumers sign up for Medi-Cal or Covered California plans
- Issuing guidance to Medi-Cal managed care plans requiring member outreach to help ensure contact information is up to date

d. CalOptima Supports Senate Bill 1342

In alignment with CalOptima's 2021–22 Legislative Platform, your Board's Legislative Ad Hoc Committee recommended that CalOptima support Senate Bill (SB) 1342, sponsored by the County of Orange and co-introduced by Senator Pat Bates and Assemblywoman Sharon Quirk-Silva. SB 1342 would authorize counties to create multidisciplinary teams (MDTs) to support older adults. Within the MDTs, county departments and aging service providers could exchange information to improve interagency care coordination and service delivery for older adults and their caregivers. By eliminating data silos, MDTs could develop coordinated care plans for wraparound services to better address the health and social needs of older adults. If SB 1342 is signed into law, CalOptima would join the MDT established by Orange County, resulting in improved care for CalOptima's 104,000+ members over the age of 65.

e. Fiscal Year (FY) 2022 Federal Spending Package Signed into Law

On March 15, President Joe Biden signed into law the bipartisan FY 2022 Consolidated Appropriations Act, which funds the federal government at $1.5 trillion through September 30, 2022, as well as extends all current telehealth flexibilities in Medicare until five months following the termination of the COVID-19 PHE. *Of note, for the first time in more than a decade, members of Congress were able to request spending allocations for specific community projects, also known as earmarks.* The final legislation funds the following projects in Orange County that may impact CalOptima members and stakeholders:

- CHOC Children's: $325,000 to expand capacity for mental health treatment services in response to the COVID-19 pandemic (requested by Rep. Lou Correa and Sen. Dianne Feinstein)
- City of Huntington Beach: $500,000 to establish a mobile crisis response program that addresses mental health, substance abuse and similar 9-1-1 calls for service in the field (requested by Sen. Dianne Feinstein)
- County of Orange: $2 million to develop a second Be Well OC campus in Irvine to deliver coordinated behavioral health services to all Orange County residents (requested by Rep. Young Kim)
- County of Orange: $5 million to develop a Coordinated Re-entry Center to help justice-involved individuals with mental health or substance use disorders reintegrate into the community (requested by Rep. Lou Correa and Sen. Dianne Feinstein)
- North Orange County Public Safety Task Force: $5 million to expand homeless outreach and housing placement services (requested by Rep. Young Kim and Sen. Dianne Feinstein)

f. Hospital Directed Payments Totaling $138.9 Million to be Distributed in April

On March 14, 2022, CalOptima received approximately $138.9 million in funding from DHCS for three Hospital Directed Payment programs. The funding for the Private Hospital Directed Payments and Enhanced Payment Program was based on encounter data submitted for dates of

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service beginning January 1, 2020, through June 30, 2020. The Quality Improvement Program payment covers the period of July 2020 through December 2020. Staff anticipates releasing the funding to qualified hospitals by mid-April 2022.

g. COVID-19 Clinics Continue as Percentage of Vaccinated Members Climbs

In mid-March, CalOptima reached an important milestone — more than half a million members (506,205) are now vaccinated. The growth in our vaccination rate is supported by our ongoing community-based clinics. At three March clinics, another 278 people were vaccinated, and 191 $25 Member Health Rewards were distributed. The County of Orange Social Services Agency continues to attend to encourage enrollment in CalFresh for those who qualify. Future clinics are April 9, April 16 and April 23. Vaccination percentages by age group is as follows:

- 5- 11 23.9%
- 12-15 54.8%
- 16-49 64.9%
- 50-64 75%
- 65-74 81.4%
- 75+ 81.4%

h. CalOptima Gains Media Coverage

- On February 24, The Precinct Reporter posted an online article on CalOptima's vaccine clinic at the Second Baptist Church, quoting Pastor Ivan Pitts, one of CalOptima's trusted messengers from our outreach video series.
- On March 4, Michael Hunn's appointment as permanent CEO was covered in the Orange County Register. The news was also included in **Health Leaders**, **Orange County Breeze** and **California Healthline**.
- On March 9, the Orange County Register published a story about U.S. Health and Human Services Secretary Xavier Becerra's roundtable discussion about mental health at Be Well OC. Michael Hunn was quoted.
- On March 15, Healthline ran an online article about why people with chronic conditions are living longer without disability. Chief Medical Officer Richard Pitts, D.O., Ph.D., was interviewed.
- On March 25, U.S. News ran an article on diet recommendations for men and quoted Jessie Fragoso, a registered dietitian at CalOptima.

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Management Reports

2. Annual Legislative Update

Verbal Update

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CalOptima

Better. Together.

FY 2022-23 Budget Planning: Part 1

Board of Directors Meeting
April 7, 2022

Nancy Huang, Chief Financial Officer

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Overview

- Lines of Business
- FY 2022-23 State Budget Outlook
- FY 2022-23 CalOptima Budget
  - FY 2022-23 Budget Objectives
  - Budget Components
    - Operating Budget
      - Preliminary Enrollment Projections
      - Medical Cost: Budget Categories
      - Administrative Expense: Budget Categories
    - Capital Budget Overview
- FY 2022-23 Budget Process

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Lines of Business

	Start Date	Program Type	Contractor/ Regulator
Medi-Cal CalOptima Better. Together.	October 1995	California's Medicaid program	California Department of Health Care Services (DHCS)
OneCare (HMO SNP) CalOptima Better. Together.	October 2005	Medicare Advantage Special Needs Plan (SNP)	Centers for Medicare & Medicaid Services (CMS)
PACE CalOptima Better. Together.	October 2013	Medicare and Medicaid Program	Three-way contract: CMS, DHCS and CalOptima
OneCare Connect CalOptima Better. Together.	July 2015	Medicare and Medicaid Duals Demonstration	Three-way contract: CMS, DHCS and CalOptima

- Medi-Cal Program includes (1) Classic, (2) Medi-Cal Expansion and (3) Whole Child Model
- OneCare Connect will transition to OneCare (D-SNP) effective January 2023

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FY 2022-23 State Budget Outlook

- Public Health Emergency (PHE) Status
  - DHCS anticipates PHE will end mid-July 2022
  - State will have 14 months to unwind eligibility activities
  - Per CMS guidance, each of the 14.5 million Medi-Cal beneficiaries will need to be redetermined

- Medi-Cal Enrollment Forecast
  - 3.7% FY over FY increase
  - Nearly 900,000 members by August, with slow descent thereafter
  - May 2022: Older Adult Expansion (+15,000)
  - January 2023: Dual members from Cal MediConnect (+15,000)

FY 2022-23 State Budget Outlook (cont.)

- Program Updates:
  - Medi-Cal Rx transition completed January 2022
  - Continuation of Prop 56 supplemental provider payments
  - Continued implementation of CalAIM programs

FY 2022-23 Budget Objectives

- Balanced Operating Budget
  - Forecasted membership, revenue and medical expenses
  - Zero-based general and administrative budget
  - Separate reporting on allocated reserve spending and reserve balance
- Building Infrastructure and Capacity
  - ITS digital transformation and workplace modernization
  - Move toward same day treatment authorizations and claims payments
- Improving Quality and Efficiency
  - High quality of care and Pay For Value/Compliance
  - Remove barriers to healthcare access for members

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Budget Components

Operating Budget

- Enrollment
- Revenue
- Medical Costs
- Administrative Expenses

Capital Budget

- Information Technology Services (ITS)
- 505 Building Improvements
- 500 Building Improvements
- PACE Center

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Preliminary Enrollment Projections

Total Average Member Months

LOB	FY 2020	FY 2021	FY 2022	FY 2023
Medi-Cal	723,961	792,070	859,772	891,953
OneCare Connect	14,203	14,764	14,740	7,324
OneCare	1,459	1,667	2,273	9,555
PACE	378	387	424	477
Total	740,001	808,888	877,209	909,310

Membership (June of Each Fiscal Year)

LOB	FY 2020	FY 2021	FY 2022	FY 2023
Medi-Cal	742,630	825,156	897,540	877,911
OneCare Connect	14,391	14,799	14,648	-
OneCare	1,451	1,929	2,405	16,568
PACE	388	397	445	508
Total	758,860	842,281	915,038	894,987

* Based on Actuals July 2019 through February 2022
Note: Assumes Public Health Emergency will end by July 2022

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Medical Cost: Budget Categories

- Provider capitation payments less administrative portion
- Claims payments to hospitals and providers
- LTC/Skilled Nursing Facilities (SNF)
- Prescription Drugs
  - OneCare Connect, OneCare and PACE
- Case management and other medical (i.e., care coordination activities)

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Administrative Expense: Budget Categories

- Salaries, Wages and Employee Benefits
- Non-salary Expenses
  - Professional Fees
  - Purchased Services
  - Printing and Postage
  - Other Operating Expenses
- Delegated administrative expenses from health network capitation

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Capital Budget Overview

- Information Technology Services
- 505 Building Improvements
- 500 Building Improvements
- PACE Center

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FY 2022-23 Budget Process

Budget Preparation:

- Feb – March: Departments prepare budgets
- April – May: Executive Team reviews and approves proposed budget

Budget Approvals:

- April 7 Board: Budget Planning: Part 1
- May 5 Board: Budget Planning: Part 2
- May 19 FAC: Budget review and approval
- June 2 Board: Budget review and approval

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Our Mission

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

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MINUTES
REGULAR MEETING
OF THE
CALOPTIMA BOARD OF DIRECTORS

March 3, 2022

A Regular Meeting of the CalOptima Board of Directors was held on March 3, 2022, at CalOptima, 505 City Parkway West, Orange, California. The meeting was held via teleconference (Go-to-Webinar) in light of the COVID-19 public health emergency and of Assembly Bill (AB) 361 (Chaptered September 16, 2021), which allows for temporary relaxation of certain Brown Act requirements related to teleconferenced meetings. Chairman Andrew Do called the meeting to order at 2:01 p.m. and Director Isabel Becerra led the Pledge of Allegiance.

ROLL CALL

Members Present: Supervisor Andrew Do, Chairman; Clayton Corwin, Vice Chair; Isabel Becerra; Supervisor Doug Chaffee; Clayton Chau, M.D. (non-voting); Jose Mayorga M.D.; Scott Schoeffel; Nancy Shivers; Tran Trieu, M.D. (at 2:15 p.m.)
(All Board Member attendees participated in person except Supervisor Chaffee, Director Shivers who attended remotely)

Members Absent: Blair Contratto

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

PRESENTATIONS/INTRODUCTIONS

None.

The Clerk of the Board noted for the record that since the publication of the Board agenda and materials, that Consent Calendar Item 16, Approve New CalOptima Policy GG.1666 PP Mobile Texting has been continued to a future Board meeting to allow for further study.

MANAGEMENT REPORTS

1. Chief Executive Officer Report

Michael Hunn, Interim Chief Executive Officer, highlighted several items from his report including, an update on enrolling eligible members into the CalFresh program. Mr. Hunn noted that CalOptima is working in collaboration with the Orange County Social Services Agency (SSA) to raise awareness about the program as part of the efforts to address social determinants of health (SDOH). According to SSA data, approximately 344,000 CalOptima members may be eligible to enroll and benefit from the CalFresh program.

Mr. Hunn also provided a detailed update on the Point In Time Count, which he and several other CalOptima employees participated in counting persons experiencing homelessness that were living on the streets in Orange County. Mr. Hunn said that they spoke to people who were living in cars, living behind buildings, and living in shelters, noting that it was an eye-opening experience. He added that the presumption is every single one of the people they talked to belongs to CalOptima and they need

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our help to get them the services they need.

Mr. Hunn also provided information on the upcoming vaccination clinics and vaccination rates for CalOptima members.

2. Medi-Cal Rx Update

Kris Gericke, Pharm. D., Pharmacy Director, provided an update on the Department of Health Care Services (DHCS) implementation of the Medi-Cal Pharmacy Carve Out (Medi-Cal Rx) transition. The Medi-Cal Rx program went into effect on January 1, 2022, and DHCS' selected Pharmacy Benefit Manager (PBM), Magellan Rx, is administering the new pharmacy program. Under the new program, Magellan Rx is responsible for the following activities: claims processing for all pharmacy services billed by pharmacies; Pharmacy Prior Authorizations (PAs); Pharmacy-related customer service and grievances for both beneficiaries and providers; and health plan coordination activities. These services were previously handled by the individual health plans.

Ms. Gericke noted that there have been significant issues with eligibility, prior authorizations, claims denials and grievance and appeals since the transition to Medi-Cal Rx. She said that Magellan Rx is working on solutions to improve performance, however, not quickly enough to mitigate the various problems. On February 8, 2022, CalOptima notified providers on how they can contact CalOptima Pharmacy Management directly for assistance with medication access issues and staff have been contacting providers, pharmacies, and/or the Magellan Rx liaison to help resolve issues. Ms. Gericke noted that since January 1, 2022, CalOptima Customer Service has received more than 1,700 member calls related to medication issues.

In addition to working with DHCS, providers, pharmacies, and members, CalOptima is collaborating with state trade associations, including the Local Health Plans of California and the California Association of Health Plans. CalOptima CEO Michael Hunn met with the California Health and Human Services Secretary, Dr. Mark Ghaly, to reiterate outstanding priority issues. Discussions continue with DHCS, Magellan, CalOptima and its provider partners to address ongoing concerns.

Chairman Do requested a regular update on the Medi-Cal Rx transition going forward given the issues CalOptima's members and providers are experiencing.

PUBLIC COMMENTS

- Hai Hoang from the Illumination Institute – Oral re: CalFresh Program and technical difficulties

CONSENT CALENDAR

3. Minutes

a. Approve Minutes of the February 3, 2022, Regular Meeting of the CalOptima Board of Directors
b. Receive and File Minutes of the November 18, 2021, Regular Meeting of the CalOptima Board of Directors' Finance and Audit Committee

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

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

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

7. Approve Modifications to Policy GA.5004: Travel Policy

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

9. Adopt Resolution No. 22-0303-01, Authorizing Remote Teleconference Meetings for the CalOptima Board of Directors and its Advisory Committees in Accordance with California Government Code section 54953, subdivision (e)

10. Ratify an Amendment to CalOptima's Primary Medi-Cal Agreement with the California Department of Health Care Services (DHCS) Related to Rate Changes

11. Authorize and Direct Execution of Amendment(s) to CalOptima's Primary Medi-Cal Agreement with the California Department of Health Care Services Related to Rate Changes

12. Ratify Amendments to CalOptima's Primary Agreement with the California Department of Health Care Services (DHCS) Related to the Calendar Year (CY) 2022 Risk Mitigation Contract Amendment, CY 2021 COVID Vaccine Incentive Program Contract Amendment and 2022 Community Supports Contract Amendment

13. Authorize an Amendment to Contract MS-21-22-41 with the California Department of Aging to Expand Member Slots in the Multipurpose Senior Services Program

14. Authorize Extending Contract with Health Management Associates for Consulting Services to Assist with Preparation and Remediation for the Department of Health Care Services (DHCS) Routine Medical Audit Scheduled for January 2022 and Authorize Expenditures from Existing Reserves for such Services

15. Approve Modifications to CalOptima Policy GG.1665 Telehealth and Other Technology-Enabled Services

16. Approve New CalOptima Policy GG.1666 PP Mobile Texting
This item was continued to a future meeting.

17. Approve CalOptima Policies GG.1105: Coverage of Organ and Tissue Transplants and GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization

18. Approve Proposed Changes to the CalOptima Medical Affairs Policies related CalAIM Enhanced Care Management and Community Supports

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

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Action: ***On motion of Director Becerra, seconded and carried, the Board of Directors approved Consent Calendar Items 3a through 19d, minus Item 16, as presented. (Motion carried 7-0-0; Supervisor Chaffee and Director Contratto absent)***

REPORTS/DISCUSSION ITEMS

20. Adopt Resolution Approving and Adopting Updated CalOptima Policy GA.8058: Salary Schedule; Authorize the Interim Chief Executive Officer to Implement Cost-of-Living Adjustments and Changes to Executive Level Job Titles, and Appropriation of Funds and Authorization of Unbudgeted Expenditures

Action: ***On motion of Director Corwin, seconded and carried, the Board of Directors: 1.) Adopted Resolution Approving Updated CalOptima Policy GA.8058: Salary Schedule and Attachment A – CalOptima Annual Base Salary Schedule (Attachment A); 2.) Authorized the Interim Chief Executive Officer (CEO) to implement six percent (6%) salary increases as cost-of-living adjustments (COLAs) for all employees; 3.) Authorized the Interim CEO to implement changes to the chief and executive director positions with one (1) net increase to the total number of executive level positions; and 4.) Appropriated funds and authorized unbudgeted expenditures in an amount up to $3.6 million from salary savings to fund COLAs and changes to executive level positions through June 30, 2022. (Motion carried 7-0-0; Supervisor Chaffee and Director Contratto absent)***

21. Authorize CalFresh Outreach Strategy to Enroll Eligible CalOptima Members into the CalFresh Program to Address Food Insecurity

Director Schoeffel did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote.

Action: ***On motion of Director Shivers, seconded and carried, the Board of Directors: 1.) Authorized implementation of a CalFresh Outreach Strategy to promote enrollment of identified CalOptima members who are potentially eligible and not yet enrolled in the CalFresh program; 2.) Authorized unbudgeted expenditures and appropriated up to $2,000,000 from existing reserves to implement the CalFresh Outreach Strategy; and 3.) Authorized the Chief Executive Officer (CEO) to execute agreements for expenditures as necessary to implement proposed activities. (Motion carried 6-0-0; Director Schoeffel, Supervisor Chaffee, and Director Contratto absent)***

Chairman Do noted that he will speak with the Social Services Agency (SSA) regarding some of the issues identified with regard to the CalFresh system. He also suggested that SSA, the County, CalOptima and others create a network in Orange County where members can receive assistance in

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completing the necessary paperwork to receive CalFresh benefits to which they are entitled but may have barriers to completing the enrollment.

22. Approve Amendment VIII to the Kaiser Foundation Health Plan Inc. Contract for Health Care Services, for the Medi-Cal COVID-19 Vaccination Incentive Program
Director Schoeffel did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote.

Action: ***On motion of Director Becerra, seconded and carried, the Board of Directors approved Amendment VIII to the Kaiser Foundation Health Plan Inc. (Kaiser) Health Maintenance Organization (HMO) Medi-Cal Contract for Health Care Services, to include language supporting the COVID-19 Vaccine Incentive Program and vaccination incentive payments, effective April 1, 2022. (Motion carried 6-0-0; Director Schoeffel, Supervisor Chaffee and Director Contratto absent)***

23. Authorize Contract with Moss Adams LLP for Independent Financial Auditing Services

Action: ***On motion of Vice Chair Corwin, seconded and carried, the Board of Directors authorized the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to enter into a contract with Moss Adams LLP for independent financial auditing services effective the contract execution date through March 3, 2025, with two one-year extension options. (Motion carried 6-0-0; Supervisor Chaffee, and Directors Contratto and Shivers absent)***

24. Authorizing Insurance Policy Procurements and Renewals for Policy Year 2022-23
Director Schoeffel did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote.

Action: ***On motion of Director Mayorga, seconded and carried, the Board of Directors authorized Procurement and Renewal of Insurance Policies for Policy Year (PY) 2022-23 at a premium cost not to exceed $4,250,000 (Motion carried 5-0-0; Director Schoeffel, Supervisor Chaffee, and Directors Contratto and Shivers absent)***

25. Authorize Formation of the CalOptima Foundation
Yunkyung Kim, Chief Operating Officer, introduced the item. Ms. Kim noted that the previous CalOptima Foundation was dissolved a few years ago and was primarily used for Regional Extension Center Grant. She added that with current changes in health care delivery and the CalAIM initiatives, staff believes this is a perfect time to take the administrative steps necessary to form the CalOptima Foundation, which would benefit our members, stakeholders, and the community.

Chairman Do raised the issue of behested payments and the need to ensure elected officials are correctly reporting any donations to the foundation to the Fair Political Practices Commission.

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Action: ***On motion of Director Schoeffel, seconded and carried, the Board of Directors approved Report items as presented. (Authorize the Chief Executive Officer, with the assistance of legal counsel, to take the administrative steps necessary to form the CalOptima Foundation as a private non-profit entity under section 501(c)(3) of the Internal Revenue Code. (Motion carried 7-0-0; Supervisor Chaffee and Director Contratto absent)***

Chairman Do noted that the Advisory Committee Updates would be heard after Closed Session as they were experiencing technical difficulties.

CLOSED SESSION
The Board adjourned to Closed Session at 3:19 p.m. Pursuant to Government Code section 54957(b)(1): PERFORMANCE REVIEW OF INTERIM CEO MICHAEL HUNN

The Board returned to open session at 3:56 p.m. The Clerk reestablished a quorum.

ROLL CALL

Members Present:	Supervisor Andrew Do, Chairman; Clayton Corwin, Vice Chair; Isabel Becerra, Clayton Chau, M.D. (non-voting); Jose Mayorga M.D.; Scott Schoeffel; Nancy Shivers, Tran Trieu, M.D. (All Board Member attendees participated in person except Supervisor Chaffee, Director Shivers who attended remotely.)
Members Absent:	Supervisor Doug Chaffee; Blair Contratto
Others Present:	Michael Hunn, Interim Chief Executive Officer; James Novello, Outside General Counsel, Kennaday Leavitt; Yunkyung Kim, Chief Operating Officer; Nancy Huang, Chief Financial Officer; Richard Pitts, D.O., Ph.D., Chief Medical Officer; Sharon Dwiers, Clerk of the Board

The Board then heard the Advisory Committee Update.

ADVISORY COMMITTEE UPDATES
26. Special Joint Meeting of the Member Advisory Committee and the Provider Advisory Committee Updates
Christine Tolbert provided an update on the Special Joint Meeting of the Member Advisory and the Provider Advisory Committees. She noted that recruitment for various Committee seats is underway.

Chairman Do asked the Clerk to read the recommended action from Closed Session into the record.

The Clerk read the following:

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Action: ***On motion of Director Becerra, seconded and carried, the Board of Directors Considered the Performance of Michael Hunn as CalOptima Interim CEO and Agrees to Appoint Michael Hunn to the Role of Permanent CalOptima CEO Effective Today, March 3, 2022. Mr. Hunn's Salary, Benefits, and Compensation will Remain the Same as Set Out in his Current Contract as Follows: Annual Salary of $560,000, $550 Monthly Car Allowance, 28 Days of Annual Paid Time Off, and Participate in all Employee Benefit Programs and Plans Established by CalOptima. Amendments or Changes to Michael Hunn's Current Contract will be Decided at a Future Meeting. The Contract will be for a Term of 3 Years. (Motion carried 7-0-0; Supervisor Chaffee and Director Contratto absent)***

Chairman Do announced that the Board has agreed to schedule a regular meeting on March 17, 2022, at 2:00 p.m.

ADJOURNMENT
Hearing no further business, Chairman Do adjourned the meeting at 4:03 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: April 7, 2022

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MINUTES
REGULAR MEETING
OF THE
CALOPTIMA BOARD OF DIRECTORS

March 17, 2022

A Regular Meeting of the CalOptima Board of Directors was held on March 17, 2022, at CalOptima, 505 City Parkway West, Orange, California. The meeting was held via teleconference (Zoom) in light of the COVID-19 public health emergency and Assembly Bill (AB) 361 (Chaptered September 16, 2021) which allows for temporary relaxation of certain Brown Act requirement related to teleconferenced meetings. Chairman Andrew Do called the meeting to order at 2:04 p.m. and Director Scott Schoeffel led the Pledge of Allegiance.

ROLL CALL

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

Members Absent: Trieu Tran, M.D.

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

PRESENTATIONS/INTRODUCTIONS

None

PUBLIC COMMENTS

There were no request for public comments.

Chairman Do reordered the agenda to hear Agenda Item 4 at the top of the meeting.

REPORTS/DISCUSSION ITEMS

4. Consider Approval of an Employment Agreement and Agreement Terms for the Chief Executive Officer

The Clerk noted for the record that a non-material addition to the agreement, page 3, section 3c as follows: "including but not limited to compensation adjustment as provided for in the 2018 Grant Thorton compensation study." This revision will also be reflected in the archived materials.

Action: ***On motion of Chairman Do, seconded and carried, the Board of Directors approved an Employment Agreement for the Chief Executive Officer. (Motion carried 8-0-0; Director Tran absent)***

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1. Resolution to Adopt New Mission and Vision Statement for CalOptima

The Clerk noted for the record that the most recent version of Policy AA.1201 will be included in the archived materials.

Michael Hunn, Chief Executive Officer, introduced the new Mission and Vision statement for CalOptima after providing some history on CalOptima, its creation, and growth over the years and the various lines of business. He then introduced the new proposed Mission:

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

Mr. Hunn then introduced the new proposed Vision:

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

Mr. Hunn detailed the reasons for the new Vision and noted that with the other actions on the agenda today for Board consideration, if approved, CalOptima will be able to achieve its new Vision by 2027.

Action: ***On motion of Chairman Do, seconded and carried, the Board of Directors: 1.) Adopted Resolution of an updated Mission and Vision Statement for CalOptima; and 2.) Directed the Chief Executive Officer to revise CalOptima Policy AA.1201 to reflect CalOptima's updated Mission and Vision Statement. (Motion carried 8-0-0; Director Tran absent)***

2. Authorize Digital Transformation and Workplace Modernization Strategy

Wael Younan, Chief Information Officer, introduced the item.

Director Contratto asked that Finance staff track and report use of reserves.

Chairman Do directed staff to provide a timetable on a quarterly basis to track the progress and costs for this new technical transformation.

Action: ***On motion of Director Becerra, seconded and carried, the Board of Directors: 1.) Authorized Digital Transformation and Workplace Modernization Strategy; 2.) Approved the Creation of a Restricted Digital Transformation and Workplace Modernization Reserve in the amount of $100 million from Existing Reserves; and 3.) Authorized Additional Staffing to Support the Digital Transformation Requirements. (Motion carried 8-0-0; Director Tran absent)***

3. Consider Approval of Actions Related to Homeless Health Care Initiative for Street Medicine

Mr. Hunn introduced the item and provided background on the spending to date on the Homeless Health Care initiatives.

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Action: ***On motion of Director Chaffee, seconded and carried, the Board of Directors: 1.) Directed the Chief Executive Officer, or Designees, to Commit $8 Million in Homeless Health Initiative Funding for Purposes of Street Medicine; and 2.) Directed the Chief Executive Officer, or Designees, to Develop a Scope of Work for the Street Medicine Request for Proposals and Return to the Board in May for Approval. (Motion carried 7-0-0: Directors Shivers and Tran absent)***

CLOSED SESSION
The Board adjourned to Closed Session at 3:28 p.m. Pursuant to Government Code section 54956.8 CONFERENCE WITH REAL PROPERTY NEGOTIATORS: Property: 500 City Parkway West, Orange, CA 92868, Agency Negotiators: David Kluth, Justin Hodgdon, and Mai Hu, Newmark Knight Frank, Negotiating Parties: CGGL CITY PARKWAY LLC, Under Negotiation: Price and Terms of Payment and Pursuant to Government Code section 54956.9(b) CONFERENCE WITH LEGAL COUNSEL – POTENTIAL LITIGATION

The Board returned to open session at 4:26 p.m. The Clerk reestablished a quorum.

ROLL CALL

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

Members Absent: Trieu Tran, M.D.

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

The Clerk read following recommended action for CS-1:

Action: ***On motion of Director Chaffee, seconded and carried, the Board of Directors: A.) Approved the Acquisition of Real Property Out of Existing Reserves for the Property Located at 500 City Parkway West, Orange, CA 92868; B.) Terms: a) Price: $22,850,000.00; b) Scheduled Closing: May 2022; C.) Purchase and Sale Agreement will be Available for Public Inspection upon Execution. (Motion carried 8-0-0; Director Tran absent)***

There was no reportable action taken on CS-2.

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BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

ADJOURNMENT
Hearing no further business, Chairman Do adjourned the meeting at 4:30 pm.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: April 7, 2022

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MINUTES

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

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

December 8, 2021

A Regular Meeting of the CalOptima Board of Directors' Quality Assurance Committee was held on December 8, 2021, at CalOptima, 505 City Parkway West, Orange, California and via teleconference (Go-to-Webinar) in light of the COVID-19 public health emergency and consistent with Governor Newsom's executive orders EO-N-25-20 and EO-N-29-20, which temporarily relax the teleconferencing provisions of the Brown Act.

Acting Chair Trieu Tran, called the meeting to order at 3:02 p.m. Clerk of the Board Sharon Dwiers led the Pledge of Allegiance.

MANAGEMENT REPORTS
None.

PUBLIC COMMENTS
There were no requests for public comment.

CALL TO ORDER

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

Members Absent: None.

Others Present: Michael Hunn, Interim Chief Executive Officer (absent); Gary Crockett, Chief Counsel, Yunkyung Kim, Chief Operating Officer; Emily Fonda, M.D., Chief Medical Officer; Marie Jeannis, Executive Director of Quality & Population Health Management, Sharon Dwiers, Clerk of the Board

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

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

REPORTS
2. Consider Recommending Board of Directors Authorize Extension of CalOptima's Coronavirus (COVID-19) Member Vaccination Incentive Program (VIP) for Calendar Year 2022

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Marie Jeannis, Executive Director, Quality & Population Health Management, introduced the item and provided an overview of the vaccine incentive program.

Action: ***On motion of Director Shivers, seconded and carried, the Committee recommended that the Board of Directors 1.) Extend 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. (Motion carried 2-0-0)***

3. Consider Recommending Board of Directors Approval of Proposed Changes to CalOptima Quality Improvement Policy GG.1608: Full Scope Site Reviews

Ms. Jeannis introduced the item and provided an overview of the proposed policy changes.

Action: ***On motion of Director Tran, seconded and carried, the Committee recommended that the Board of Directors Approve Proposed Changes to CalOptima Policy GG.1608: Full Scope Site Reviews (Motion carried 2-0-0)***

4. Consider Recommending Board of Directors Approval of the Calendar Years 2022 and 2023 Health Network Medi-Cal Pay for Value Performance Program

Kelly Rex-Kimmet, Director, Quality Analytics, introduced the item.

Action: ***On motion of Director Shivers, seconded and carried, the Committee recommended that the Board of Directors Approve the Calendar Years (CYs) 2022 and 2023 Health Network Medi-Cal Pay for Value Performance Program for the Measurement Period Effective January 1, 2022, through December 31, 2023. (Motion carried 2-0-0)***

5. Consider Recommending Board of Directors Approval of the Calendar Year 2022 Health Network OneCare Connect Pay for Value Program Payment Methodology

Ms. Rex-Kimmet introduced the item.

Action: ***On motion of Director Tran, seconded and carried, the Committee recommended that the Board of Directors Approve the Calendar Year (CY) 2022 Health Network OneCare Connect (OCC) Pay for Value (P4V) Performance Program for the Measurement Period Effective January 1, 2022, through December 31, 2022. (Motion carried 2-0-0)***

6. Consider Recommending that the Board of Directors Extend the Homeless Health Initiative Vaccination Intervention and Member Incentive Strategy for Calendar Year 2022

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Ms. Jeannis introduced the item.

Action: ***On motion of Director Shivers, seconded and carried, the Committee recommended that the Board of Directors: 1.) Extend CalOptima's Homeless Health Initiative Vaccination Incentive Strategy through Calendar Year 2022, and Authorize the Provision of Vaccine Incentives for Members who Receive Booster or Additional Doses of the Coronavirus Disease (COVID-19) Vaccine; and 2.) Authorize Use of the Previously Approved Allocation of Homeless Health Initiative Funds, Not to Exceed the Original Funding Level of $400,000, to Include Provision of a $25 Nonmonetary Gift Card (one gift card per shot) to Members Experiencing Homelessness who Receive a Booster or Additional Dose of the COVID-19 Vaccine.(Motion carried 2-0-0)***

INFORMATION ITEMS

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

Monica Macias, Director, PACE Program, provided an update on the PACE Member Advisory Committee activities. Ms. Macias noted that the PACE facility continues use the revised protocols in place since the pandemic and is closely monitoring the new Omicron variant.

The following items were accepted as presented.

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

COMMITTEE MEMBER COMMENTS

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

ADJOURNMENT

Hearing no further business, Acting Chair Tran adjourned the meeting at 3:29pm. The next Quality Assurance Committee meeting is scheduled for March 9, 2021.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: March 9, 2022

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 7, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

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

Contacts

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

Recommended Actions

Approve recommended modifications to the following existing Policies and Procedures, in accordance with CalOptima's regular review process and regulatory requirements:

1. Policy GG.1603: Medical Records Maintenance
2. Policy GG.1607: Monitoring Adverse Actions
3. Policy GG.1650: Credentialing and Recredentialing of Practitioners
4. Policy GG.1651: Assessment and Re-Assessment of Organizational Providers
5. Policy GG.1655: Reporting Provider Preventable Conditions (PPC)

Background/Discussion

CalOptima staff regularly reviews agency policies and procedures to ensure that they are up-to-date and aligned with Federal and State health care program requirements, contractual obligations, and laws, as well as CalOptima Operations.

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

Additionally, glossaries for all policies have been updated to add or clarify existing definitions for interpreter, provider, organizational provider, non-physician medical practitioner, appeal, grievance, member, continuity of care, and durable medical equipment, as applicable.

1. **Policy GG.1603: Medical Records Maintenance** defines the minimum standards for maintaining a Member's Medical Records.

Policy Section	Change
Page 3. Section III.C.4.ix	Clarified that refusal of free interpreter services and request to use family member, friends, or minor child must be documented in the member's medical records in alignment with All Plan Letter (APL) 21-004: Standards for Determining Threshold Language, Nondiscrimination Requirements, and Language Assistance Services

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2. **Policy GG.1607: Monitoring Adverse Actions** establishes a process for ongoing monitoring of the actions taken by external entities including, without limitation, licensing boards or agencies, regulatory agencies and/or other entities against CalOptima Practitioners or Organizational Providers.

Policy Section	Change
Page 2. Section II. B.8-15 Page 3. Section III. B.9-10	Updated policy to reflect current operational practices and detail all required Federal and State database checks in alignment with APL 19-004: Provider Credentialing Recredentialing and Screening Enrollment and Senate Bill (SB)857 and Welfare and Institution Code (W&I Code), Section 14044
Pages 16-52 Attachment A	Updated website links and added additional verification sites to Attachment A. Ongoing Monitoring Website Information Matrix

3. **Policy GG.1650: Credentialing and Recredentialing of Practitioners** defines the process by which CalOptima evaluates and determines whether to approve or decline practitioners for participation in CalOptima programs.

Policy Section	Change
Page 6. Section III.A.3. f.	Clarified Malpractice Insurance Limits for Behavioral Health Service providers
Page 7. Section III.A.3. r.	Clarified that active enrollment includes verification that Provider did not Opt-out of Medicare Program
Page 9. Section III.D.3.a. ii.	Clarified that clean file list are approved by a Medical Director
Pages 55-68. Attachment B	Added additional resources to Attachment B. CalOptima Primary Source Verification Table

4. **Policy GG.1651: Assessment and Re-Assessment of Organizational Providers** describes the process by which CalOptima evaluates and determines an OPs eligibility to participate in CalOptima Program.

Policy Section	Change
Page 3. Section III.A.2.b. xii-xiii	Updated to include additional accreditation bodies used to verify hospitals and dialysis centers
Page 3. Section III.A.2.f.	Clarified that active enrollment includes verification that Provider did not Opt-out of Medicare Program
Page 5. Section III.D.2.ii.	Clarified that clean file list are approved by a Medical Director

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5. **Policy GG.1655: Reporting Provider Preventable Conditions (PPC)** describes the method by which CalOptima reports PPC to the Department of Health Care Services (DHCS).

Policy Section	Change
Pages 1-2. Section II	Policy updated to include references to relevant plan letters and CalOptima policies; FF.2001: Claims Processing for Covered Services and HH.2022Δ: Record Retention and Access, for additional clarity

Fiscal Impact

The recommended action to modify policies GG.1603, GG.1607, GG.1650, GG.1651 and GG.1655 is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Fiscal Year 2021-22 Operating Budget.

Rationale for Recommendation

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

Concurrence

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

Attachments

1. Policy GG.1603: Medical Records Maintenance (Redlined and Clean)
2. GG.1603_APL 21-004_Threshold, Nondiscrimination, and Language Assistance
3. Policy GG.1607: Monitoring Adverse Actions (Redlined and Clean)
4. GG.1607_APL 19-004_Provider Credentialing Recredentialing and Screening enrollment
5. GG.1607_SB 857 and Welfare and Institutions Code (W&I Code), Section 14044
6. Policy GG.1650: Credentialing and Recredentialing of Practitioners (Redlined and Clean)
7. Policy GG.1651_Assessment and Re-Assessment of Organizational Providers_Final QAC Packet
8. Policy GG.1655_Reporting Provider Preventable Conditions (PPC)_QAC Final Packet

/s/ Michael Hunn *03/31/2022*
Authorized Signature **Date**

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Policy:	GG.1603
Title:	**Medical Records Maintenance**
Department:	Medical Management
Section:	Quality Improvement
CEO Approval:	*/s/*
Effective Date:	10/01/1995
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines the minimum standards for maintaining a Member's Medical Records.

II. POLICY

A. A Practitioner ~~and~~or Provider~~,~~ shall establish and maintain Medical Records for Members that meet at least the minimum standards for documentation of care as set forth in this Policy.

B. CalOptima shall monitor a Practitioner's compliance with the provisions of this Policy during a full scope site review, as described in CalOptima Policy GG.1608Δ: Full Scope Site Reviews.

C. CalOptima shall maintain confidentiality of Member medical information, in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), CalOptima's Privacy and HIPAA Security policies, and applicable state and federal laws.

D. A Practitioner or Provider shall provide a Member with access to his or her Medical Records, in accordance with CalOptima Policy GG.1618: Member Request for Medical Records.

III. PROCEDURE

A. Organization of Medical Records

1. Each Practitioner site shall designate an individual responsible for the Medical Record system by which the site collects, processes, maintains, stores, retrieves, identifies, and distributes clinical information.

2. Active records

a. A Practitioner shall label and file all active records in a defined system to facilitate the retrieval of the record on demand and shall file such records, as follows:

i. Alphabetically by last name, first, middle; or

ii. Numerically using a terminal digit, serial, or other uniquely assigned numbering system.

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b. A Practitioner shall store active records in a secured area, which may include a centralized record room, or decentralized areas within the Practitioner site, that protects records from loss, tampering, alteration, or destruction.

3. Inactive Records

a. A Practitioner shall retain inactive records:

i. For an adult and minor Members, for ten (10) years from the last date of service;

b. A Practitioner may store inactive records in electronic or hard copy format.

c. A Practitioner shall store inactive records in a secured location with restricted access that meets the same security requirements identified for active records, as set forth in Section III.A.2.b. of this Policy.

d. A Practitioner shall ensure that an inactive record is retrievable within five (5) working days after receipt of a request for such record.

B. Filing of Information

1. A Practitioner shall file all documents chronologically within the record, with the Member's name and the name of the Member's Primary Care Practitioner (PCP) on each document. A Practitioner may file serial reports (laboratory/x-rays) in a segregated manner, in chronological order. A Practitioner shall secure the documents in the folder to prevent loss.

2. All reports shall be filed in the Medical Record within forty-eight (48) hours after receipt, with physician signature and date of review, including, but not limited to, the following:

a. Laboratory reports;

b. X-ray reports;

c. Electroencephalograms (EEGs);

d. Echocardiograms (EKGs);

e. Consultation reports;

f. Hospital reports (admission/outpatient procedures); and

g. Emergency department reports.

C. Format and Content

1. An individual record shall be established for each Member and shall be updated during each visit or encounter.

2. The record shall be in a legible hand-written or a printed format.

3. The record shall reflect the findings of each visit or encounter, including, but not limited to:

a. Recording date of service;

b. Chief complaints;

c. Unresolved and/or continuing problems addressed in subsequent visit(s);

d. Tests or therapies ordered;

e. Treatment plan and diagnosis or medical impression;

f. Any physical, psychosocial, or educational needs identified during the encounter; and

g. Abnormal results.

4. The following data sets shall be included in each Medical Record:

a. Demographic information, including, but not limited to:

i. Name and address;

ii. Age and birth date;

iii. Sex;

iv. Telephone number;

v. Emergency contact person and nearest relative (phone numbers for each);

vi. Plan Identification;

vii. Medi-Cal Number, as applicable;

viii. Primary language and linguistic service needs of non-or limited-English proficient (LEP) or hearing/speech-impaired persons are prominently noted, as applicable;

ix. Requests for language and/or interpretation services by a non-or limited-English proficient ~~member~~Member are documented, as applicable. ~~Member~~Member's refusal of ~~interpreter~~free Interpreter services ~~may~~and their request to use family members, friends, or a in an emergency only, a minor child as an Interpreter shall be documented ~~at least once and be accepted throughout~~in the Member's ~~care, unless otherwise specified~~Medical Record; and

x. Person or entity providing medical interpretation is identified, as applicable for each encounter.

b. Clinically related data, including, but not limited to:

i. Record of diagnosis and treatment;

ii. Drug orders;

iii. Vital signs, including:

1) Height;

2) Weight (body mass index) (BMI);

3) Temperature;

4) Pulse and respirations;

5) Blood pressure if the Member is at least three (3) years of age; and

6) Signature/title of person performing these functions.

iv. Allergies and adverse reactions prominently noted (recorded on front of record or on standardized location within the record);

v. Problem(s) list, maintained with current updates;

vi. List of medications, maintained with current updates, including:

1) Name;

2) Strength;

3) Dosage; and

4) Frequency.

vii. Ancillary services;

viii. Medical and surgical histories, including relevant family history for:

1) Significant health problems;

2) Reactions to drugs; and

3) Personal habits (alcohol/drugs/diet).

ix. Physical examination, by body systems, with findings and treatment plan when medically indicated. The subjective, objective, assessment plan (SOAP) format may be used;

x. Records related to all hospitalizations, such as:

1) History and physical;

2) Discharge summary;

3) Operative reports; and

4) Pathology reports.

xi. Office laboratory, surgical, or invasive procedures, including anesthetics used and specimens collected for pathological examination;

xii. Emergency room encounter visit record reflecting:

1) Assessment;

~~1)~~2) Treatment;

~~2)~~3) Discharge instructions; and

~~3)~~4) Recommended follow-up.

xiii. Prescriptions.

c. Preventive Care

i. Patient education and referrals to health education services shall be documented, including information provided on periodic exams, stool guaiac, sigmoidoscopy, colonoscopy, pelvic/pap smear, mammogram, instructions on breast self-exam, nutrition, and accident prevention;

ii. Preventive care and health maintenance services rendered;

iii. Initial Health Assessment (IHA);

iv. Initial Individualized Health Education Behavioral Assessment (IHEBA);

v. Timely provision of immunizations in accordance with the most recent schedule and recommendations published by ACIP, regardless of Member's age, sex, or medical condition, including pregnancy; and

~~iv.~~vi. Complete record of immunizations. Immunizations shall be recorded with name, manufacturer, lot number, and expiration date, and Vaccine Information Statement (VIS) documentation.

~~v.~~vii. Evidence of member-specific immunization information reported to California Immunization Registry (CAIR).

d. Additional Medical Record components and consents:

i. Adults 18 years of age or older, documentation of whether the Member has been offered information or has executed an advance health care directive.

1) The Physician Orders for Life-Sustaining Treatment (POLST) form and Five Wishes are acceptable if appropriately completed and signed by necessary parties.

2) Advance Health Care Directive Information is reviewed with the member at least every five (5) years and as appropriate to the Member's circumstance.

ii. Signed copy of Notice of Privacy;

iii. Signed consents, as appropriate, such as, but not limited to: voluntary written consent prior to examination and treatment, forms for any invasive procedure, consent to release medical information.

iv. Authorization Request Forms (ARFs);

v. Referrals;

vi. Significant telephone advice, documented with date, time, and signature;

vii. For services provided through Telehealth, documentation of verbal or written consent from the Member for the use of Telehealth as an acceptable mode of delivering health care services;

viii. Consultation reports;

e. Authentication of Medical Record Entries

i. Medical Record entries shall be dated and signed by each staff person or Practitioner at each encounter.

ii. A signature shall consist of at least the first initial, last name, and title of the person making the entry.

D. Recall System for No-Show Members

1. A PCP shall have a system in place to identify, monitor, and follow-up on any Member who does not keep his or her appointment. The PCP shall use the following guidelines, at a minimum, in managing no-show Members.

2. The PCP shall document in the record:

a. All attempts to reach the Member.

b. Instructions given to the Member when contact is made advising the Member of the need to obtain medically necessary care, and the risks of not keeping appointment.

3. If the PCP cannot reach the Member by telephone, the PCP shall send a letter to the Member advising the Member of the need to obtain care and the risks of not getting treatment.

4. If a Member exhibits a habitual pattern of missing appointments, the PCP shall refer the Member to the Member's Health Network, or CalOptima Community Network, for assistance in managing the Member's non-compliance.

5. If a Member's non-compliance presents a severe threat to the Member's health, a case manager from the Member's Health Network (or CalOptima Community Network Member) shall attempt to contact the Member at home in person. If the case manager cannot locate the Member at the last known location, the PCP shall send a second (2nd) letter, by certified mail, indicating termination of all responsibility for that condition for which the Member is non-compliant.

6. The PCP shall file a copy of all communications in the Member's Medical Record.

E. Confidentiality of Records

1. All Member records and Member-related information shall be handled with strict confidentiality.

2. The Medical Records Department Manager or Office Manager shall be responsible for maintaining, monitoring, and enforcing staff compliance in keeping Member information confidential, and in the release of Member information when requested by the Member or under other conditions of release, in accordance with CalOptima Policy GG.1618: Member Request for Medical Records, CalOptima HIPAA privacy policies, and applicable state and federal laws.

3. Each new employee shall be advised of the importance of strict confidentiality, including being given a written copy of the confidentiality requirements. The employee shall be responsible for reading and affixing his or her signature to the statement indicating his or her understanding and willingness to abide by the requirements.

F. Monitoring and Evaluation

1. CalOptima shall evaluate the Practitioner's compliance with these guidelines through the full scope site review, as set forth in CalOptima Policy GG.1608Δ: Full Scope Site Reviews.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
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. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima Contract for Health Care Services
E. CalOptima Policy GG.1608Δ: Full Scope Site Reviews
F. CalOptima Policy GG.1618: Member Request for Medical Records
~~G. Department of Health Care Services (DHCS) Policy Letter (PL) 99-003: Cultural and Linguistics~~
~~H.~~G. Department of Health Care Services (DHCS) All Plan Letter (APL) 05-010: Advanced Directive Form
~~I.~~H. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-004: Immunization Requirements
~~J.~~I. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-009: Telehealth Services Policy
~~K.~~J. Department of Health Care Services (DHCS) All Plan Letter (APL) 20-006: Site Reviews: Facility Site Review and Medical Record Review
K. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-004: Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services
L. Title 22, California Code of Regulations (CCR), §75055
M. Title 28, California Code of Regulations (CCR), §§1300.67.1(c) and 1300.80(b)(4)
N. Title 42, United States Code, §1396a(w)
O. California Welfare & Institutions Code §14124.1
P. California Probate Code §§~~-~~4701 and 4780-4785
Q. California Business and Professions Code §2290.5
R. Title 42, Code of Federal Regulations (CFR) §§422.128 and 489.100
~~S. Standards for Determining Threshold Languages and Requirement For Section 1557 Of The Affordable Care Act (APL) 17-011~~

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
05/10/2010	Department of Health Care Services (DHCS)
03/19/2021	Department of Health Care Services (DHCS)
12/14/2021	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

Date	Meeting
03/04/2021	Regular Meeting of CalOptima Board of Directors
TBD	Regular Meeting of CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/01/1995	GG.1603	Medical Records Maintenance	Medi-Cal
Revised	05/01/1999	GG.1603	Medical Records Maintenance	Medi-Cal
Revised	11/01/1999	GG.1603	Medical Records Maintenance	Medi-Cal
Revised	05/01/2007	GG.1603	Medical Records Maintenance	Medi-Cal
Revised	01/01/2010	GG.1603	Medical Records Maintenance	Medi-Cal
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Revised	11/01/2017	GG.1603	Medical Records Maintenance	Medi-Cal OneCare OneCare Connect
Revised	03/01/2019	GG.1603	Medical Records Maintenance	Medi-Cal OneCare OneCare Connect
Revised	03/04/2021	GG.1603	Medical Records Maintenance	Medi-Cal OneCare OneCare Connect
Revised	TBD	GG.1603	Medical Records Maintenance	Medi-Cal OneCare OneCare Connect

IX. GLOSSARY

Term	Definition
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, and as subsequently amended.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that health network.
Individualized Health Education Behavioral Assessment (IHEBA)	An assessment designed to identify high-risk behaviors of a Member to assist a PCP in prioritizing the Member's individual health education needs related to lifestyle, behavior, environment and cultural linguistic background, and to document focused health education interventions, referrals and follow up.
Interpreter	A person who renders a message spoken in one language into one or more languages. An Interpreter must be qualified per requirements outlined in Welfare and Institutions Code, section 14029.91(a)(1)(B) and Title 45 Code of Federal Regulations, section 92.101(b)(3).
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 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.
Member	A beneficiary enrolled in a CalOptima program.
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing covered services.

Term	Definition
Primary Care Practitioner/Physician (PCP)	A Practitioner/Physician responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For Members who are Seniors or Persons with Disabilities or eligible for the Whole Child Model, "Primary Care Practitioner" or "PCP" shall additionally mean any Specialty Care Provider who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a Non-physician Medical Practitioner (NMP) (e.g., Nurse Practitioner [NP], Nurse Midwife, Physician Assistant [PA]) authorized to provide primary care services under supervision of a physician. For SPD or Whole Child Model beneficiaries, a PCP may also be a specialty care provider or clinic.
Provider	~~All contracted Providers including physicians, Non-physician Medical Practitioners, ancillary providers, and facilities or institutions who furnish covered services.~~Medi-Cal: A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, or other person or institution that furnishes Covered Services. OneCare: 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.
Telehealth	The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a Member's health care while the Member is at the originating site, and the health care provider is at a distant site. Telehealth facilitates Member self-management and caregiver support for Members and includes synchronous interactions and asynchronous store and forward transfers.

Policy:	GG.1603
Title:	**Medical Records Maintenance**
Department:	Medical Management
Section:	Quality Improvement
CEO Approval:	*/s/*
Effective Date:	10/01/1995
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines the minimum standards for maintaining a Member's Medical Records.

II. POLICY

A. A Practitioner or Provider shall establish and maintain Medical Records for Members that meet at least the minimum standards for documentation of care as set forth in this Policy.

B. CalOptima shall monitor a Practitioner's compliance with the provisions of this Policy during a full scope site review, as described in CalOptima Policy GG.1608Δ: Full Scope Site Reviews.

C. CalOptima shall maintain confidentiality of Member medical information, in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), CalOptima's Privacy and HIPAA Security policies, and applicable state and federal laws.

D. A Practitioner or Provider shall provide a Member with access to his or her Medical Records, in accordance with CalOptima Policy GG.1618: Member Request for Medical Records.

III. PROCEDURE

A. Organization of Medical Records

1. Each Practitioner site shall designate an individual responsible for the Medical Record system by which the site collects, processes, maintains, stores, retrieves, identifies, and distributes clinical information.

2. Active records

a. A Practitioner shall label and file all active records in a defined system to facilitate the retrieval of the record on demand and shall file such records, as follows:

i. Alphabetically by last name, first, middle; or

ii. Numerically using a terminal digit, serial, or other uniquely assigned numbering system.

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b. A Practitioner shall store active records in a secured area, which may include a centralized record room, or decentralized areas within the Practitioner site, that protects records from loss, tampering, alteration, or destruction.

3. Inactive Records

a. A Practitioner shall retain inactive records:

i. For an adult and minor Members, for ten (10) years from the last date of service;

b. A Practitioner may store inactive records in electronic or hard copy format.

c. A Practitioner shall store inactive records in a secured location with restricted access that meets the same security requirements identified for active records, as set forth in Section III.A.2.b. of this Policy.

d. A Practitioner shall ensure that an inactive record is retrievable within five (5) working days after receipt of a request for such record.

B. Filing of Information

1. A Practitioner shall file all documents chronologically within the record, with the Member's name and the name of the Member's Primary Care Practitioner (PCP) on each document. A Practitioner may file serial reports (laboratory/x-rays) in a segregated manner, in chronological order. A Practitioner shall secure the documents in the folder to prevent loss.

2. All reports shall be filed in the Medical Record within forty-eight (48) hours after receipt, with physician signature and date of review, including, but not limited to, the following:

a. Laboratory reports;

b. X-ray reports;

c. Electroencephalograms (EEGs);

d. Echocardiograms (EKGs);

e. Consultation reports;

f. Hospital reports (admission/outpatient procedures); and

g. Emergency department reports.

C. Format and Content

1. An individual record shall be established for each Member and shall be updated during each visit or encounter.

2. The record shall be in a legible hand-written or a printed format.

3. The record shall reflect the findings of each visit or encounter, including, but not limited to:

a. Recording date of service;

b. Chief complaints;

c. Unresolved and/or continuing problems addressed in subsequent visit(s);

d. Tests or therapies ordered;

e. Treatment plan and diagnosis or medical impression;

f. Any physical, psychosocial, or educational needs identified during the encounter; and

g. Abnormal results.

4. The following data sets shall be included in each Medical Record:

a. Demographic information, including, but not limited to:

i. Name and address;

ii. Age and birth date;

iii. Sex;

iv. Telephone number;

v. Emergency contact person and nearest relative (phone numbers for each);

vi. Plan Identification;

vii. Medi-Cal Number, as applicable;

viii. Primary language and linguistic service needs of non-or limited-English proficient (LEP) or hearing/speech-impaired persons are prominently noted, as applicable;

ix. Requests for language and/or interpretation services by a non-or limited-English proficient Member are documented, as applicable. Member's refusal of free Interpreter services and their request to use family members, friends, or a in an emergency only, a minor child as an Interpreter shall be documented in the Member's Medical Record; and

x. Person or entity providing medical interpretation is identified, as applicable for each encounter.

b. Clinically related data, including, but not limited to:

i. Record of diagnosis and treatment;

ii. Drug orders;

iii. Vital signs, including:

1) Height;

2) Weight (body mass index) (BMI);

3) Temperature;

4) Pulse and respirations;

5) Blood pressure if the Member is at least three (3) years of age; and

6) Signature/title of person performing these functions.

iv. Allergies and adverse reactions prominently noted (recorded on front of record or on standardized location within the record);

v. Problem(s) list, maintained with current updates;

vi. List of medications, maintained with current updates, including:

1) Name;

2) Strength;

3) Dosage; and

4) Frequency.

vii. Ancillary services;

viii. Medical and surgical histories, including relevant family history for:

1) Significant health problems;

2) Reactions to drugs; and

3) Personal habits (alcohol/drugs/diet).

ix. Physical examination, by body systems, with findings and treatment plan when medically indicated. The subjective, objective, assessment plan (SOAP) format may be used;

x. Records related to all hospitalizations, such as:

1) History and physical;

2) Discharge summary;

3) Operative reports; and

4) Pathology reports.

xi. Office laboratory, surgical, or invasive procedures, including anesthetics used and specimens collected for pathological examination;

xii. Emergency room encounter visit record reflecting:

1) Assessment;

2) Treatment;

3) Discharge instructions; and

4) Recommended follow-up.

xiii. Prescriptions.

c. Preventive Care

i. Patient education and referrals to health education services shall be documented, including information provided on periodic exams, stool guaiac, sigmoidoscopy, colonoscopy, pelvic/pap smear, mammogram, instructions on breast self-exam, nutrition, and accident prevention;

ii. Preventive care and health maintenance services rendered;

iii. Initial Health Assessment (IHA);

iv. Initial Individualized Health Education Behavioral Assessment (IHEBA);

v. Timely provision of immunizations in accordance with the most recent schedule and recommendations published by ACIP, regardless of Member's age, sex, or medical condition, including pregnancy; and

vi. Complete record of immunizations. Immunizations shall be recorded with name, manufacturer, lot number, and expiration date, and Vaccine Information Statement (VIS) documentation.

vii. Evidence of member-specific immunization information reported to California Immunization Registry (CAIR).

d. Additional Medical Record components and consents:

i. Adults 18 years of age or older, documentation of whether the Member has been offered information or has executed an advance health care directive.

1) The Physician Orders for Life-Sustaining Treatment (POLST) form and Five Wishes are acceptable if appropriately completed and signed by necessary parties.

2) Advance Health Care Directive Information is reviewed with the member at least every five (5) years and as appropriate to the Member's circumstance.

ii. Signed copy of Notice of Privacy;

iii. Signed consents, as appropriate, such as, but not limited to: voluntary written consent prior to examination and treatment, forms for any invasive procedure, consent to release medical information.

iv. Authorization Request Forms (ARFs);

v. Referrals;

vi. Significant telephone advice, documented with date, time, and signature;

vii. For services provided through Telehealth, documentation of verbal or written consent from the Member for the use of Telehealth as an acceptable mode of delivering health care services;

viii. Consultation reports;

e. Authentication of Medical Record Entries

i. Medical Record entries shall be dated and signed by each staff person or Practitioner at each encounter.

ii. A signature shall consist of at least the first initial, last name, and title of the person making the entry.

D. Recall System for No-Show Members

1. A PCP shall have a system in place to identify, monitor, and follow-up on any Member who does not keep his or her appointment. The PCP shall use the following guidelines, at a minimum, in managing no-show Members.

2. The PCP shall document in the record:

a. All attempts to reach the Member.

b. Instructions given to the Member when contact is made advising the Member of the need to obtain medically necessary care, and the risks of not keeping appointment.

3. If the PCP cannot reach the Member by telephone, the PCP shall send a letter to the Member advising the Member of the need to obtain care and the risks of not getting treatment.

4. If a Member exhibits a habitual pattern of missing appointments, the PCP shall refer the Member to the Member's Health Network, or CalOptima Community Network, for assistance in managing the Member's non-compliance.

5. If a Member's non-compliance presents a severe threat to the Member's health, a case manager from the Member's Health Network (or CalOptima Community Network Member) shall attempt to contact the Member at home in person. If the case manager cannot locate the Member at the last known location, the PCP shall send a second (2nd) letter, by certified mail, indicating termination of all responsibility for that condition for which the Member is non-compliant.

6. The PCP shall file a copy of all communications in the Member's Medical Record.

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3. Each new employee shall be advised of the importance of strict confidentiality, including being given a written copy of the confidentiality requirements. The employee shall be responsible for reading and affixing his or her signature to the statement indicating his or her understanding and willingness to abide by the requirements.

F. Monitoring and Evaluation

1. CalOptima shall evaluate the Practitioner's compliance with these guidelines through the full scope site review, as set forth in CalOptima Policy GG.1608Δ: Full Scope Site Reviews.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
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VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency

05/10/2010	Department of Health Care Services (DHCS)
03/19/2021	Department of Health Care Services (DHCS)
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VII. BOARD ACTION(S)

Date	Meeting
03/04/2021	Regular Meeting of CalOptima Board of Directors
TBD	Regular Meeting of CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/01/1995	GG.1603	Medical Records Maintenance	Medi-Cal
Revised	05/01/1999	GG.1603	Medical Records Maintenance	Medi-Cal
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IX. GLOSSARY

Term	Definition
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State of California—Health and Human Services Agency
Department of Health Care Services

WILL LIGHTBOURNE
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: April 8, 2021

ALL PLAN LETTER 21-004
SUPERSEDES ALL PLAN LETTER 17-011 AND
POLICY LETTERS 99-003 AND 99-004

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: STANDARDS FOR DETERMINING THRESHOLD LANGUAGES, NONDISCRIMINATION REQUIREMENTS, AND LANGUAGE ASSISTANCE SERVICES

PURPOSE:
This All Plan Letter (APL) serves to inform all Medi-Cal managed care health plans (MCPs) of the dataset for threshold and concentration languages and clarifies the threshold and concentration standards specified in state and federal law and MCP contracts. This dataset identifies the threshold and concentration languages in which, at a minimum, MCPs must provide written translated member information.

This APL also provides guidance on federal and state requirements regarding nondiscrimination, discrimination grievance procedures, language assistance, and communications with individuals with disabilities as set forth in the federal regulations implementing Section 1557 of the Patient Protection and Affordable Care Act (ACA),[1] Title 42 of the Code of Federal Regulations (CFR) Part 438,[2] Senate Bill (SB) 223 (Atkins, Chapter 771, Statutes of 2017),[3] and SB 1423 (Hernandez, Chapter 568, Statutes of 2018).[4]

BACKGROUND:

DHCS Threshold and Concentration Standard Languages
Federal law[5] requires the Department of Health Care Services (DHCS) to establish a methodology for identifying the prevalent non-English languages spoken by eligible beneficiaries throughout the state, and in each MCP's service area, for the purpose of

[1] 45 CFR, Part 92 is available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=5294f5df71aa8d51bd6be5f16bb9aab2&mc=true&node=pt45.1.92&rgn=div5#_top
[2] 42 CFR, Part 438 is available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=9a6ca82b62335f91daacca12e91a0c5c&mc=true&node=pt42.4.438&rgn=div5
[3] SB 223 is available at: http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201720180SB223
[4] SB 1423 is available at: https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201720180SB1423
[5] 42 CFR 438.10(d)(1)

requiring MCPs to provide written translations of member information in these languages.[6] State law[7] requires DHCS to identify these languages by calculating whether individuals who speak a non-English language meet certain numeric thresholds, or are geographically concentrated in certain ZIP codes. Pursuant to these laws, DHCS determines the languages in which, at a minimum, MCPs must provide translated written member information. DHCS refers to these languages as the threshold and concentration standard languages.

Nondiscrimination, Language Assistance, and Effective Communication for Individuals with Disabilities

Section 1557 (Title 42 of the United States Code (USC), Section 18116)[8] is the nondiscrimination provision of the ACA, which prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities. Section 1557 builds on the following long-standing federal civil rights laws and incorporates all of the existing nondiscrimination requirements of those laws: Title VI of the Civil Rights Act of 1964 (Title VI), Title IX of the Education Amendments of 1972 (Title IX), Section 504 of the Rehabilitation Act of 1973 (Section 504), and the Age Discrimination Act of 1975 (Age Act). Section 1557 requires covered programs to ensure effective communication with individuals with disabilities and provide meaningful access to individuals with limited English proficiency (LEP) who are eligible to be served, or likely to be encountered, in health programs and activities.[9] Covered programs include any health program or activity, any part of which receives federal financial assistance from the United States Department of Health and Human Services (HHS); any program or activity administered by HHS under Title I of the ACA; or any program or activity administered by any entity established under such Title. These requirements apply to MCPs' Medi-Cal lines of business.

HHS Office for Civil Rights (OCR) implemented Section 1557 through federal regulations set forth in Part 92 of Title 45 of the CFR in May of 2016. The 2016 version of these regulations included a requirement that covered health programs include a nondiscrimination notice and language taglines in non-English languages advising of the availability of free language assistance services in certain communications and publications. On June 19, 2020, HHS OCR published revised regulations eliminating these specific requirements and replacing them with a four-factor analysis that a covered program must engage in to determine the level of language assistance required under federal law.[10]

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[6] 42 CFR 438.10(d)(2)-(3)
[7] Welfare and Institutions Code (WIC), Section 14029.91 is available at: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=14029.91.
[8] The USC is searchable at: http://uscode.house.gov/
[9] See, e.g., 45 CFR 92.101 and 92.102 (HHS regulations issued pursuant to Section 1557).
[10] 45 CFR 92.101

Although the specific federal requirements relating to nondiscrimination notices and language taglines in Part 92 of Title 45 of the CFR have been repealed, MCPs must continue to provide nondiscrimination notices and language taglines under the four-factor analysis and state law, consistent with APL 20-015: State Nondiscrimination and Language Assistance Requirements[11] and this APL. In addition, 42 CFR Part 438 contains complementary language assistance requirements specific to MCPs, such as the requirement to provide taglines in the prevalent non-English languages in the state, in a conspicuously visible font size, explaining the availability of written translation or oral interpretation services and how to request auxiliary aids and services for people with disabilities.[12]

MCPs are also subject to federal requirements contained in the Americans with Disabilities Act (ADA), including standards for communicating effectively with people with disabilities to ensure they benefit equally from government programs.[13] Additional communication-related regulations are set forth in Title 42 CFR section 438.10.

In California, SB 223 and SB 1423 codified into state law certain nondiscrimination and language assistance service requirements specific to DHCS[14] and MCPs.[15] SB 223 and SB 1423 also incorporated additional characteristics protected under state nondiscrimination law, including gender, gender identity, marital status, ancestry, religion, and sexual orientation.[16]

POLICY:

DHCS Threshold and Concentration Language Requirements

Member information[17] is essential information regarding access to and usage of MCP services. MCPs are required to provide translated written member information, using a

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[11] APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx
[12] 42 CFR 438.10(d)(2)-(3).
[13] ADA Title II Regulations are available at: https://www.ada.gov/regs2010/titleII_2010/titleII_2010_regulations.htm.
[14] WIC 14029.92, which is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14029.92.&lawCode=WIC
[15] WIC 14029.91
[16] WIC 14029.92 and 14029.91. For additional state-law-protected characteristics, see Government Code (GOV), section 11135, which is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=11135.&lawCode=GOV
[17] Member information includes documents that are vital or critical to obtaining services and/or benefits and includes, but is not limited to, the Member Handbook/Evidence of Coverage; provider directory; welcome packets; marketing information; form letters, including Notice of Action letters and any notices related to Grievances, actions, and Appeals, including Grievance and Appeal acknowledgement and resolution letters; plan generated preventive health

qualified translator (see requirements for qualified translators in the section on Written Translation below), to the following language groups within their service areas, as determined by DHCS:

- A population group of eligible beneficiaries[18] residing in the MCP's service area who indicate their primary language as a language other than English, and that meet a numeric threshold of 3,000 or five-percent (5%) of the eligible beneficiary population, whichever is lower (Threshold Standard Language); and
- A population group of eligible beneficiaries residing in the MCP's service area who indicate their primary language as a language other than English and who meet the concentration standards of 1,000 in a single ZIP code or 1,500 in two contiguous ZIP codes (Concentration Standard Language).

The updated dataset attached to this APL delineates the required threshold and concentration languages, as determined by DHCS, for the above-mentioned groups within each MCP's service area(s). DHCS updates this dataset at least once every three fiscal years to address potential changes to both numeric threshold and concentration standard languages as well as to reflect changes necessitated by state and federal law. DHCS is providing an updated dataset with this APL iteration and MCPs must comply with the update within 180 days of the publication of this APL.

Nondiscrimination, Language Assistance, and Effective Communication for Individuals with Disabilities

MCPs must comply with all of the nondiscrimination requirements set forth under federal and state law and this APL. This includes the posting of the nondiscrimination notice in member information and all other informational notices, and the provision of the required taglines that inform LEP individuals of the availability of free language assistance services and auxiliary aids and services for people with disabilities.

DHCS has updated its template of the nondiscrimination notice to conform with state law, including SB 223 and SB 1423, and the requirements in this APL, as well as to include contact information for members to file a discrimination grievance directly with

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reminders (e.g., appointments and immunization reminders, initial health examination notices and prenatal follow-up); member surveys; notices advising LEP persons of free language assistance; and newsletters. Examples of Member Information can also be found in APL 18-016: Readability and Suitability of Written Health Education Materials, which is available at the following link: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx#2011.

[18] "Eligible beneficiary" is defined in the MCP contract as any Medi-Cal beneficiary who is residing in the MCP's service area with one of the covered aid codes. Note: threshold language calculations include all Medi-Cal beneficiaries who are "eligible" to enroll, either mandatorily or by choice, in the MCP in the county and are not based on actual MCP enrollment.

the DHCS OCR. DHCS has also updated its taglines template to conform to changes in federal law and to include additional languages to maintain consistency in translation with Medi-Cal fee-for-service (FFS). DHCS does not require MCPs to use the DHCS-provided template language verbatim as long as all notices and associated taglines are compliant with federal and state law and the requirements contained in this APL. All MCP nondiscrimination notices must include information about how to file a discrimination grievance directly with DHCS OCR, in addition to information about how to file a discrimination grievance with the MCP and HHS OCR (i.e., file a grievance with HHS OCR if there is a concern of discrimination based on race, color, national origin, age, disability, or sex).

MCPs must immediately, but in no event later than 180 days following the publication of this APL iteration, update their nondiscrimination notices and taglines to align with the templates language provided with this APL. MCPs must submit these deliverables to DHCS for review and approval prior to use.[19]

MCPs are required to make the nondiscrimination notice available, upon request or as otherwise required by law, in the threshold and concentration languages,[20] or in an ADA-compliant, accessible format.[21]

Nondiscrimination Notice
MCPs must post a nondiscrimination notice (see the attached DHCS template for the nondiscrimination notice) that informs members, potential enrollees,[22] and the public about nondiscrimination, protected characteristics, and accessibility requirements, and conveys the MCP's compliance with the requirements. MCPs are not prohibited from using a more inclusive list of protected characteristics than those included in the DHCS-provided template, as long as all protected characteristics listed in the DHCS-provided template are included.

The nondiscrimination notice must be posted in at least a 12-point font[23] and be included in the Member Handbook/Evidence of Coverage, member information, and all other informational notices targeted to members, potential enrollees, and the public.[24]

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[19] The DHCS templates for the nondiscrimination notice and taglines are provided as attachments to this APL.
[20] WIC 14029.91(a)(2)
[21] 45 CFR 92.202
[22] "Potential enrollee" is defined in the MCP contract as a Medi-Cal recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an enrollee of a specific plan.
[23] Per 42 CFR 438.10, the font size must be no smaller than 12-point font.
[24] WIC 14029.91(f)

Informational notices include not only documents intended for the public, such as outreach, education, and marketing materials, but also written notices requiring a response from an individual and written notices to an individual such as those pertaining to rights or benefits. Additionally, the nondiscrimination notice must be posted in at least a 12-point font in conspicuous physical locations where the MCP interacts with the public,[25] as well as on the MCP's website in a location that allows any visitor to the website to easily locate the information.[26] The nondiscrimination notice must include all legally-required elements,[27] as well as information on how to file a discrimination grievance directly with DHCS OCR, in addition to information about how to file a discrimination grievance with the MCP and HHS OCR, as provided in the DHCS nondiscrimination notice template.

MCPs are not prohibited from posting the nondiscrimination notice in additional publications and communications.

Discrimination Grievances
MCPs must designate a discrimination grievance coordinator who is responsible for ensuring compliance with federal and state nondiscrimination requirements. The MCP's discrimination grievance coordinator must investigate grievances alleging any action that would be prohibited by, or out of compliance with, federal or state nondiscrimination laws.[28] MCPs must also adopt grievance procedures that provide for the prompt and equitable resolution of discrimination-related grievances.[29] MCP discrimination grievance procedures must follow the requirements outlined in sections III (A) – (C) of APL 17-006, Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments, or any superseding APL, including timely acknowledgment and resolution of discrimination grievances. Members are not required to file a discrimination grievance with the MCP before filing a discrimination grievance directly with DHCS OCR or the HHS OCR.[30]

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[25] The physical notice must be in a conspicuous location and easily readable by a member of the public (for example, in a patient waiting area), not behind private office doors.
[26] WIC 14029.91(f)
[27] WIC 14029.91(e)(1)-(5); GOV 11135
[28] WIC 14029.91(e)(4); 45 CFR 84.7; 34 CFR 106.8; 28 CFR 35.107; California's Medicaid State Plan, Section 7, Attachments 7.2-A and 7.2-B. See also Gov. Code 11135.
[29] See, e.g., 45 CFR 84.7; 34 CFR 106.8; 28 CFR 35.107.
[30] WIC 14029.91(e)(4)-(5)

The MCP's discrimination grievance coordinator must be available to:

1. Answer questions and provide appropriate assistance to MCP staff and members regarding the MCP's state and federal nondiscrimination legal obligations.
2. Advise the MCP about nondiscrimination best practices and accommodating persons with disabilities.
3. Investigate and process any ADA, section 504, section 1557, and/or Government Code section 11135 grievances received by the MCP.

MCPs must ensure that all discrimination grievances are investigated by the MCP's designated discrimination grievance coordinator.[31] MCPs are prohibited from using a medical peer review body to investigate and resolve discrimination grievances. MCPs must not claim that a discrimination grievance investigation or resolution is confidential under Evidence Code section 1157 and/or Business and Professions Code section 805. Concurrent or subsequent referral of a discrimination grievance to a peer review body for provider disciplinary or credentialing purposes may be appropriate if quality of care issues are implicated, or if required by the MCP contract.

The MCP contract requires MCPs to forward copies of all member grievances alleging discrimination on the basis of any characteristic protected by federal or state nondiscrimination law to DHCS. This includes, without limitation, sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, creed, health status, or identification with any other persons or groups defined in Penal Code section 422.56. This requirement includes language access complaints and complaints alleging failure to make reasonable accommodations under the ADA.

Within ten calendar days of mailing a discrimination grievance resolution letter to a member, MCPs must submit detailed information regarding the grievance to DHCS OCR's designated discrimination grievance email box. MCPs must submit the following information in a secure format to DHCS.DiscriminationGrievances@dhcs.ca.gov:

1. The original complaint;
2. The provider's or other accused party's response to the grievance;
3. Contact information for the MCP personnel responsible for the MCP's investigation and response to the grievance;
4. Contact information for the member filing the grievance and for the provider or other accused party that is the subject of the grievance;

[31] See, e.g., 45 CFR 84.7; 34 CFR 106.8; 28 CFR 35.107.

5. All correspondence with the member regarding the grievance, including the grievance acknowledgment and grievance resolution letter(s) sent to the member; and
6. The results of the MCP's investigation, copies of any corrective action taken, and any other information that is relevant to the allegation of discrimination.

Language Assistance Taglines
DHCS determined the tagline requirements in this APL based on a combination of federal and state law and DHCS policy. MCPs are required to post taglines in a conspicuously visible font size (no less than 12-point font), in English and the top California languages as identified below in this APL and in the DHCS provided taglines template that is attached to this APL.[32] These taglines inform members, potential enrollees, and the public of the availability of no-cost language assistance services, including assistance in non-English languages and the provision of free auxiliary aids and services for people with disabilities.[33]

Like the nondiscrimination notice, these taglines must be posted in the Member Handbook/Evidence of Coverage, conspicuous physical locations where the MCP interacts with the public, on the MCP's website in a location that allows any visitor to the website to easily locate the information, and in all member information and other informational notices, in accordance with federal and state law and this APL.[34]

MCPs are not prohibited from including taglines in languages that exceed those identified for California in this APL.

In 2016, HHS OCR released a Frequently Asked Questions (FAQ) document and included as a resource a table displaying its list of the top 15 languages spoken by individuals with LEP in each state, the District of Columbia, Puerto Rico and each U.S. Territory. HHS OCR created this list for use in identifying languages in which to provide translated taglines. The top 15 non-English languages spoken by LEP individuals in California, as identified by HHS OCR in 2016, are Arabic, Armenian, Cambodian, Chinese, Farsi, Hindi, Hmong, Japanese, Korean, Punjabi, Russian, Spanish, Tagalog,

[32] WIC 14029.91(a)(3) requires that these taglines be provided in at least the top 15 languages spoken by LEP individuals in the state; however, DHCS requires MCPs to provide these taglines in English, the top 15 non-English languages spoken by LEP individuals in the state, and Laotian, Ukrainian, and Mien.
[33] 42 CFR 438.10(d)(2)-(3)
[34] WIC 14029.91(f)

Thai, and Vietnamese.[35] Although state law only requires that taglines be provided in the top 15 non-English languages in California, DHCS made a policy decision to align the MCP required tagline languages with those used in Medi-Cal FFS for consistency between programs. As a result, in addition to the top 15 non-English languages spoken by LEP individuals in California, as identified by HHS OCR in 2016, MCPs must also provide taglines in Laotian, Ukrainian and Mien (i.e.; English and 18 non-English languages).

Language Assistance Services
Language assistance services must be provided free of charge, be accurate and timely, and protect the privacy and independence of the LEP individual. There are two primary types of language assistance services: oral and written. LEP individuals are not required to accept language assistance services, although a qualified interpreter may be used to assist in communicating with an LEP individual who has refused language assistance services.[36]

Oral Interpretation
MCPs must provide oral interpretation services from a qualified interpreter (see qualifications below), on a 24-hour basis, at all key points of contact,[37] at no cost to members.[38] Oral interpretation must be provided in all languages and is not limited to threshold or concentration standard languages.

Interpretation can take place in-person, through a telephonic interpreter, or via internet or video remote interpreting (VRI) services. However, MCPs are prohibited from using remote audio or VRI services that do not comply with federal quality standards,[39] or relying on unqualified bilingual/multilingual staff, interpreters, or translators. MCPs should not solely rely on telephone language lines for interpreter services. Rather, telephonic interpreter services should supplement face-to-face interpreter services, which are a more effective means of communication.

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[35] For more information about the HHS OCR language table and the data used, please refer to the HHS OCR FAQ. The FAQ can be accessed at: https://www.hhs.gov/civil-rights/for-individuals/section-1557/1557faqs/top15-languages/index.html. The language table can be accessed at: https://www.hhs.gov/sites/default/files/resources-for-covered-entities-top-15-languages-list.pdf.
[36] See 45 CFR 92.101(c)
[37] Per the MCP contract, key points of contact include medical care settings (e.g., telephone, advice and urgent care transactions, and outpatient encounters with health care providers, including pharmacists) and non-medical care settings (e.g., member services, orientations, and appointment scheduling).
[38] WIC 14029.91(a) and 42 CFR 438.10(d)(2) and (d)(4)
[39] See 45 CFR 92.101(b)(3)(iii); 45 CFR 92.102; 28 CFR 35.160(d); and 28 CFR 36.303(f).

An interpreter is a ˛erson who renders a messa˛e spoken in one lan˛ua˛e into one or more lan˛ua˛es. An interpreter must be qualified and have knowledge in both lan˛ua˛es of the relevant terms or concepts particular to the program or activity and the dialect spoken by the LEP individual. In order to be considered a qualified interpreter for an LEP individual, the interpreter must: 1) have demonstrated proficiency in speaking and understanding both English and the language spoken by the LEP individual; 2) be able to interpret effectively, accurately, and impartially, both receptively and expressly, to and from the language spoken by the LEP individual and English, using any necessary specialized vocabulary, terminology, and phraseology; and 3) adhere to generally accepted interpreter ethics principles, including client confidentiality.[40]

MCPs that provide a qualified interpreter for an individual with LEP through remote audio interpreting services must provide real-time audio over a dedicated high-speed, wide-bandwidth video connection or wireless connection that delivers high-quality audio without lags or irregular pauses in communication; a clear, audible transmission of voices; and adequate training to users of the technology and other involved individuals so that they may quickly and efficiently set up and operate the remote interpreting services.[41]

MCPs are prohibited from requiring LEP individuals to provide their own interpreters, or from relying on bilingual/multilingual staff members who do not meet the qualifications of a qualified interpreter.[42] Some bilingual/multilingual staff may be able to communicate effectively in a non-English language when communicating information directly in that language, but may not be competent to interpret in and out of English. Bilingual/multilingual staff may be used to communicate directly with LEP individuals only when they have demonstrated to the MCP that they meet all of the qualifications of a qualified interpreter listed above.[43]

Further, the use of family members, friends, and particularly minor children as interpreters may compromise communications with LEP individuals. LEP individuals may be reluctant to reveal personal and confidential information in front of these individuals. In addition, family members, friends, and minor children may not be trained in interpretation skills and may lack familiarity with specialized terminology. As a result, use of such persons could result in inaccurate or incomplete communications, a breach of the LEP individual's confidentiality, or reluctance on the part of the LEP individual to reveal critical information. MCPs are prohibited from relying on an adult or minor child

[40] WIC 14029.91(a) and 45 CFR 92.101(b)(3)
[41] 45 CFR 92.101(b)(3)(iii)
[42] WIC 14029.91(a)(1)(C) and CFR 92.101(b)(4)
[43] WIC 14029.91(a)(1)(C)

accompanying an LEP individual to interpret or facilitate communication except when: 1) there is an emergency involving an imminent threat to the safety or welfare of the individual or the public and a qualified interpreter is not immediately available; or, 2) the LEP individual specifically requests that an accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide that assistance, and reliance on that accompanying adult for that assistance is appropriate under the circumstances.[44] Prior to using a family member, friend or, in an emergency only, a minor child as an interpreter for an LEP individual, MCPs must first inform the individual that they have the right to free interpreter services and second, ensure that the use of such an interpreter will not compromise the effectiveness of services or violate the LEP individual's confidentiality. MCPs must also ensure that the LEP individual's refusal of free interpreter services and their request to use family members, friends, or a minor child as an interpreter is documented in the medical record.

Written Translation

Translation is the replacement of written text from one language into another. MCPs must use a qualified translator when translating written content in paper or electronic form.[45] A qualified translator is a translator who: 1) adheres to generally accepted translator ethics principles, including client confidentiality; 2) has demonstrated proficiency in writing and understanding both written English and the written non-English language(s) in need of translation; and, 3) is able to translate effectively, accurately, and impartially to and from such language(s) and English, using any necessary specialized vocabulary, terminology, and phraseology.[46] At a minimum, MCPs must provide written translations of member information in the threshold and concentration languages identified in this APL in the DHCS Threshold and Concentration Language Requirements section. In that same section of this APL, DHCS has also provided an explanation of the information that is considered "member information" for purposes of this requirement.

Effective Communication with Individuals with Disabilities

MCPs must comply with all applicable requirements of federal and state disability law.[47] MCPs are required to take appropriate steps to ensure effective communication with individuals with disabilities.[48] MCPs must provide appropriate auxiliary aids and services

[44] WIC 14029.91(a)(1)(D) and 45 CFR 92.101(b)(4)
[45] 45 CFR 92.101(b)(3)(ii)
[46] 45 CFR 92.101(b)(3)(ii)
[47] Without limitation, MCPs must comply with Section 1557 of the ACA, Title II of the ADA, Section 504 of the Rehabilitation Act, and GOV 11135.
[48] 45 CFR 92.102(a); 28 CFR 35.160-35.164

to persons with impaired sensory, manual, or speaking skills,[49] including the provision of qualified interpreters and written materials in alternative formats, free of charge and in a timely manner, when such aids and services are necessary to ensure that individuals with disabilities have an equal opportunity to participate in, or enjoy the benefits of, the MCP's services, programs, and activities.[50] Without limitation, MCPs must provide interpretive services and make member information available in the following alternative formats: Braille, audio format, large print (no less than 20 point font), and accessible electronic format (such as a data CD). In determining what types of auxiliary aids and services are necessary, MCPs must give "primary consideration" to the individual's request of a particular auxiliary aid or service.[51] DHCS' expectation is that MCPs collect and store members' alternative format selections. DHCS is currently working on finalizing the necessary data elements that will be required for regular reporting of this information to DHCS. At this time, we are requesting that MCPs begin tracking and recording the Beneficiary Client Index Number, name, date of request, and requested alternative format. DHCS will provide further guidance on the process for submitting the alternative format data in the near future. DHCS is also working on a process that will allow DHCS to share information with the MCPs that the department collects as well.

Auxiliary aids and services include:

- Qualified interpreters on-site or through VRI services; note takers; real-time computer-aided transcription services; written materials; exchange of written notes; telephone handset amplifiers; assistive listening devices; assistive listening systems; telephones compatible with hearing aids; closed caption decoders; open and closed captioning, including real-time captioning; voice, text, and video-based telecommunication products and systems, text telephones (TTYs), videophones, captioned telephones, or equally effective telecommunications devices; videotext displays; accessible information and communication technology; or other effective methods of making aurally delivered information available to individuals who are deaf or hard of hearing.
- Qualified readers; taped texts; audio recordings; Braille materials and displays; screen reader software; magnification software; optical readers; secondary auditory programs; large print materials (no less than 20 point font); accessible information and communication technology; or other effective methods of making visually delivered materials available to individuals who are blind or have low vision.[52]

[49] 45 CFR 92.102(b)
[50] 28 CFR 35.160; 45 CFR 92.102
[51] 28 CFR 35.160
[52] 45 CFR 92.102(b)(1)

When providing interpretive services, MCPs must use qualified interpreters to interpret for an individual with a disability, whether through a remote interpreting service or an on-site appearance. A qualified interpreter for an individual with a disability is an interpreter who: 1) adheres to generally accepted interpreter ethics principals, including client confidentiality; and 2) is able to interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary, terminology, and phraseology.[53] For an individual with a disability, qualified interpreters can include, for example, sign language interpreters, oral transliterators (individuals who represent or spell in the characters of another alphabet), and cued language transliterators (individuals who represent or spell by using a small number of handshapes).

MCPs that provide a qualified interpreter for an individual with a disability through VRI services must provide real-time, full-motion video and audio over a dedicated high-speed, wide-bandwidth video connection or wireless connection that delivers high-quality video images that do not produce lags, choppy, blurry, or grainy images, or irregular pauses in communication; a sharply delineated image that is large enough to display the interpreter's face, arms, hands, and fingers, and the participating individual's face, arms, hands, and fingers, regardless of body position; a clear, audible transmission of voices; and adequate training to users of the technology and other involved individuals so that they may quickly and efficiently set up and operate the VRI.[54]

MCPs must not require an individual with a disability to provide their own interpreter. Moreover, MCPs are prohibited from relying on an adult or minor child accompanying an individual with a disability to interpret or facilitate communication except when: 1) there is an emergency involving an imminent threat to the safety or welfare of the individual or the public and a qualified interpreter is not immediately available; or, 2) the individual with a disability specifically requests that an accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide that assistance, and reliance on that accompanying adult for that assistance is appropriate under the circumstances.[55] Prior to using a family member, friend, or, in an emergency only, a minor child as an interpreter for an individual with a disability, MCPs must first inform the individual that they have the right to free interpreter services and second, ensure that the use of such an interpreter will not compromise the effectiveness of services or violate the individual’s confidentiality. MCPs must also ensure that the refusal of free interpreter services and the individual's request to use a family member, friend, or a minor child as an interpreter is documented in the medical record.

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[53] 45 CFR 92.102(b)(2)
[54] 28 CFR 35.160(d); 28 CFR 36.303(f); 45 CFR 92.102
[55] 28 CFR 35.160(c) 28 CFR 36.303(c)

In addition to requiring effective communication with individuals with disabilities, HHS OCR regulations pursuant to Section 1557 incorporate other long-standing requirements of federal law prohibiting discrimination based on disability.[56] MCPs are reminded that they must make reasonable modifications to policies, practices, or procedures when such modifications are necessary to avoid discrimination based on disability. This could include, for example, assisting a member who cannot write to fill out required forms, even when such assistance is not generally provided to members without a disability.

Policies and Procedures

Within 180 days of the release of this APL, MCPs must submit policies and procedures demonstrating their compliance with the ADA, Section 504 of the Rehabilitation Act, Section 1557, including the implementing federal regulations, SB 223/SB 1423, and GOV 11135, and must update and resubmit these policies and procedures to DHCS following any substantive change in federal or state nondiscrimination law. MCP policies and procedures must ensure that, upon a substantive change in federal or state nondiscrimination law, training regarding the change will be incorporated into one or more appropriate existing, regularly scheduled MCP staff trainings.

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. 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 Managed Care Operations Division contract manager.

Sincerely,

Original Signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

[56] 45 CFR. 92.103-92.105

Policy:	GG.1607Δ
Title:	**Monitoring Adverse Actions**
Department:	Medical Management
Section:	Quality Improvement
CEO Approval:	/s/
Effective Date:	12/01/1995
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE ☐ Administrative

I. PURPOSE

This policy establishes a process for ongoing monitoring of the actions taken by external entities including, without limitation, licensing boards or agencies, regulatory agencies and/or other entities against CalOptima Practitioners or Organizational Providers (OPs).

II. POLICY

A. CalOptima and its Health Networks shall perform ongoing monitoring of a Practitioner or OPs sanctions, complaints, adverse actions, and quality issues between recredentialing cycles.

B. Adverse actions include, but are not limited to, the following:

1. Any adverse action by the Medical Board of California, or the appropriate licensing board/agency, taken or pending, including, but not limited to, an accusation filed, temporary restraining order or interim suspension order sought or obtained, public letter of reprimand, or any formal restriction, probation, suspension, or revocation of licensure, or cease of practice with charges pending;

2. An action taken by a Peer Review Body (as defined in State or Federal law), or other organizations, that results in the filing of a report under Business & Professions Code Sections 805 or 805.01 with the Medical Board of California or the appropriate licensing board/agency and/or a report with the National Practitioner Data Bank (NPDB);

3. A revocation of a Drug Enforcement Agency (DEA) license;

4. A conviction of a felony or misdemeanor of moral turpitude;

5. ~~Any~~An action against a certification under the Medicare or Medicaid programs;

6. A cancellation, non-renewal, or material reduction in medical liability insurance policy coverage;

7. ~~Any~~An action taken by the California Department of Public Health, Division of Licensing and Certification;

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8. ~~Any~~An action taken by the Health and Human Services Office of the Inspector General (OIG~~);~~) including placement on the List of Excluded Individuals/Entities (LEIE);

~~9. Any~~An action taken by System for Award Management (SAM~~); or~~

9. ~~Any~~) to list a provider ~~listed~~ as debarred, excluded or otherwise ineligible to contract;

10. Placement of the provider on the CMS Preclusion List;

11. Placement of the provider on the Medi-Cal Procedure/Drug Code Limitation List;

12. Adding the provider to the Department of Health Care Service (DHCS) Restricted Provider Database (RPD);

13. Confirmation that the provider is listed as active on the National Plan and Provider Enumeration System (NPPES);

14. Placement of the provider on the DHCS Suspended and Ineligible Provider List; or

~~10.~~15. Placement of the provider on the Medicare Opt-Out List.

C. CalOptima shall refer information of adverse actions taken against CalOptima Practitioners or OPs to CalOptima's Quality Improvement Department and Medical Director for review and referral to the Credentialing Peer Review Committee (CPRC) for consideration as part of the quality review process at re-credentialing and between credentialing cycles.

D. Adverse actions that impact a provider's participation in federal or state health care programs, including, but not limited to, debarments, suspension, and exclusion will be immediately referred to CalOptima's Regulatory Affairs & Compliance Department for evaluation of potential compliance actions (*e.g.*, overpayment refunds) in accordance with CalOptima Policy HH.2021Δ: Exclusion and Preclusion Monitoring.

III. PROCEDURE

A. CalOptima monitors Practitioners and OPs on an ongoing basis to identify adverse actions that may affect participation in CalOptima ~~program.~~ programs.

B. CalOptima monitors various state and federal boards, agencies, and databanks for adverse actions including:

1. OIG exclusion list: upon credentialing and recredentialing and ongoing on a monthly basis;

2. SAM list: upon credentialing and recredentialing and ongoing on a monthly basis;

3. Business & Professions Code Sections 805 and 805.01 reports upon credentialing and recredentialing, and continuous monitoring through NPDB reports~~;~~ as updates are released;

4. Medicare Opt-Out Physicians: upon credentialing and recredentialing and ongoing on a quarterly basis;

5. Medi-Cal Provider Suspended and Ineligible list: upon credentialing and recredentialing and ongoing on a monthly basis;

6. Medical Board of California notifications: as published via e-mail notifications of license suspensions, restrictions, revocations, surrenders and disciplinary actions;

7. California State Licensing Boards for all Practitioners within FACETS~~;~~; upon credentialing and recredentialing and checked monthly and quarterly as reports are published;

8. CMS Preclusion List as published by CMS~~,~~: upon credentialing and recredentialing~~,~~ and ongoing on a monthly basis~~.~~;

9. Medi-Cal Procedure/Drug Code Limitation List: upon credentialing and recredentialing and on a monthly basis; and

10. DHCS Restricted Provider Database (RPD) on a monthly basis.

C. CalOptima shall review all information within thirty (30) calendar days of its release.

D. Any adverse actions identified through ongoing monitoring shall be tracked and as appropriate, communicated via Provider Alert to the CalOptima Medical Director, Provider Relations, Health Network Relations, and Provider Data Management Systems (PDMS) Departments.

E. Upon credentialing and recredentialing, adverse actions identified in the tracking database will be summarized and added to the Practitioner and OP file.

F. The QI Department shall report, in a confidential manner, all adverse action findings to the CPRC.

G. CalOptima shall also monitor and consider internal quality data (e.g~~.~~., potential quality issues (PQIs), and ~~member grievances~~Member Grievances) between recredentialing cycles as in accordance with CalOptima Policies GG.1611: Potential Quality Issue Review Process, CMC.9001: Member Complaint Process, CMC.9002: Member Grievance Process, HH.1102: Member Grievance, MA.9002: Member Grievance Process.

H. The QI Department shall forward all Practitioner and OP potential quality issues received from internal and external sources to a CalOptima Medical Director for review and potential action, in accordance with CalOptima Policy GG.1611: Potential Quality Issue Review Process.

I. CalOptima shall inform affected Practitioners or OPs of the appeal process through the mailing of written notification within thirty (30) calendar days, in accordance with CalOptima Policies HH.1101: CalOptima Provider Complaint and MA.9006: Provider Complaint Process.

J. CalOptima's Quality Improvement Department shall maintain credentialing information in a Credentialing file, in accordance with CalOptima Policy GG.1604Δ: Confidentiality of Credentialing Files and shall ensure that all Credentialing files are up to date.

K. All suspensions and terminations from any licensing or regulating agency will be reported through the Regulatory Affairs & Compliance Department to the Department of Health Care Services (DHCS) within ten (10) business days of final notification to CalOptima.

1. The report to DHCS shall include the following:

   a. Contract status (by delegated entity, if applicable) with the named provider.

   b. The number of ~~members~~Members receiving services from the provider by all lines of business including any delegated entity, LTSS, or OneCare Connect.

L. Any actions that may affect provider directories will follow processes outlined in CalOptima Policy EE.1101: Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-Based Directory.

IV. ATTACHMENT(S)

A. Ongoing Monitoring Website Information Matrix

V. REFERENCE(S)

~~A. California Business and Professions Code, §§805 and 805.01~~
~~B.~~A. CalOptima 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. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima PACE Program Agreement
E. CalOptima Policy CMC.9001: Member Complaint Process
F. CalOptima Policy CMC.9002: Member Grievance Process
G. CalOptima Policy EE.1101: Additions, Changes and Terminations to CalOptima ~~Providers~~Provider Information, CalOptima Providers Directory, and Web-based Directory~~.~~
H. CalOptima Policy GG.1604Δ: Confidentiality of Credentialing Files
I. CalOptima Policy GG.1611: Potential Quality Issue Review Process
J. CalOptima Policy GG.1615: Corrective Action Plan for Practitioners
K. CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners
L. CalOptima Policy HH.1101: CalOptima Provider Complaint
M. CalOptima Policy HH.1102: Member ~~ Grievance
N. CalOptima Policy HH.2021Δ: Exclusion and Preclusion Monitoring
O. CalOptima Policy MA.9002: Member Grievance Process
P. CalOptima Policy MA.9006: Provider Complaint Process
~~Q.~~A. ~~CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect~~
~~R.~~Q. Department of Health Care Services All Plan Letter ~~16-001~~21-003: Medi-Cal Network Provider and ~~Subcontract Suspensions,~~Subcontractor Terminations ~~and Decertifications~~
R. Department of Health Care Services All Plan Letter 19-004: Provider Credentialing/Recredentialing and Screening/Enrollment
S. Title 42 United States Code §11101 et seq.
T. California Welfare and Institutions Code, §14044
U. California Business and Professions Code, §§805 and 805.01

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
08/04/2017	Department of Health Care Services (DHCS)	Approved as Submitted
03/25/2020	Department of Health Care Services (DHCS)	Approved as Submitted
09/23/2020	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
06/01/2017	Regular Meeting of the CalOptima Board of Directors

Date	Meeting
11/29/2018	Regular Meeting of the CalOptima Credentialing Peer Review Committee
02/12/2019	Regular Meeting of the CalOptima Quality Improvement Committee
09/18/2019	Regular Meeting of the CalOptima Quality Assurance Committee
10/03/2019	Regular Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	12/01/1995	GG.1607	Credentialing, Adverse Activity Files	Medi-Cal
Revised	08/01/1998	GG.1607	Credentialing, Adverse Activity Files	Medi-Cal
Revised	11/01/1999	GG.1607	Credentialing, Adverse Activity Files	Medi-Cal
Revised	03/01/2007	MA.7009b	Credentialing, Adverse Activity Files	Medi-Cal
Revised	04/01/2007	GG.1607	Credentialing, Adverse Activity Files	Medi-Cal
Revised	11/01/2011	GG.1607	Adverse Activity Process	Medi-Cal
Revised	11/01/2011	MA.7009b	Adverse Activity Process	OneCare
Retired	02/01/2013	MA.7009b	Adverse Activity Process	OneCare
Revised	02/01/2013	GG.1607	Adverse Activity Process	Medi-Cal OneCare
Revised	06/01/2014	GG.1607	Adverse Activity Process	Medi-Cal OneCare OneCare Connect
Revised	06/01/2017	GG.1607Δ	Monitoring Adverse Activities	Medi-Cal OneCare OneCare Connect PACE
Revised	10/03/2019	GG.1607Δ	Monitoring Adverse Actions	Medi-Cal OneCare OneCare Connect PACE
Revised	04/01/2020	GG.1607Δ	Monitoring Adverse Actions	Medi-Cal OneCare OneCare Connect PACE
Revised	TBD	GG.1607Δ	Monitoring Adverse Actions	Medi-Cal OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Behavioral Health Providers	For purposes of this policy, a licensed practitioner including, but not limited to, physicians, nurse specialists, psychiatric nurse practitioners, licensed psychologists (PhD or PsyD), licensed clinical social worker (LCSW), marriage and family therapist (MFT or MFCC), professional clinical counselors and qualified autism service providers, furnishing covered services.
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.
Grievance	Medi-Cal: An oral or written expression of dissatisfaction about any matter other than an action that is an adverse benefit determination, as identified within the definition of an Appeal, and may include, but is not limited to: the quality of care or services provided, interpersonal relationships with a Provider or CalOptima's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima to make an authorization decision. OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. 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." PACE: A complaint, either written or oral, expressing dissatisfaction with service delivery or the quality of care furnished, as defined by the federal PACE regulation 42 CFR Section 460.120.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Long Term Support Services (LTSS) Providers	For purposes of this policy, A licensed practitioner such as physicians, NMP's, social workers, and nurse managers
Member	A beneficiary enrolled in a CalOptima program.
Non-Physician Medical Practitioner (NMP)	Med-Cal: A nurse midwife, physician's assistant, or nurse practitioner who provides primary care.

Term	Definition
	PACE: Means a nurse practitioner, certified nurse midwife, or physician assistant authorized to provide Primary Care under Physician supervision.
Organizational Providers (OPs)	Medi-Cal: 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, portable x-ray suppliers. OneCare ~~/&~~ OneCare Connect: Hospitals, Intermediate Care Facilities (ICF), Intermediate Care Facilities for the Developmentally Disabled (ICF/DD), Intermediate Care Facilities for the Developmentally Disabled-Nursing (ICF/DD-N), Intermediate Care Facilities for the Developmentally Disabled-Habilitative (ICF/DD-H), Skilled Nursing Facilities (SNF), sub-acute facilities-adult, sub-acute facilities-pediatric, home health agencies, extended care facility , nursing home, free-standing surgical center, seating clinic, urgent care centers, radiology facilities, laboratory facilities, pathology facilities, and Durable Medical Equipment (DME) vendors.
~~Non-Physician Medical Practitioner (NMP)~~	~~Means a nurse practitioner, certified nurse midwife, or physician assistant authorized to provide Primary Care under Physician supervision.~~
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), Licensed Midwife (LM) Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
Service Health Delivery Organizations (HDOs)	Organizations that are contracted to provide services that support member needs such as ambulance, non-emergency medical transportation, durable medical equipment and providers of other member facing services such as, transportation services, meal services, and homecare services.
Substance Use Disorder (SUD) Providers	Licensed, certified or registered by one of the following: a physician licensed by the Medical Board of California, a psychologist licensed by the Board of Psychology, a clinical social worker or marriage and family therapist licensed by California Board of Behavioral Sciences, or an intern registered with California Board of Psychology or California Board of Behavioral sciences.

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Policy:	GG.1607Δ
Title:	**Monitoring Adverse Actions**
Department:	Medical Management
Section:	Quality Improvement
CEO Approval:	*/s/*
Effective Date:	12/01/1995
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE ☐ Administrative

I. PURPOSE

This policy establishes a process for ongoing monitoring of the actions taken by external entities including, without limitation, licensing boards or agencies, regulatory agencies and/or other entities against CalOptima Practitioners or Organizational Providers (OPs).

II. POLICY

A. CalOptima and its Health Networks shall perform ongoing monitoring of a Practitioner or OPs sanctions, complaints, adverse actions, and quality issues between recredentialing cycles.

B. Adverse actions include, but are not limited to, the following:

1. Any adverse action by the Medical Board of California, or the appropriate licensing board/agency, taken or pending, including, but not limited to, an accusation filed, temporary restraining order or interim suspension order sought or obtained, public letter of reprimand, or any formal restriction, probation, suspension, or revocation of licensure, or cease of practice with charges pending;

2. An action taken by a Peer Review Body (as defined in State or Federal law), or other organizations, that results in the filing of a report under Business & Professions Code Sections 805 or 805.01 with the Medical Board of California or the appropriate licensing board/agency and/or a report with the National Practitioner Data Bank (NPDB);

3. A revocation of a Drug Enforcement Agency (DEA) license;

4. A conviction of a felony or misdemeanor of moral turpitude;

5. An action against a certification under the Medicare or Medicaid programs;

6. A cancellation, non-renewal, or material reduction in medical liability insurance policy coverage;

7. An action taken by the California Department of Public Health, Division of Licensing and Certification;

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8. An action taken by the Health and Human Services Office of the Inspector General (OIG) including placement on the List of Excluded Individuals/Entities (LEIE);

9. An action taken by System for Award Management (SAM) to list a provider as debarred, excluded or otherwise ineligible to contract;

10. Placement of the provider on the CMS Preclusion List;

11. Placement of the provider on the Medi-Cal Procedure/Drug Code Limitation List;

12. Adding the provider to the Department of Health Care Service (DHCS) Restricted Provider Database (RPD);

13. Confirmation that the provider is listed as active on the National Plan and Provider Enumeration System (NPPES);

14. Placement of the provider on the DHCS Suspended and Ineligible Provider List; or

15. Placement of the provider on the Medicare Opt-Out List.

C. CalOptima shall refer information of adverse actions taken against CalOptima Practitioners or OPs to CalOptima's Quality Improvement Department and Medical Director for review and referral to the Credentialing Peer Review Committee (CPRC) for consideration as part of the quality review process at re-credentialing and between credentialing cycles.

D. Adverse actions that impact a provider's participation in federal or state health care programs, including, but not limited to, debarments, suspension, and exclusion will be immediately referred to CalOptima's Regulatory Affairs & Compliance Department for evaluation of potential compliance actions (*e.g.*, overpayment refunds) in accordance with CalOptima Policy HH.2021Δ: Exclusion and Preclusion Monitoring.

III. PROCEDURE

A. CalOptima monitors Practitioners and OPs on an ongoing basis to identify adverse actions that may affect participation in CalOptima programs.

B. CalOptima monitors various state and federal boards, agencies, and databanks for adverse actions including:

1. OIG exclusion list: upon credentialing and recredentialing and ongoing on a monthly basis;

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3. Business & Professions Code Sections 805 and 805.01 reports upon credentialing and recredentialing, and continuous monitoring through NPDB reports as updates are released;

4. Medicare Opt-Out Physicians: upon credentialing and recredentialing and ongoing on a quarterly basis;

5. Medi-Cal Provider Suspended and Ineligible list: upon credentialing and recredentialing and ongoing on a monthly basis;

6. Medical Board of California notifications: as published via e-mail notifications of license suspensions, restrictions, revocations, surrenders and disciplinary actions;

7. California State Licensing Boards for all Practitioners within FACETS: upon credentialing and recredentialing and checked monthly and quarterly as reports are published;

8. CMS Preclusion List as published by CMS: upon credentialing and recredentialing and ongoing on a monthly basis;

9. Medi-Cal Procedure/Drug Code Limitation List: upon credentialing and recredentialing and on a monthly basis; and

10. DHCS Restricted Provider Database (RPD) on a monthly basis.

C. CalOptima shall review all information within thirty (30) calendar days of its release.

D. Any adverse actions identified through ongoing monitoring shall be tracked and as appropriate, communicated via Provider Alert to the CalOptima Medical Director, Provider Relations, Health Network Relations, and Provider Data Management Systems (PDMS) Departments.

E. Upon credentialing and recredentialing, adverse actions identified in the tracking database will be summarized and added to the Practitioner and OP file.

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b. The number of Members receiving services from the provider by all lines of business including any delegated entity, LTSS, or OneCare Connect.

L. Any actions that may affect provider directories will follow processes outlined in CalOptima Policy EE.1101: Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-Based Directory.

IV. ATTACHMENT(S)

A. Ongoing Monitoring Website Information Matrix

V. REFERENCE(S)

A. CalOptima 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
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Q. Department of Health Care Services All Plan Letter 21-003: Medi-Cal Network Provider and Subcontractor Terminations
R. Department of Health Care Services All Plan Letter 19-004: Provider Credentialing/Recredentialing and Screening/Enrollment
S. Title 42 United States Code §11101 et seq.
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Date	Regulatory Agency	Response
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VIII. REVIEW/REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	12/01/1995	GG.1607	Credentialing, Adverse Activity Files	Medi-Cal
Revised	08/01/1998	GG.1607	Credentialing, Adverse Activity Files	Medi-Cal
Revised	11/01/1999	GG.1607	Credentialing, Adverse Activity Files	Medi-Cal
Revised	03/01/2007	MA.7009b	Credentialing, Adverse Activity Files	Medi-Cal
Revised	04/01/2007	GG.1607	Credentialing, Adverse Activity Files	Medi-Cal
Revised	11/01/2011	GG.1607	Adverse Activity Process	Medi-Cal
Revised	11/01/2011	MA.7009b	Adverse Activity Process	OneCare
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1

Ongoing Monitoring Website Information

Licensing Board, Address and Phone Numbers	Practitioner Types	Website/links	Report Frequency
Medical Board of California 2005 Evergreen Street, Suite 1200 Sacramento, CA 95815 PH:(916) 263-2382 or (800) 6332322 Enforcement Central File Room PH: (916) 263-2525 FAX: (916) 263-2420 805's Discipline Coord. (916) 263-2449	MD	~~www.mbc.ca.gov~~**https://search.dca.ca.gov/** **All communications for disciplinary actions will be done by e-mail to subscribers.** ~~Link to subscribe for actions: http://www.mbc.ca.gov/Subscribers/~~ ~~Link for all Disciplinary Actions/License Alerts distributed: http://www.mbc.ca.gov/Publications/Disciplinary_Actions/~~	Bi-Monthly subscribers will be sent information regarding Accusations. Decisions will be sent on a daily basis as the decisions become final.

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Osteopathic Medical Board of CA 1300 National Drive, Suite #150 Sacramento, CA 95834-1991 (916) 928-8390 Office (916) 928-8392 Fax E-mail:osteopathic@dca.ca.gov	DO	https://search.dca.ca.gov/ ~~www.ombc.ca.gov~~ **Direct Link t~~T~~o Enforcement Actions:** http://www.ombc.ca.gov/consumers/enforce_action.shtml	Quarterly via the Website E-Mail Distribution list.

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Medical Board of California Board of Podiatric Medicine 2005 Evergreen Street, Ste. 1300 Sacramento, CA 95815-3831 PH: (916) 263-2647 Fax:(916) 263-2651	DPM	https://search.dca.ca.gov/ ~~www.bpm.ca.gov~~ ~~Direct Link toEnforcement Resources: http://www.bpm.ca.gov/consumers/index.shtml~~ ~~Subscribers list http://www.mbc.ca.gov/Subscrib ers/~~ -	Board of Podiatric Medicine: Changes to viewing information. On the website go to recent Disciplin ry Actions, separated into categories, Decisions, Accusations filed, etc. varies/ check monthly
Acupuncture Board 1747 N. Market Blvd Suite 180 Sacramento, CA 95834 PH: (916) 515-5200 Fax: (916) 928-2204	LAC/AC	https://search.dca.ca.gov/ www.acupuncture.ca.gov ~~Direct Link to Disciplinary Actions: www.acupuncture.ca.gov/consumers/board_actions.shtml~~	Monthly ~~running report listed Alpha~~ ~~Newer actions highlighted with date in blue.~~

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Ongoing Monitoring Website Information

Licensing Board, Address and Phone Numbers	Practitioner Types	Website/links	Report Frequency
Board of Behavioral Sciences 1625 N Market Blvd., Suite S-200 Sacramento, CA 95834 PH: (916) 574-7830 Fax: (916) 574-8625	Licensee Licensed Clinical Social Workers (LCSW) Licensed Marriage and Family Therapists (LMFT) Licensed Professional Clinical Counselors (LPCC) Licensed Educational Psychologists (LEP)	https://search.dca.ca.gov/ ~~www.bbs.ca.gov~~	Via Subscriptions Only Information must be obtained via subscription. Monthly
CA Board of Chiropractic Examiners Board of Chiropractic Examiners 901 P Street, Suite 142A Sacramento, CA 95814 PH (916) 263-5355 FAX (916) 327-0039 Email: chiro.info@dca.ca.gov	DC	https://search.dca.ca.gov/ ~~www.chiro.ca.gov~~ ~~Monthly Reports~~ ~~http://www.chiro.ca.gov/enforcement/actions.shtml~~	Monthly

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Dental Board of California 2005 Evergreen Street, Suite 1550 Sacramento, CA 95815 PH: (916) 263-2300 PH: (877)729-7789 Toll Free Fax #: (916) 263-2140 Email:dentalboard@dca.ca.gov	DDS, DMD	https://search.dca.ca.gov/ ~~www.dbc.ca.gov~~ ~~Direct Link to Disciplinary Actions:~~ ~~http://www.dbc.ca.gov/consumers/hotsheets.shtml~~	Monthly

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California Board of Occupational Therapy (CBOT) 2005 Evergreen St. Suite 2250 Sacramento, CA 95815 PH: (916) 263-2294 Fax: (916) 263-2701	OT, OTA	https://search.dca.gov/ www.bot.ca.gov ~~Direct Link To Enforcement Actions:~~ ~~http://www.bot.ca.gov/consumers/disciplinary_action.shtml~~	Update as needed (whenever they have an update). Depends on when there is an OT placed on probation or revoked. Listed Alpha by type of action. E-Mail Submission
California State Board of Optometry 2450 Del Paso Road, Suite 105 Sacramento, CA 95834 PH:(916) 575-7170 Fax (916) 575-7292 Email: optometry@dca.ca.gov	OD	https://searc . ca.ca.gov/ ~~www.optometry.ca.gov~~ ~~Direct Link To Enforcement Actions:~~ ~~http://www.optometry.ca.gov/consumers/disciplinary.shtml~~	Listed by year, in Alpha Order by type of Action Website will be updated as actions are adopted. Monthly review.

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Licensing Board, Address and Phone Numbers	Practitioner Types	Website	Report Frequency
Physical Therapy Board of California 2005 Evergreen St. Suite 1350 Sacramento, CA 95815 PH: (916) 561-8200 Fax: (916) 263-2560	PT	https://search.dca.ca.gov/ ~~www.ptb.ca.gov~~	**None** – This entity does not release sanction information reports, organizatio s are required to conduct individual queries every 12-18 months on credentialed practitioners. Emails are sent monthly
Physician Assistant Board (PAB) 2005 Evergreen Street Suite 1100 Sacramento, CA 95815 PH: (916) 561-8780 FAX(916) 263-2671 Email:pacommittee@mbc.ca.gov	PA/PAC	https://search.dca.ca.gov/ ~~www.pac.ca.gov~~ ~~Direct Link To Enforcement Actions:~~ ~~www.pac.ca.gov/forms_pubs/disciplinaryactions.shtml~~	Monthly
Board of Psychology 1625 North Market Blvd, Suite N-215 Sacramento, CA 95834 bopmail@dca.ca.gov Office Main Line (916)-574-7720 **Toll Free Number: 1-866-5033221.**	PhD, PsyD	https://search.dca.ca.gov/ ~~www.psychboard.ca.gov~~	**Via Subscriptions Only** Information must be obtained via subscription. Varies Monthly

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CA Board of Registered Nursing 1747 North Market Blvd, Suite 150 Sacramento, CA 95834 Mailing Address: Board of Registered Nursing P.O. Box 944210 Sacramento, CA 94244-2100 Phone: (916) 322-3350 FAX (916) 574-7693. Email: enforcement_brn@dca.ca.gov	Certified Nurse Midwife (CNM) Certified Nurse Anesthetist (CRNA) Clinical Nurse Specialist (CNS) Critical Care Nurse (CCRN) Nurse Practitioner (NP) Registered Nurse (RN) Psychiatric Mental Health Nursing (PMHN) Public Health Nurse (PHN)	https://search.dca.ca.gov/ ~~www.rn.ca.gov~~ ~~Unlicensed Practice/Nurse Imposter Citations:~~ ~~http://www.rn.ca.gov/enforcement/unlicprac.shtml~~	**None**–This entity does not release sanction information reports, organizations are required to conduct individual queries every 12-18 months on credentialed practitioners.

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Speech-Language Pathology & Audiology Board 2005 Evergreen Street, Suite 2100 Sacramento, CA 95815 Email: speechandhearing@dca.ca.gov Main Phone Line: (916) 263-2666 Main Fax Line: (916) 263-2668	SP, AU	**https://search.dca.ca.gov/** ~~**http://www.speechandhearing.ca.gov/**~~ ~~Direct Link to Accusations Pending and Disciplinary Actions:~~ ~~**http://www.speechandhearing.ca.gov/consumers/enforcement.shtml**~~	**Quarterly** Disciplinary Actions are listed by fiscal year. ~~Pending Actions are listed alphabetically by first name.~~
HHS Officer of Inspector General Office of Investigations Health Care Administrative Sanctions Room N2-01-26 7500 Security Blvd. Baltimore, MD21244-1850	OIG - List of Excluded Individuals and Entities (LEIE) excluded from ~~Federal Health~~Federal Health Care Programs: Medicare /Medicaid sanction & exclusions	~~**www.oig.hhs.gov**~~ **Direct Link for individuals:** **http://exclusions.oig.hhs.gov/**	**Monthly**

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CMS.gov Centers for Medicare & Medicaid Services	Medicare Opt-Out Affidavits. Effective 1/29/18	**https://www.cms.gov/Medicare/Provider-Enrollment-andCertification/MedicareProviderSupEnroll/OptOutAffidavits.html** For a listing of all physicians and practitioners that are currently opted out of Medicare: **https://data.cms.gov/dataset/Op t-Out-Affidavits/7yuw-754z**	**Quarterly**
CMS.gov Centers for Medicare & Medicaid Services	The CMS Preclusion List Effective 1/01/19	CMS made ~~will make~~ the initial Preclusion List available to Plans ~~beginning January 1, 2019~~ on a secure website and updates are ~~will be~~ made available approximately every 30 days, on the 25th business day of each month. ~~around the first business day of each month.~~ ~~Details on how it will be distributed to Quality Improvement is TBD.~~	**Monthly and Upon Initial and Recredentialing Cycle.**

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Department of Health Care Services (DHCS) **Medi-Cal Provider Suspended and Ineligible List** Office of Investigations Health Care Administrative Sanctions Room N2-01-26 7500 Security Blvd. Baltimore, MD21244-1850	Medi-Cal Reports exclusions and reinstatements from the State Medi-Cal Program	www.medi-cal.ca.gov **Direct Link to Suspended and Ineligible Provider List**: http://files.medi-cal.ca.gov/pubsdoco/SandlLanding.asp	**Monthly**
SAM (System for Award Management) formerly known as Excluded Parties List System (EPLS)	Individuals and Organizations debarred from participating in government contracts or receiving government benefits or financial assistance	https://www.sam.gov/portal/SAM/#1 SAM Registration https://uscontractorregistration.com/	**Monthly via Lexis Nexis Monitoring**
DEA Office of Diversion Control **800-882-9539** **deadiversionwebmaster@usdoj.gov**	**DEA Verification**	~~www.deadiversion.usdoj.gov/~~ **Direct Link to Validation Form** **https://www.cms.gov/Medicare/Provider-Enrollment-**	**Monthly via Lexis Nexis Monitoring**

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		andCertification/MedicareProvider SupEnroll/OptOutAffidavits.html ~~https://www.deadiversion.usdoj.gov/webforms/validateLogin.jsp~~	
Terrorist Watch List/Office of Foreign Assets Control	Practitioner & Medical Groups	https://sanctionssearch.ofac.treas.gov/	~~Weekly~~Monthly
Drug Code Limitation	Listing of practitioners and/or medical groups placed on P/DCL sanction	https://files.medi-cal.ca.gov/pubsdoco/pdcl_home.aspx	Monthly
Department of Health Care Service (DHCS)- Restricted Provider Database	Practitioners, Medical Groups, Pharmacy	Effective 3/2020 started reviewing restricted provider list.	Monthly

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Additional Websites for Initial and Recredentialing Verifications

Site ~~Name, Address~~Name, Address and Phone Numbers	Service	Website	Instructions and Comments
~~The Licensed Facility Information system (LFIS)~~ ~~The Automated Licensing Information and Report Tracking System (ALIRTS) Contains license and utilization data nformation of healthcare facilities in California.~~ ~~The Licensed Facility nformation system (LFIS) is maintained by the Office of Statewide Health Planning and Development to collect and display icensing and other basic information about California's hospitals, long term care facilities, primary care and specialty clinics, home health~~	~~Organizational Providers License Verification:~~ ~~Hospitals~~ ~~Long term care facilities~~ ~~Home Health Agencies~~ ~~Hospices~~ ~~Primary care and Specialty clinics~~	~~www.alirts.oshpd.ca.gov/Default.aspx~~ ~~Direct Link:~~ ~~www.alirts.oshpd.ca.gov/LFIS/LFISHome.aspx~~	~~The main source of the information in LFIS is the licenses issued b Department of Health Services (DHS) Licensing and Certification District Offices. Contact information for these District Offices is available at:~~ ~~www.dhs.ca.gov/LNC/default.htm~~ ~~To search for a facility~~ ~~• Enter name in box that is found in top right corner~~ Search or ~~• Link to Advance Search on the left under Login.~~ ~~LFIS Home~~ ~~Alirts Home~~ ~~Advanced Search~~ ~~You may search by using the following four search categories, Facility Name, Facility Number, License and Legal Entity. Enter your search parameters within the one category you selected and click the Search button to the right.~~

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Additional Websites for Initial and Recredentialing Verifications

~~agencies and hospices.~~			

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Additional Websites for Initial and Recredentialing Verifications

The California Department of Public Health (CDPH) General Information (916) 558-1784	**Organizational Providers License Verification:** Hospitals Ambulatory Surgery Centers Home Health Agencies Hospices Dialysis Centers ~~Others~~ Community Based Adult Services (CBAS) Skilled Nursing Facilities Federal Qualified Health Centers (FQHC)	~~http://www.cdph.ca.gov/Pages/DEFAULT.aspx~~ ~~Licensed Facility Report~~ ~~http://hfcis.cdph.ca.gov/Reports/GenerateReport.aspx?rpt=FacilityListing~~ ~~Health Facilities Search~~ ~~http://hfcis.cdph.ca.gov/search.aspx~~ ~~https://www.cdph.ca.gov/~~	Health Information Health Facilities Consumer Information System Find a facility Public Inquiry/Reports Type of Facility Select Excel or PDF format Health Facilities Search To check a particular facility, check the applicable box for the type (e.g. SNF or Hospital) then enter the Name or zip code and the facility will appear for you to select. You will be able to obtain copies of site visits for SNFs at this site.

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Additional Websites for Initial and Recredentialing Verifications

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Revised 05-01-18, Revised 12/21/18, Revised 1/11/2019, Revised 1/24/2020 Revised 3/10/2020, Revised 6/14/2021, 7/30/2021

This document is for informational purposes only and subject to change.
Please visit the individual websites listed for the most current up-to-date information. -

Additional Websites for Initial and Recredentialing Verifications

National Plan and Provider Enumeration System (NPPES) NPI Enumerator PO Box 6059 Fargo, ND 58108-6059 800-465-3203 customerservice@npienumerator.com The Centers for Medicare & Medicaid Services (CMS) has developed the National Plan and Provider Enumeration System (NPPES) to assign these unique identifiers. The NPI Registry enables you to search for a provider's NPPES information. All information produced by the NPI Registry is provided in accordance with the NPPES Data Dissemination Notice. Information in the NPI Registry is updated daily. You may run simple queries to retrieve this read-only data.	**Organizational Providers and Practitioners Numbers for the following:** • NPI • Medicare • Medi-Cal	https://nppes.cms.hhs.gov/NPPES/Welcome.do Search NPI Records https://npiregistry.cms.hhs.gov/ **Search the NPI Registry** • Search for an **Individual Provider** • Search for an **Organizational Provider**	Source for obtaining NPI Numbers, Medicare PIN and UPIN Numbers and Medicaid provider numbers Select Search the NPI Registry Complete the appropriate sections for Individual or for Organizations for individuals First Name Last Name for organizations Organization Name

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Additional Websites for Initial and Recredentialing Verifications

Board Certification, Address and Phone Numbers	Practitioner Types	Website	Instructions and Comments	Verification Type
Nursing Board Certification for Nurse Practitioners/Advance Practice Nurses ~~**American Academy of Nurse Practitioners Certification Board (AANPCB) (1/2017)**~~ ~~*(Formerly the American Academy of Nurse Practitioners Certification Program (AANPCP)*~~ ~~**Center (ANCC)**~~ ~~**National Certification Corporation for the Obstetrics, Gynecology and Neonatal Nursing Specialties(ncc)**~~ ~~**Pediatric Nursing Certification Board (PNCB)**~~ ~~**American Association of Critical Care Nurses (AACN)**~~	NP	**American Academy of Nurse Practitioners Certification Board (AANPCB)** —www.aanpcert.org/ **American Nursing Credentialing Center (ANCC)** –www.nursecredentialing.org **National Nursing Credentialing Center (NCC)** ~~ncc~~ – www.nccwebsite.org **Pediatric Nursing Certification Board(PNCB)** –www.pncb.org **American Association of Critical Care Nurses (AACN)**	Informational only to verify board certification	**Board Certification**

Revised 05-01-18, Revised 12/21/18, Revised 1/11/2019, Revised 1/24/2020 Revised 3/10/2020, Revised 6/14/2021, 7/30/2021

This document is for informational purposes only and subject to change.
Please visit the individual websites listed for the most current up-to-date information. -

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Additional Websites for Initial and Recredentialing Verifications

		-www.aacn.org		
National Commission on Certification of PA's (NCCPA)	PAC	https://portal.nccpa.net/verifypachttp://www.nccpa.net/	Informational only to verify board certification	**Board Certification**

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Additional Websites for Initial and Recredentialing Verifications

American Midwifery Certification Board **(AMCB~~amcb~~)** 849 International Drive, Suite 120 Linthicum, MD 21090 Phone 410-694-9424	CNM and CM	http://www.amcbmidwife.org/	Under the Verify AMCB Certification ▪ Click Search button ▪ Enter last Name, First Name and Certification Number ▪ Click Search Button	**Board Certification** Informational only to verify board certification needed
~~**Board Certification, Address and Phone Numbers**~~	~~**Practitioner Types**~~	~~**Website**~~	~~**Instructions and Comments**~~	~~**Verification Type**~~
American Board of Professional Psychology (ABPP) 600 Market Street Suite 201 Chapel Hill, NC 27516 Phone 919-537-8031 email: office@abpp.org	PhD, PsyD	http://www.abpp.org/	Under Find a Board Certified Psychologists Click Verification Note there is a $25 charge, credits much be purchased prior to your verification search.	**Board Certification** Informational only to verify board certification if needed

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Additional Websites for Initial and Recredentialing Verifications

Three specialty certifying boards are currently approved under California aw for DPM: **American Board of Foot and Ankle Surgery** (formerly The American Board of Podiatric Surgery 7/1/14) (Also includes the following certifications: Foot Surgery and Reconstruction Rear foot/Ankle Surgery (RRA)~~).~~ **The American Board of Podiatric Medicine** (Conducts the certification process in Podiatric Orthopedics and Primary Podiatric Medicine **American Board of Multiple Specialties in Podiatry.** (~~-~~Includes Certification for Primary Care, Foot and ankle Surgery, diabetic wound care and limb salvage	DPM	American Board of Foot and Ankle Surgery. https://www.abfas.org/ The American Board of Podiatric Medicine conducts the certification process in Podiatric Orthopedics and Primary Podiatric Medicine. https://www.abpmed.org/ American Board of Multiple Specialties in Podiatry. http://abmsp.org/	Informational only to verify board certification	**Board Certification**
National Practitioner Data Bank-NPDB	NPDB	**NPDB** https://www.npdb.hrsa.gov/		

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Ongoing Monitoring Website Information

Licensing Board, Address and Phone Numbers	Practitioner Types	Website/links	Report Frequency
Medical Board of California 2005 Evergreen Street Suite 1200 Sacramento CA 95815 PH: (916) 263-2382 or 1 (800) 633-2322 **Enforcement Central File Room** PH: (916) 263-2525 FAX: (916) 263-2420 805's Discipline Coord: PH: (916) 263-2449	MD	https://search.dca.ca.gov/ **All communications for disciplinary actions will be done by e-mail to subscribers.**	Bi-monthly subscribers wil be sent information regarding Accusations. Decisions will be sent on a daily basis as the decision ' ecome final.

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Licensing Board, Address and Phone Numbers	Practitioner Types	Website/links	Report Frequency
Osteopathic Medical Board of CA 1300 National Drive Suite 150 Sacramento CA 95834-1991 (916) 928-8390 Office (916) 928-8392 Fax Email: osteopathic@dca.ca.gov	DO	https://search.dca.ca.gov/ **Direct Link to Enforcement Actions:** http://www.ombc.ca.gov/consumers/enforce_action.shtml	Quarterly via the website Email distribution list.

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Licensing Board, Address and Phone Numbers	Practitioner Types	Website/links	Report Frequency
Medical Board of California Board of Podiatric Medicine 2005 Evergreen Street Suite 1300 Sacramento CA 95815-3831 PH: (916) 263-2647 Fax:(916) 263-2651	DPM	https://search.dca.ca.gov/	Board of Podiatric Medicine: Changes to viewing information on the website go to recent Disciplinary Actions, separated into categories, Decisions, Accusations filed, etc. varies/ **check Monthly**
Acupuncture Board 1747 N. Market Blvd Suite 180 Sacramento CA 95834 PH: (916) 515-5200 Fax: (916) 928-2204	LAC/AC	https://search.dca.ca.gov/	**Monthly**

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Licensing Board, Address and Phone Numbers	Practitioner Types	Website/links	Report Frequency
Board of Behavioral Sciences 1625 N Market Blvd Suite S-200 Sacramento CA 95834 PH: (916) 574-7830 Fax: (916) 574-8625	Licensee Licensed Clinical Social Workers (LCSW) Licensed Marriage and Family Therapists (LMFT) Licensed Professional Clinical Counselors (LPCC) Licensed Educational Psychologists (LEP)	https://search.dca.ca.gov/	Via Subscriptions Only Information must be obtained via subscription. **Monthly**
CA Board of Chiropractic Examiners Board of Chiropractic Examiners 901 P Street Suite 142A Sacramento CA 95814 PH: (916) 263-5355 FAX: (916) 327-0039 Email: chiro.info@dca.ca.gov	DC	https://search.dca.ca.gov/	**Monthly**

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Licensing Board, Address and Phone Numbers	Practitioner Types	Website/links	Report Frequency
Dental Board of California 2005 Evergreen Street Suite 1550 Sacramento CA 95815 PH: (916) 263-2300 PH Toll Free: 1 (877) 729-7789 Fax: (916) 263-2140 Email: dentalboard@dca.ca.gov	DDS, DMD	https://search.dca.ca.gov/	**Monthly**

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Licensing Board, Address and Phone Numbers	Practitioner Types	Website/links	Report Frequency
California Board of Occupational Therapy (CBOT) 2005 Evergreen St. Suite 2250 Sacramento CA 95815 PH: (916) 263-2294 Fax: (916) 263-2701	OT, OTA	https://search.dca.ca.gov/	Update as needed (whenever they have an update). Depends on when there is an OT placed on probation or revoked. Listed Alpha b[illegible] of action. Email Submission

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Ongoing Monitoring Website Information

Licensing Board, Address and Phone Numbers	Practitioner Types	Website/links	Report Frequency
California State Board of Optometry 2450 Del Paso Road Suite 105 Sacramento CA 95834 PH: (916) 575-7170 Fax: (916) 575-7292 Email: optometry@dca.ca.gov	OD	https://search.dca.ca.gov/	Listed by year, in Alpha Order by type of Action Website will be updated as actions are adopted. **Monthly review.**

Licensing Board, Address and Phone Numbers	Practitioner Types	Website	Report Frequency
Physical Therapy Board of California 2005 Evergreen St. Suite 1350 Sacramento CA 95815 PH: (916) 561-8200 Fax: (916) 263-2560	PT	https://search.dca.ca.gov/	**None** – This entity does not release sanction information reports, organizations are required to conduct individual queries every 12-18 months on credentialed practitioners. Emails are sent monthly

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Licensing Board, Address and Phone Numbers	Practitioner Types	Website	Report Frequency
Physician Assistant Board (PAB) 2005 Evergreen Street Suite 1100 Sacramento CA 95815 PH: (916) 561-8780 FAX: (916) 263-2671 Email: pacommittee@mbc.ca.gov	PA/PAC	https://search.dca.ca.gov/	**Monthly**
Board of Psychology 1625 North Market Blvd Suite N-215 Sacramento CA 95834 PH: (916)-574-7720 **PH Toll Free: 1 (866) 503-3221** Email: bopmail@dca.ca.gov	PhD, PsyD	https://search.dca.ca.gov/	**Via Subscriptions Only** Information must be obtained via subscription. **Varies Monthly**
CA Board of Registered Nursing 1747 North Market Blvd Suite 150 Sacramento CA 95834 Mailing Address: Board of Registered Nursing P.O. Box 944210	Certified Nurse Midwife (CNM) Certified Nurse Anesthetist (CRNA) Clinical Nurse Specialist (CNS) Critical Care Nurse	https://search.dca.ca.gov/	**None**–This entity does not release sanction information reports, organizations are required to conduct individual queries every 12-18 months on credentialed practitioners.

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Licensing Board, Address and Phone Numbers	Practitioner Types	Website	Report Frequency
Sacramento CA 94244-2100 PH: (916) 322-3350 FAX: (916) 574-7693 Email: enforcement_brn@dca.ca.gov	(CCRN) Nurse Practitioner (NP) Registered Nurse (RN) Psychiatric Mental Health Nursing (PMHN) Public Health Nurse (PHN)		
Speech-Language Pathology & Audiology Board 2005 Evergreen Street Suite 2100 Sacramento CA 95815 PH: (916) 263-2666 Fax: (916) 263-2668 Email: speechandhearing@dca.ca.gov	SP, AU	https://search.dca.ca.gov/	**Quarterly** Disciplinary Actions are listed by fiscal year.
HHS Officer of Inspector General Office of Investigations Health Care Administrative Sanctions Room N2-01-26 7500 Security Blvd. Baltimore MD 21244-1850	OIG - List of Excluded Individuals and Entities (LEIE) excluded from Federal Health Care Programs: Medicare /Medicaid sanction & exclusions	**Direct Link for individuals:** http://exclusions.oig.hhs.gov/	**Monthly**

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Licensing Board, Address and Phone Numbers	Practitioner Types	Website	Report Frequency
CMS.gov Centers for Medicare & Medicaid Services	Medicare Opt-Out Affidavits. Effective 1/29/18	https://www.cms.gov/Medicare/Provider-Enrollment-andCertification/MedicareProviderSupEnroll/OptOutAffidavits.html For a listing of all physicians and practitioners that are currently opted out of Medicare: https://data.cms.gov/dataset/Opt-Out-Affidavits/7yuw-754z	**Quarterly**
CMS.gov Centers for Medicare & Medicaid Services	The CMS Preclusion List Effective 1/01/19	CMS made the initial Preclusion List available to Plans on a secure website and updates are made available approximately every 30 days, on the 25th business day of each month.	**Monthly and Upon Initial and Recredentialing Cycle.**

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Department of Health Care Services (DHCS) **Medi-Cal Provider Suspended and Ineligible List** Office of Investigations Health Care Administrative Sanctions Room N2-01-26 7500 Security Blvd Baltimore MD 21244-1850	Medi-Cal Reports exclusions and reinstatements from the State Medi-Cal Program	www.medi-cal.ca.gov **Direct Link to Suspended and Ineligible Provider List**: http://files.medi-cal.ca.gov/pubsdoco/SandlLanding.asp	**Monthly**
SAM (System for Award Management) formerly known as Excluded Parties List System (EPLS)	Individuals and Organizations debarred from participating in government contracts or receiving government benefits or financial assistance	https://www.sam.gov/portal/SAM/#1 SAM Registration https://uscontractorregistration.c om/	**Monthly via Lexis Nexis Monitoring**
DEA Office of Diversion Control **1 (800) 882-9539** deadiversionwebmaster@usdoj.gov	**DEA Verification**	**Direct Link to Validation Form** https://www.cms.gov/Medicare/Provider-Enrollment-andCertification/MedicareProviderSupEnroll/OptOutAffidavits.html	**Monthly via Lexis Nexis Monitoring**

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Terrorist Watch List/Office of Foreign Assets Control	**Practitioner & Medical Groups**	**https://sanctionssearch.ofac.treas.gov/**	**Monthly**
Drug Code Limitation	**Listing of practitioners and/or medical groups placed on P/DCL sanction**	**https://files.medi-cal.ca.gov/pubsdoco/pdcl_home.aspx**	**Monthly**
Department of Health Care Service (DHCS)- Restricted Provider Database	**Practitioners, Medical Groups, Pharmacy**	Effective 3/2020 started reviewing restricted provider list	**Monthly**

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Additional Websites for Initial and Recredentialing Verifications

Site Name, Address and Phone Numbers	Service	Website	Instructions and Comments
The California Department of Public Health (CDPH) General Information PH: (916) 558-1784	**Organizational Providers License Verification:** Hospitals Ambulatory Surgery Centers Home Health Agencies Hospices Dialysis Centers Community Based Adult Services (CBAS) Skilled Nursing Facilities Federal Qualified Health Centers (FQHC)	https://www.cdph.ca.gov/	Health Information Health Facilities Consumer Information System Find a facility Public Inquiry/Reports Type of Facility Select Excel or PDF format Health Facilities Search To check a particular facility, check the applicable box for the type (e.g. SNF or Hospital) then enter the Name or zip code and the facility will appear for you to select. You will be able to obtain copies of site visits for SNFs at this site.

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Additional Websites for Initial and Recredentialing Verifications

National Plan and Provider Enumeration System (NPPES) NPI Enumerator PO Box 6059 Fargo ND 58108-6059 PH Toll Free: 1 (800) 465-3203 Email: customerservice@npienumerator.com The Centers for Medicare & Medicaid Services (CMS) has developed the National Plan and Provider Enumeration System (NPPES) to assign these unique identifiers. The NPI Registry enables you to search for a provider's NPPES information. All information produced by the NPI Registry is provided in accordance with the NPPES Data Dissemination Notice. Information in the NPI Registry is updated daily. You may run simple queries to retrieve this read-only data.	**Organizational Providers and Practitioners Numbers for the following:** • NPI • Medicare • Medi-Cal	https://nppes.cms.hhs.gov/NPPES/Welcome.do Search NPI Records https://npiregistry.cms.hhs.gov/ **Search the NPI Registry** • Search for an **Individual Provider** • Search for an **Organizational Provider**	Source for obtaining NPI Numbers, Medicare PIN and UPIN Numbers and Medicaid provider numbers Select Search the NPI Registry Complete the appropriate sections for Individual or for Organizations for individuals First Name Last Name for organizations Organization Name

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Additional Websites for Initial and Recredentialing Verifications

Board Certification, Address and Phone Numbers	Practitioner Types	Website	Instructions and Comments	Verification Type
Nursing Board Certification for Nurse Practitioners/Advance Practice Nurses	NP	**American Academy of Nurse Practitioners Certification Board (AANPCB)** www.aanpcert.org/ **American Nursing Credentialing Center (ANCC)** www.nursecredentialing.org **National Nursing Credentialing Center (NCC)** www.nccwebsite.org **Pediatric Nursing Certification Board(PNCB)** www.pncb.org **American Association of Critical Care Nurses (AACN)** www.aacn.org	Informational only to verify board certification	**Board Certification**
National Commission on Certification of PA's (NCCPA)	PAC	**https://portal.nccpa.net/verifypac**	Informational only to verify board certification	**Board Certification**

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Revised 05-01-18, Revised 12/21/18, Revised 1/11/2019, Revised 1/24/2020 Revised 3/10/2020, Revised 6/14/2021, 7/30/2021

This document is for informational purposes only and subject to change.
Please visit the individual websites listed for the most current up-to-date information. -

Additional Websites for Initial and Recredentialing Verifications

American Midwifery Certification Board (AMCB) 849 International Drive Suite 120 Linthicum MD 21090 PH: (410) 694-9424	CNM and CM	http://www.amcbmidwife.org/	Under the Verify AMCB Certification • Click Search button • Enter last Name, First Name and Certification Number • Click Search Button	**Board Certification** Informational only to verify board certification needed
American Board of Professional Psychology (ABPP) 600 Market Street Suite 201 Chapel Hill NC 27516 PH: (919) 537-8031 Email: Office@abpp.org	PhD, PsyD	http://www.abpp.org/	Under Find a Board Certified Psychologists □ Click Verification Note there is a $25 charge, credits much be purchased prior to your verification search.	**Board Certification** Informational only to verify board certification if needed

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Additional Websites for Initial and Recredentialing Verifications

Three specialty certifying boards are currently approved under California aw for DPM: **American Board of Foot and Ankle Surgery** (formerly The American Board of Podiatric Surgery 7/1/14) (Also includes the following certifications: Foot Surgery and Reconstruction Rear foot/Ankle Surgery (RRA) **The American Board of Podiatric Medicine** (Conducts the certification process in Podiatric Orthopedics and Primary Podiatric Medicine **American Board of Multiple Specialties in Podiatry.** (Includes Certification for Primary Care, Foot and ankle Surgery, diabetic wound care and limb salvage	DPM	American Board of Foot and Ankle Surgery. https://www.abfas.org/ The American Board of Podiatric Medicine conducts the certification process in Podiatric Orthopedics and Primary Podiatric Medicine. https://www.abpmed.org/ American Board of Multiple Specialties in Podiatry. http://abmsp.org/	Informational only to verify board certification	**Board Certification**
National Practitioner Data Bank-NPDB	NPDB	**NPDB** https://www.npdb.hrsa.gov/		

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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 12, 2019**

ALL PLAN LETTER 19-004
SUPERSEDES ALL PLAN 17-019

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: PROVIDER CREDENTIALING / RECREDENTIALING AND SCREENING / ENROLLMENT

PURPOSE:
The purpose of this All Plan Letter (APL) is to inform Medi-Cal managed care health plans (MCPs) of their responsibilities related to the screening and enrollment of all network providers pursuant to the Centers for Medicare and Medicaid Services' (CMS) Medicaid and Children's Health Insurance Program Managed Care Final Rule (Final Rule), CMS-2390-F, dated May 6, 2016.[1] Additionally, this APL clarifies MCPs' contractual obligations related to credentialing and recredentialing as required in Title 42 of the Code of Federal Regulations (CFR), Section 438.214.[2] The screening and enrollment responsibilities are located in Part 1 and the credentialing and recredentialing responsibilities are located in Part 2 of this APL. This APL supersedes APL 17-019.[3]

BACKGROUND:
On February 2, 2011, CMS issued rulemaking CMS-6028-FC to enhance fee-for-service (FFS) provider enrollment screening requirements pursuant to the Affordable Care Act.[4] The intent of Title 42 of the CFR, Part 455, Subparts B and E was to reduce the incidence of fraud and abuse by ensuring that providers are individually identified and screened for licensure and certification.[5]

The Final Rule extended the provider screening and enrollment requirements of Title 42 of the CFR, Part 455, Subparts B and E to MCP network providers. These requirements are designed to reduce the number of providers who do not meet CMS provider enrollment requirements from participating in the MCPs' provider networks.

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[1] CMS-2390-F is available at: https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf
[2] 42 CFR, Part 438 is available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=ed7b5cfe19321ccc382dbc8dbfef17cb&mc=true&node=pt42.4.438&rgn=div5
[3] APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx
[4] CMS-6028-FC is available at: https://www.gpo.gov/fdsys/pkg/FR-2011-02-02/pdf/2011-1686.pdf
[5] 42 CFR, Part 455 is available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=3471319414e845a757a46ec42cde2b72&mc=true&node=pt42.4.455&rgn=div5

MCPs are required to maintain contracts with their network providers (Network Provider Agreement) and perform credentialing and recredentialing activities on an ongoing basis. However, prior to the Final Rule, the MCPs' network providers were not required to enroll in the Medi-Cal program. Title 42 of the CFR, Section 438.602(b) now requires states to screen and enroll, and periodically revalidate, all network providers of managed care organizations, prepaid inpatient health plans, and prepaid ambulatory health plans, aligning with the FFS enrollment requirements described in Title 42 of the CFR, Part 455, Subparts B and E. These requirements apply to both existing contracting network providers as well as prospective network providers.

The Medi-Cal FFS delivery system currently enforces a statewide set of enrollment standards. The Medi-Cal managed care program and MCPs must comply with statewide Medi-Cal FFS enrollment standards and federal enrollment standards when verifying enrollment of providers through a state-level enrollment pathway or developing a provider enrollment pathway.[6] The 21st Century Cures Act (Cures Act) required managed care network provider enrollment to be implemented by January 1, 2018.[7]

The MCPs' screening and enrollment requirements are separate and distinct from their credentialing and recredentialing processes. The credentialing and recredentialing process is one component of the comprehensive quality improvement system required in all MCP contracts.[8] Credentialing is defined as the recognition of professional or technical competence.[9] The credentialing process may include registration, certification, licensure, and/or professional association membership. The credentialing process ensures that providers are properly licensed and certified as required by state and federal law.

[6] Welfare and Institutions Code (WIC), Sections 14043 through 14045. WIC, Sections 14043 through 14045 are available at: https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=WIC&division=9.&title=&part=3.&chapter=7.&article=1.3.
[7] Title 42 of the United States Code (USC), Section 1396u-2(d)(6)(A). The USC is searchable at: http://uscode.house.gov/
[8] MCP Contract, Exhibit A, Attachment 4, Credentialing and Recredentialing. MCP contracts are available at: https://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx
[9] MCP Contract, Exhibit A, Attachment 1, Definitions.

POLICY:

Part 1: Medi-Cal Managed Care Screening and Enrollment Requirements

Available Enrollment Options

MCP network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program.[10, 11] State-level enrollment pathways are available either through the Department of Health Care Services' (DHCS) Provider Enrollment Division (PED) or another state department with a recognized enrollment pathway.[12] MCPs have the option to develop and implement a managed care provider screening and enrollment process that meets the requirements of this APL, or MCPs may direct their network providers to enroll through a state-level enrollment pathway. DHCS' PED is the primary developer of state-level enrollment pathways for FFS providers. If an MCP chooses to enroll a provider type into their network that does not have an enrollment pathway through PED, DHCS will recognize all other state-level enrollment pathways.

MCPs may screen and enroll network providers in a manner that is substantively equivalent to DHCS' provider enrollment process. However, MCPs may also rely on the enrollment and screening results conducted by DHCS or other MCPs. MCPs can access the California Health and Human Services' (CHHS) Open Data Portal to obtain a list of currently enrolled Medi-Cal FFS providers.[13] MCPs are required to issue network providers a "verification of enrollment" that MCPs can rely on to prevent enrollment duplication. MCPs may collaborate with each other to share provider screening and enrollment results.

Providers who enroll through a state-level enrollment process may participate in both the Medi-Cal FFS program as well as contract with an MCP (provided the MCP chooses to contract with the provider). However, providers who only enroll through an MCP cannot participate in the Medi-Cal FFS program. Although DHCS does not require that managed care providers enroll as FFS providers, if a provider wishes to participate in, or receive reimbursement from the Medi-Cal FFS program, the provider must enroll as a Medi-Cal FFS provider through a state-level enrollment pathway. For providers who are

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[10] "Network provider" is defined in 42 CFR, Section 438.2, available at: https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=1&SID=1b74655ecc02b0de9edb16df3de9284e&ty=HTML&h=L&mc=true&r=SECTION&n=se40.32.438_12

[11] More information on network provider status is available in APL19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status.

[12] For a complete list of state-level enrollment pathways, refer to the resource listing on the PED Frequently Asked Questions (FAQ) webpage, available at: https://www.dhcs.ca.gov/provgovpart/Pages/PEDFrequentlyAskedQuestions.aspx

[13] The CHHS Open Data Portal can be found at: https://data.chhs.ca.gov/dataset/profile-of-enrolled-medi-cal-fee-for-service-ffs-providers-as-of-june-1-2017

typically required to enroll but are restricted due to a moratorium, MCPs must develop their own enrollment pathway if the MCP chooses to include them in their network.

MCPs are not required to enroll providers that are providing services pursuant to temporary Letters of Agreement, continuity of care arrangements, or on an urgent or emergent basis. Additionally, pursuant to the July 24, 2018, CMS Medicaid Provider Enrollment Compendium (MPEC), MCPs will no longer be required to enroll providers that do not have a state-level enrollment pathway.[14] Additionally, DHCS will only process provider applications that have a state-level enrollment pathway established by DHCS' PED[15]; therefore, applications submitted to DHCS from providers that do not have a state-level enrollment pathway through PED will be denied. MCPs who choose to enroll these providers must do so through their own established enrollment process, through the recognized enrollment process developed by another MCP, or, if applicable, through a state-level enrollment pathway established by another state department.

MCP Enrollment Processes

If the MCP elects to enroll a provider, the MCP must comply with the following processes:

General Requirements:

A. MCP Provider Application and Application Fee

MCPs are not required to use DHCS' provider enrollment forms. However, MCPs must ensure that they collect all the appropriate information, data elements, and supporting documentation required for each provider type.[16] In addition, MCPs must ensure that every network provider application they process is reviewed for both accuracy and completeness. MCPs must ensure that all information specified in Title 22 of the California Code of Regulations (CCR), including but not limited to, Sections 51000.30, 51000.31, 51000.32, 51000.35, 51000.45, and 51000.60, including all required submittals and attachments of the application package, are received.[17] As part of the application process, the MCP must obtain the provider's consent to allow DHCS and the MCP to share information relating to a provider's application and eligibility, including but not limited to issues related to program integrity.

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[14] The MPEC is available at: https://www.medicaid.gov/affordable-care-act/downloads/program-integrity/mpec-7242018.pdf

[15] More information on PED's enrollment process and pathways is available at: https://www.dhcs.ca.gov/provgovpart/pages/pave.aspx

[16] Application packages by provider type can be found at the following: https://www.dhcs.ca.gov/provgovpart/Pages/ApplicationPackagesAlphabeticalbyProviderType.aspx. For associated definitions and provider types, see 22 CCR, Sections 51000 – 51000.26 and 51051.

[17] The CCR is searchable at: https://govt.westlaw.com/calregs/Search/Index

MCPs may collect an application fee, established by CMS from unenrolled prospective network providers, to cover the administrative costs of processing a provider's screening and enrollment application. The MCP's application fee policy must be comparable to, and must not exceed, the state's application fee.[18] Before collecting this fee, the MCP should be certain that the network provider is not already enrolled.

B. Medi-Cal Provider Agreement and Network Provider Agreement

All Medi-Cal providers are required to enter into a provider enrollment agreement with the state as a condition of participating in the Medi-Cal program.[19, 20] As part of the enrollment process, MCPs are responsible for ensuring that all successfully enrolled providers execute and sign the Medi-Cal Provider Agreement (DHCS Form 6208).[21] This provider agreement is separate and distinct from the Network Provider Agreement (see below). MCPs must maintain the original signed Medi-Cal Provider Agreement for each provider. MCPs are responsible for maintaining all provider enrollment documentation in a secure manner and location that ensures the confidentiality of each provider's personal information. These enrollment records must be made available upon request to DHCS, CMS, or other authorized governmental agencies.

The agreement between the MCP and a provider (Network Provider Agreement) is separate and distinct from the Medi-Cal Provider Agreement. Both the Medi-Cal Provider Agreement and the Network Provider Agreement are required for MCP network providers. The Medi-Cal Provider Agreement does not expand or alter the MCP's existing rights or obligations relating to its Network Provider Agreement.

C. Review of Ownership and Control Disclosure Information

As a requirement of enrollment, providers must disclose the information required by Title 42 of the CFR, Sections 455.104, 455.105, and 455.106, and Title 22 of the CCR, Section 51000.35. Providers who are unincorporated sole proprietors are not required to disclose the ownership or control information described in Title 42 of the CFR, Section 455.104. Providers that apply as a partnership, corporation, governmental entity, or nonprofit organization must disclose ownership or control information as required by Title 42 of the CFR, Section 455.104.

Full disclosure throughout the enrollment process is required for participation in the Medi-Cal program. These disclosures must be provided when:

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[18] For more information on DHCS' current application fee, see the "Latest News" section of the PED homepage, available at: https://www.dhcs.ca.gov/provgovpart/pages/ped.aspx
[19] Social Security Act (SSA), Section 1902(a)(27). SSA, Section 1902 is available at: https://www.ssa.gov/OP_Home/ssact/title19/1902.htm
[20] WIC, Section 14043.1(c).
[21] The Medi-Cal Provider Agreement (DHCS Form 6208) and other relevant forms related to provider agreement requirements are available at: http://files.medi-cal.ca.gov/pubsdoco/prov_enroll.asp

- A prospective provider submits the provider enrollment application.
- A provider executes the Medi-Cal Provider Agreement.
- A provider responds to an MCP's request during the enrollment re-validation process.
- Within 35 days of any change in ownership of the network provider.

Upon MCP request, a network provider must submit within 35 days:

- Full and complete information about the ownership of any subcontractor with whom the network provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and,
- Any significant business transactions between the network provider and any wholly owned supplier, or between the provider and any subcontractor, during the five-year period ending on the date of the request.[22]

Additionally, MCPs must comply with the requirements contained in Title 22 of the CCR, Section 51000.35. MCPs are not required to utilize the DHCS disclosure forms (DHCS Forms 6207 and 6216); however, MCPs must collect all information and documentation required by Title 22 of the CCR, Section 51000.35.

D. Limited, Moderate, and High Risk Assignment

MCPs must screen initial provider applications, including applications for a new practice location, and any applications received in response to a network provider's reenrollment or revalidation request to determine the provider's categorical risk level as limited, moderate, or high. If a provider fits within more than one risk level, the MCP must screen the provider at the highest risk level.

The federal requirements for screening and for MCPs to stratify their network providers by risk level are set forth in Attachment A of this APL. These federal requirements list provider types considered as limited risk, moderate risk, and high risk, and define the screening requirements for each level of risk. A provider's designated risk level is also affected by findings of license verification, site reviews, checks of suspended and terminated provider lists, and criminal background checks. MCPs must not enroll a provider who fails to comply with the screening criteria for that provider's assigned level of risk.

Providers are subject to screening based on verification of the following requirements:

<u>Limited-Risk Providers</u>:

- Meet state and federal requirements;

[22] 42 CFR, Section 455.105(b)

- Hold a license certified for practice in the state and has no limitations from other states; and
- Have no suspensions or terminations on state and federal databases.

Medium-Risk Providers

- Screening requirements of limited-risk providers; and
- Pre-enrollment and post-enrollment onsite visits to verify that the information submitted to the MCP and DHCS is accurate, and to determine compliance with state and federal enrollment requirements.

High-Risk Providers:

- Screening requirements of medium-risk providers; and
- Criminal background checks based in part on a set of fingerprints.

The MCP and DHCS will adjust the categorical risk level when any of the following circumstances occur:

- The state imposes a payment suspension on a provider based on a credible allegation(s) of fraud, waste, or abuse.
- The provider has an existing Medicaid overpayment based on fraud, waste, or abuse.
- The provider has been excluded by the Office of Inspector General or another state's Medicaid program within the previous ten years, or when a state or federal moratorium on a provider type has been lifted.

Providers are categorized as high-risk if that provider would have been prevented from applying for enrollment due to a moratorium and the moratorium was lifted in the past six months.[23, 24]

DHCS will provide the information necessary to determine provider risk level to MCPs on a regular basis. MCPs may also obtain this information upon request from their DHCS Managed Care Operations Division (MCOD) contract manager.

E. Additional Criteria for High Risk Providers – Fingerprinting and Criminal Background Check

High-risk providers are subject to criminal background checks, including fingerprinting and the screening requirements for medium-risk providers. Regardless of whether a high-risk provider has undergone fingerprinting in the past, the requirement to submit to a criminal background check and fingerprinting remains the same. Any person with a 5%

[23] 42 CFR, Section 455.450(e)(2)
[24] WIC, Section 14043.38(b)(4)

or more direct or indirect ownership in a high-risk applicant must submit to a criminal background check.[25] In addition, information discovered in the process of onsite reviews or data analysis may lead to a request for fingerprinting and criminal background checks for applicants.

DHCS will coordinate all criminal background checks. MCPs must direct providers to fill out Form BCIA 8016 on the California Department of Justice (DOJ) website.[26] MCPs must ensure providers include the correct agency information on the Live Scan form when submitting their application to the California DOJ so their application is processed correctly. The agency-specific information must be included in the appropriate fields as detailed below:

Applicant Submission

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

Contributing Agency Information

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

[25] WIC, Section 14043.38(c)
[26] The Live Scan form is available on Forms for Applicant Agencies webpage on the DOJ website, available at: https://oag.ca.gov/fingerprints/forms.

When fingerprinting is required, MCPs must furnish the provider with the Live Scan form and instructions on where to deliver the completed form. It is critical that MCPs distribute the designated Live Scan form as this ensures the criminal history check results are forwarded directly to DHCS. The provider shall deliver the completed Live Scan form to the California DOJ. The provider is responsible for paying for any Live Scan processing fees. MCPs must notify DHCS upon initiation of each criminal background check for a provider that has been designated as high risk. DHCS will provide notification of the Live Scan results directly to the MCP. The MCP must maintain the security and confidentiality of all of the information it receives from DHCS relating to the provider's high-risk designation and the results of the criminal background checks.

F. Site Visits

MCPs must conduct pre- and post-enrollment site visits of medium-risk and high-risk providers to verify that the information submitted to the MCP and DHCS is accurate, and to determine the applicant's compliance with state and federal enrollment requirements, including but not limited to, Title 22 of the CCR, Sections 51000.30, 51000.31, 51000.32, 51000.35, 51000.45, and 51000.60. MCPs must conduct post-enrollment site visits for medium-risk network providers at least every five years, and their high-risk network providers every three years or as necessary. Post-enrollment onsite visits verify that the information submitted to the MCP and DHCS is accurate, and to determine if providers are in compliance with state and federal enrollment requirements. In addition, all providers enrolled in the Medi-Cal program, including providers enrolled through MCPs, are subject to unannounced onsite inspections at all provider locations.[27]

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

- The provider was temporarily suspended from the Medi-Cal program.
- The provider's license was previously suspended.
- There is conflicting information in the provider's enrollment application.
- There is conflicting information in the provider's supporting enrollment documentation.
- As part of the provider enrollment process, the MCP receives information that raises a suspicion of fraud.

[27] 42 CFR, Section 455.432

G. Federal and State Database Checks

During the provider enrollment/reenrollment process, MCPs are required to check the following databases to verify the identity and determine the exclusion status of all providers:[28]

- Social Security Administration's Death Master File.[29]
- National Plan and Provider Enumeration System (NPPES).[30]
- List of Excluded Individuals/Entities (LEIE).[31]
- System for Award Management (SAM).[32]
- CMS' Medicare Exclusion Database (MED).[33]
- DHCS' Suspended and Ineligible Provider List.[34]
- Restricted Provider Database (RPD).[35]

In addition to checking all the databases upon a provider's enrollment/reenrollment, MCPs must also review the SAM, LEIE, and RPD databases on a monthly basis. All databases must be reviewed upon a provider's enrollment/reenrollment to ensure that the provider continues to meet enrollment criteria. Each MCP network provider must maintain good standing in the Medicare and Medicaid/Medi-Cal programs. Any provider terminated from the Medicare or Medicaid/Medi-Cal program may not participate in the MCP's provider network.

H. Denial or Termination of Enrollment/Appeal Process

MCPs may enroll providers to participate in the Medi-Cal managed care program. However, if the MCP declines to enroll a provider, it must refer the provider to DHCS for further enrollment options. If the MCP acquires information, either before or after enrollment that may impact the provider's eligibility to participate in the Medi-Cal program, or a provider refuses to submit to the required screening activities, the MCP may decline to accept that provider's application. However, only DHCS can deny or terminate a provider's enrollment in the Medi-Cal program.[36]

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[28] 42 CFR, Section 455.436
[29] Information on requesting access to the Social Security Administration's Death Master File is available at: https://www.ssa.gov/dataexchange/request_dmf.html
[30] NPPES is available at: https://nppes.cms.hhs.gov
[31] LEIE is available at: https://oig.hhs.gov/exclusions/exclusions_list.asp
[32] SAM is available at: https://www.sam.gov/SAM/
[33] An overview of MED is available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MED/Overview-MED.html. The MED database is the source that is used to populate the LEIE list. MCPs can use the LEIE if they are not able to access MED.
[34] The Suspended and Ineligible Provider List is available at: http://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp
[35] The Restricted Provider Database is available at: https://eportal.dhcs.ca.gov/dhcs/ai-rp. For information on gaining access to the database, refer to the FAQ included with this APL.
[36] 42 CFR, Section 455.416

If at any time the MCP determines that it does not want to contract with a prospective provider, and/or that the prospective provider will not meet enrollment requirements, the MCP must immediately suspend the enrollment process. The MCP must inform the prospective provider that he/she may seek enrollment through DHCS.[37]

MCPs are not obligated to establish an appeal process for screening and enrollment decisions. Providers may only appeal a suspension or termination to DHCS when the suspension or termination occurs as part of DHCS' denial of the Medi-Cal FFS enrollment application.[38]

I. Provider Enrollment Disclosure

At the time of application, MCPs must inform their network providers, as well as any providers seeking to enroll with an MCP, of the differences between the MCP's and DHCS' provider enrollment processes, including the provider's right to enroll through DHCS.

DHCS has provided a disclosure statement in Attachment B of this APL, which MCPs may use to advise providers. MCPs are not required to use this exact form, but any disclosure used must contain, at a minimum, the same information contained in Attachment B. DHCS may periodically require MCPs to provide additional disclosures to providers relating to differences in the enrollment processes.

The provider enrollment disclosure must include, but is not limited to, the following elements:

- A statement that certain enrollment functions will not be performed by the MCP, but will continue to be performed by DHCS, including fingerprinting, criminal background checks, and decisions to deny or terminate enrollment.
- A notice that some of the enrollment requirements and rights found in the state enrollment process may not be applicable when a provider chooses to enroll through an MCP, including provisional provider status with Medi-Cal FFS, processing timelines of the enrollment application, and the ability to appeal an MCP's decision to suspend the enrollment process.
- A provision informing the provider that if the MCP receives any information that impacts the provider's eligibility for enrollment, the MCP will suspend processing of the provider's enrollment application and make the provider aware of the option to apply through DHCS' Medi-Cal FFS provider enrollment process.

[37] Provider enrollment information can be found at: https://www.dhcs.ca.gov/provgovpart/Pages/PED.aspx
[38] 42 CFR, Section 455.422

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

J. Post Enrollment Activities

Revalidation of Enrollment
To ensure that all enrollment information is accurate and up-to-date, all providers must resubmit and recertify the accuracy of their enrollment information as part of the revalidation process. MCPs may align revalidation efforts with their recredentialing efforts to reduce duplication of activities. MCPs must revalidate the enrollment of each of their network providers at least every five years.[39] MCPs are not required to revalidate providers that were enrolled through DHCS or revalidated by another MCP.

Retention of Documents
MCPs are required to retain all provider screening and enrollment materials and documents for ten years.[40] Additionally, MCPs must make all screening and enrollment documents and materials promptly available to DHCS, CMS, and any other authorized governmental entities upon request.

K. Miscellaneous Requirements

Timeframes
Within 120 days of receipt of a provider application, the MCP must complete the enrollment process and provide the applicant with a written determination. MCPs may allow providers to participate in their network for up to 120 days, pending the outcome of the screening process.[41]

Delegation of Screening and Enrollment
MCPs may delegate their authority to perform screening and enrollment activities to a subcontractor. When doing so, the MCP remains contractually responsible for the completeness and accuracy of the screening and enrollment activities. To ensure that the subcontractor meets both the MCP's and DHCS' standards, the delegating MCP must evaluate the subcontractor's ability to perform these activities, including an initial review to ensure that the subcontractor has the administrative capacity, experience, and budgetary resources to fulfill its responsibilities. The MCP must continuously monitor, evaluate, and approve the delegated functions.

[39] 42 CFR, Section 455.414
[40] 42 CFR, Section 438.3(u)
[41] 42 CFR, Section 438.602(b)(2)

Part 2: Medi-Cal Managed Care Credentialing and Recredentialing Requirements
MCPs must ensure that each of its network providers is qualified in accordance with current legal, professional, and technical standards, and is appropriately licensed, certified, or registered. MCPs must implement the provider credentialing and recredentialing policy described below by developing and maintaining written policies and procedures that include initial credentialing, recredentialing, recertification, and reappointment of their network providers. Each MCP must ensure that its governing body, or the designee of its governing body, reviews and approves these policies and procedures, and must ensure that the responsibility for recommendations regarding credentialing decisions rest with a credentialing committee or other peer-review body.

Some screening and enrollment requirements overlap with credentialing and recredentialing requirements. Any such overlap does not require an MCP to duplicate any of the activities described in this APL. However, if an MCP relies on the screening and enrollment activities conducted by another MCP, or by DHCS, the MCP must comply with all credentialing and recredentialing requirements described in this APL.

Provider Credentialing
MCPs are required to verify the credentials of their network providers, and to verify the following items, as required for the particular provider type, through a primary source,[42] as applicable:[43]

- The appropriate license and/or board certification or registration.
- Evidence of graduation or completion of any required education.
- Proof of completion of any relevant medical residency and/or specialty training.
- Satisfaction of any applicable continuing education requirements.

MCPs must also receive the following information from every network provider, but do not need to verify this information through a primary source:

- Work history.
- Hospital and clinic privileges in good standing.
- History of any suspension or curtailment of hospital and clinic privileges.
- Current Drug Enforcement Administration identification number.
- National Provider Identifier number.
- Current malpractice insurance in an adequate amount, as required for the particular provider type.
- History of liability claims against the provider.

[42] "Primary source" refers to an entity, such as a state licensing agency, with legal responsibility for originating a document and ensuring the accuracy of the document's information.
[43] The listed requirements are not applicable to all provider types. When applicable to the provider's designation, the information must be obtained.

- Provider information, if any, entered in the National Practitioner Data Bank, when applicable.[44]
- History of sanctions from participating in Medicare and/or Medicaid/Medi-Cal. Providers terminated from either Medicare or Medicaid/Medi-Cal, or on the Suspended and Ineligible Provider List, may not participate in the MCP's provider network.
- History of sanctions or limitations on the provider's license issued by any state agencies or licensing boards.

MCPs are required to credential all contracted providers that render services to assigned members, whether the providers have a state-level FFS enrollment pathway or not, in accordance with state and federal law.

Attestations

For all network providers types who deliver Medi-Cal covered medical services, the provider's application to contract with the MCP must include a signed and dated statement attesting to all the following:

- Any limitations or inabilities that affect the provider's ability to perform any of the position's essential functions, with or without accommodation.
- A history of loss of license or felony conviction.
- A history of loss or limitation of privileges or disciplinary activity.
- A lack of present illegal drug use.
- The application's accuracy and completeness.[45]

Provider Recredentialing

DHCS requires each MCP to verify every three years that each network provider delivering medical services continues to possess valid credentials. MCPs must review new applications from providers and verify the items listed under the Provider Credentialing section of this APL, in the same manner, as applicable. Recredentialing must include documentation that the MCP has considered information from other sources pertinent to the credentialing process, such as quality improvement activities, member grievances, and medical record reviews. The recredentialing application must include the same attestation as contained in the provider's initial application.

MCPs must maintain a system for reporting to the appropriate oversight entities all serious quality deficiencies that result in the suspension or termination of a network provider. MCPs must maintain policies and procedures for disciplinary actions, including

[44] National Practitioner Data Bank is available at: https://www.npdb.hrsa.gov/
[45] For more information, see Policy Letter (PL) 02-003, or any future iterations of this PL. PLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/PolicyLetters.aspx

reduction, suspension, or termination of a provider's privileges, and must implement and maintain a provider appeal process.

MCPs must also conduct onsite reviews of their network provider sites.[46] MCPs must perform site reviews as part of each provider's initial credentialing process when both the site and provider have been added to the MCP's provider network; thereby, both the site review and credentialing requirements can be completed at the same time. A new site review is not required when new providers join an approved site within three years of the site's previous passing review.

Delegation of Provider Credentialing and Recredentialing

MCPs may delegate their authority to perform credentialing reviews to a professional credentialing verification organization. The MCP remains contractually responsible for the completeness and accuracy of these activities. If an MCP delegates credential verification activities, it should establish a formal and detailed agreement with the entity performing those activities. These agreements must be revised when the parties change the agreement's terms and conditions. To ensure accountability for these activities, the MCP must establish a system that:

- Evaluates the subcontractor's ability to perform delegated activities that includes an initial review to assure that the subcontractor has the administrative capacity, experience, and budgetary resources to fulfill its responsibilities.
- Ensures that the subcontractor meets MCP and DHCS standards.
- Continuously monitors, evaluates, and approves the delegated functions.

Entities such as medical groups or independent physician organizations may conduct delegated credentialing activities and may obtain a Provider Organization Certification (POC) from the National Committee on Quality Assurance (NCQA) at their discretion. The POC focuses on the entity's role as the agent performing the credentialing functions on behalf of an MCP. The MCP may accept evidence of NCQA POC in lieu of a monitoring site visit at delegated physician organizations. If an MCP delegates credential verification activities, it should establish a formal and detailed written agreement with that entity. Such agreements need not be revised until the parties to the agreement change the agreement's terms and conditions.

Health Plan Accreditation

MCPs that receive a rating of "excellent," "commendable," or "accredited" from the NCQA will be deemed to have met DHCS' requirements for credentialing. Such MCPs will be exempt from DHCS' medical review audit of credentialing practices. However, MCPs retain overall responsibility for ensuring that credentialing requirements are met.

[46] For more information, see PL 14-004, and any future iterations of this PL.

Credentialing accreditation from entities other than the NCQA will be considered by DHCS upon request.

MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations and other contract requirements as well as DHCS guidance, including applicable APLs, PLs and Dual Plan Letters. These requirements must be communicated by each MCP to all delegated entities and subcontractors. For questions regarding this APL, please contact your MCOD contract manager.

Sincerely,

Original signed by Sarah Brooks

Sarah Brooks, Deputy Director
Health Care Delivery Systems

Attachments

Attachment A
Provider Types and Categories of Risk[47]

(1) Limited Risk Provider Types. Physician or non-physician practitioners and medical groups or clinics:

- Ambulatory Surgical Centers (ASCs)
- End-Stage Renal Disease (ESRD) facilities
- Federally Qualified Health Centers (FQHCs)
- Histocompatibility laboratories
- Hospitals, including Critical Access Hospitals (CAHs)
- Indian Health Service (IHS) facilities
- Mammography screening centers
- Mass immunization roster billers
- Organ Procurement Organizations (OPOs)
- Portable x-ray suppliers
- Providers or suppliers that are publicly traded on the New York Stock Exchange (NYSE) or the NASDAQ
- Public or Government-Owned Ambulance Services Suppliers
- Religious Nonmedical Health Care Institutions (RNHCIs)
- Rural Health Clinics (RHCs)
- Radiation therapy centers
- Skilled Nursing Facilities (SNFs)

(2) Moderate Risk Provider Types. Provider and supplier categories:

- Community mental health centers
- Comprehensive outpatient rehabilitation facilities
- Currently enrolled (re-validating) home health agencies
  - Exception: Any such provider that is publicly traded on the NYSE or the NASDAQ is considered “limited” risk
- Currently enrolled (re-validating) suppliers of Durable Medical Equipment, Prosthetics, Orthotics, or Supplies (DMEPOS)
  - Exception: Any such supplier that is publicly traded on the NYSE or NASDAQ is considered “limited” risk
- Hospice organizations
- Independent clinical laboratories
- Independent diagnostic testing facilities
- Non-public, non-government owned or affiliated ambulance services suppliers
  - Exception: Any such provider or supplier that is publicly traded on the NYSE or NASDAQ is considered “limited” risk.

(3) High Risk Provider Types. Characteristics and provider types:

[47] The CMS-6028-FC Tables 1–3. Federal Register / Vol. 76, No. 22 / February 2, 2011 / Rules and Regulations is available at: https://www.govinfo.gov/content/pkg/FR-2011-02-02/pdf/2011-1686.pdf

- Prospective (newly enrolling) home health agencies and prospective (newly enrolling) suppliers of DMEPOS
- Providers prevented from applying for enrollment due to a moratorium and the moratorium was lifted in the past six months
- Diabetes Prevention Program (DPP) providers

Attachment B
Managed Care Provider Enrollment Disclosure

Background

Beginning January 1, 2018, federal law requires that managed care providers that have a state-level FFS enrollment pathway must enroll in the Medi-Cal program if they wish to provide services to Medi-Cal managed care beneficiaries. Managed care providers have two options for enrolling with the Medi-Cal program. Providers may enroll through either (1) DHCS; or (2) an MCP. If a provider enrolls through DHCS, the provider is eligible to provide services to Medi-Cal FFS beneficiaries and contract with MCPs. If the provider enrolls through an MCP, the provider may only provide services to Medi-Cal managed care beneficiaries and may not provide services to Medi-Cal FFS beneficiaries.

Generally, federal and state laws and regulations that apply to fee-for-service (FFS) providers will also apply to the enrollment process for managed care providers. Regardless of the enrollment option a provider chooses, the provider is required to enter into two separate agreements: (1) the Network Provider Agreement and (2) the Medi-Cal Provider Agreement. The Network Provider Agreement is the contract between an MCP and a provider defining their contractual relationship. The Medi-Cal Provider Agreement is the agreement between DHCS and the provider and is required for all providers enrolled in the Medi-Cal program.

Enrollment Options

A. **Enrollment through an MCP.** The following provides an overview of the MCP enrollment process:

- The provider will submit a provider enrollment application to the MCP using a process developed by the MCP.
- As part of the application process, the provider will be required to agree that DHCS and the MCP may share information relating to a provider's application and eligibility, including but not limited to issues related to program integrity.
- The MCP will be responsible for gathering all necessary documents and information associated with the MCP application.
- The provider should direct any questions it has regarding its MCP application to the MCP.
- If the provider's application requires fingerprinting, criminal background checks, and/or the denial or termination of enrollment, these functions will be performed by DHCS and the results shared with the MCP.
- While the MCP enrollment process will be substantially similar to the DHCS enrollment process, timelines relating to the processing of the enrollment

application may differ. In addition, MCPs will not have the ability to grant provisional provider status nor to authorize FFS reimbursement.
- Providers will not have the right to appeal an MCP's decision to cease the enrollment process
- The MCP will complete the enrollment process within 120 days of the provider's submission of its application. During this time, the provider may participate in the MCP's network for up to 120 days, pending approval from the MCP.
- Once the enrolling MCP places a provider on the Enrolled Provider List, the provider is eligible to contract with all MCPs. However, an MCP is not required to contract with an enrolled provider.
- Only DHCS is authorized to deny or terminate a provider's enrollment in the Medi-Cal program.
- Accordingly, if the MCP receives any information that impacts the provider's enrollment, the MCP will suspend processing the provider's enrollment application and refer the provider to DHCS' PED for enrollment where the application process will start over again.
- In order for the provider to participate in the Medi-Cal FFS program, the provider must first enroll through DHCS.

B. Enrollment through DHCS. The following provides information on DHCS' enrollment process:

- DHCS' Provider Enrollment page and the Provider Enrollment information on DHCS' website will be updated to reflect that PED is no longer accepting paper applications for provider types supported in the Provider Application and Validation for Enrollment (PAVE) portal. There will be links per provider type that will guide applicants to PAVE. For those provider not yet fully migrated into PAVE, the provider will use DHCS' standardized application form(s) when applying for participation in the Medi-Cal program until such time that the application is migrated into PAVE processing.[48]
- Federal and state laws and regulations that apply to FFS providers will apply to the enrollment process for managed care providers.
- Upon successful enrollment through DHCS, the provider will be eligible to contract with MCPs and provide services to FFS beneficiaries.

There may be other important aspects of the enrollment process that are not set forth in this information bulletin. Please check the DHCS website for provider enrollment updates. Providers should consult with their own legal counsel before determining which enrollment process best suit its needs and objectives.

[48] For more information, see the "Application Packages by Provider Type" webpage on the DHCS website, available at: https://www.dhcs.ca.gov/provgovpart/Pages/ApplicationPackagesAlphabeticalbyProviderType.aspx)

Medi-Cal Procedure/Drug Code Limitation Introduction

Page updated: August 2020

In accordance with SB 857 and Welfare and Institutions Code (W&I Code), Section 14044, a Procedure/ Drug Code Limitation (P/DCL) may be imposed on a provider's use of one or more codes (CPT®, NDC or HCPCS) for a period of up to 18 months, if one of the following conditions exists:

- The Department of Health Care Services (DHCS) determines, by audit or other investigation, that excessive services, billings or abuse have occurred by a provider
- A provider's licensing authority or a court of competent jurisdiction limits a licensee's practice of medicine, where the limitation precludes the licensee from performing services that could otherwise be reimbursed

A provider placed on P/DCL sanction will not be able to receive reimbursement for those services under restriction. In addition, providers who fill orders for lab tests, drugs, medical supplies or any other restricted services prescribed or ordered by a provider under restriction will not be reimbursed.

The limitation becomes effective after DHCS gives the provider notice of the proposed limitation, and no appeal is submitted within 45 days or following the denial of an appeal.

DHCS reviews provider appeal evidence and issues the appeal decision within 45 days of receipt. If the appeal is not granted, the code-use limitations become effective 15 days after provider notification.

In a situation where the sanction could interfere with the provider's or other prescriber's ability to render health care services to a recipient, the burden to transfer the recipient's care to another qualified provider remains the responsibility of the provider.

The P/DCL may be used separately or in tandem with other existing anti-fraud and abuse efforts.

‹‹Legend››

‹‹Symbols used in the document above are explained in the following table. ››

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.››

Policy:	GG.1650Δ
Title:	**Credentialing and Recredentialing of Practitioners**
Department:	Medical Management
Section:	Quality Improvement
CEO Approval:	*/s/*
Effective Date:	06/01/2017
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE ☐ Administrative

I. PURPOSE

This policy defines the process by which CalOptima evaluates and determines whether to approve or decline practitioners (as described in Section II. of this Policy ("Practitioners")) for participation in CalOptima programs.

II. POLICY

A. CalOptima shall establish guidelines by which CalOptima shall evaluate and select Practitioners to participate in CalOptima, in accordance with ~~Title 42, Code of Federal Regulations, Section 422.204(a) and other~~ applicable laws, regulations, and regulatory guidance.

B. CalOptima may delegate Credentialing and Recredentialing activities to a Health Network or other Delegate in accordance with CalOptima Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities. Delegated activities may include but are not limited to: Credentialing decisions, Credentialing verification, monitoring of sanctions, and processing of Credentialing applications.

1. A Health Network or Delegate shall establish policies and procedures to evaluate and approve Practitioners to participate in CalOptima programs that, at minimum, meet the requirements as outlined in this policy.

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

D. The CalOptima CPRC shall be responsible for reviewing a Practitioner's Credentialing information and determining such Practitioner's participation in CalOptima.

E. CalOptima shall credential and recredential the following Practitioners as provided in this Policy: Physicians, Non-Physicians Medical Practitioners, Behavioral Health Practitioners, Substance Use

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Disorder (SUD) Practitioners, and Long-Term Services and Supports (LTSS) Practitioners that provide care to CalOptima program Members, and are:

1. Licensed, certified, or registered by the state of California to practice independently;

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

3. Who provide care to Members under the organization's medical benefits.

F. Credentialing and recredentialing shall apply to Practitioners meeting the criteria in Section II.E. of this Policy, regardless of whether they provide care:

1. In individual or group practices;

2. In facilities; or

3. Through telemedicine/telehealth i.e., virtual care visit.

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

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

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

3. NMPs who are not PAs and who provide services under the employment agreement of a credentialed Provider.

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

I. CalOptima does not credential or recredential:

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

2. Practitioners that practice exclusively within freestanding facilities, and provide care for a Member only as a result of the Member being directed to the facility (e.g. Diagnostic Radiologists, Urgent Care, Emergency Medicine);

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

4. Covering Practitioners (e.g., locum tenens) who do not have an independent relationship with CalOptima; and

5. Practitioners who do not provide care for a Member in a treatment setting (e.g., External Physician Reviewer).

J. CalOptima shall ensure that any provider for whose provider type has an enrollment pathway with Department of Health Care Services (DHCS) is enrolled with DHCS as a provider in accordance with DHCS All Plan Letter (APL) 19-004: Provider Credentialing / Recredentialing and Screening / Enrollment, Title 42, CFR, Section 455, and as described in Sections III.A. and III.B. of this Policy.

K. CalOptima shall recredential a Practitioner at least every three (3) years, utilizing a thirty-six (36)-month cycle to the month, not to the day.

L. CalOptima shall ensure that all Practitioners maintain current California licensure, Drug Enforcement Agency (DEA) certification, and medical malpractice insurance in the interval between Credentialing cycles and shall monitor various state, federal, boards, agencies and databanks for adverse activities in accordance with CalOptima Policy GG.1607Δ: Monitoring Adverse ~~Activities.~~Actions.

M. If CalOptima declines to include a Practitioner in the CalOptima network, CalOptima shall notify, in writing, such Practitioner within thirty (30) calendar days of the date of the decision of the reason(s) for the denial.

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

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

2. Using different reimbursement amounts for different specialties, or for different Practitioners in the same specialty; and

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

O. CalOptima shall not discriminate against a Practitioner that serves high-risk populations or specializes in the treatment of costly conditions.

P. CalOptima shall not make, or decline, Credentialing and Recredentialing decisions based on a Practitioner's race, ethnicity, national identity, gender, age, sexual orientation, or the type of procedure, or patient, in which the Practitioner specializes.

Q. CalOptima shall monitor and prevent discriminatory Credentialing decisions as provided in this Policy.

R. CalOptima shall maintain the confidentiality of Credentialing files, in accordance with CalOptima Policy GG.1604Δ: Confidentiality of Credentialing Files.

S. CalOptima shall maintain Credentialing files that include documentation of required elements, as described in this Policy.

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

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

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

W. On an annual basis, the CalOptima Board of Directors shall review and approve this Policy.

III. PROCEDURE

A. Practitioner Initial Credentialing

1. In conjunction with the CalOptima Provider Relations and Contracting Departments, a Practitioner shall initiate the Credentialing process with CalOptima.

   a. Upon receipt of the request from the Practitioner, CalOptima shall send a notification electronically, explaining the expectations for completion and submission of the Credentialing application and required documents.

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

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

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

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

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

      iv. History of criminal convictions;

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

      vi. Current malpractice insurance coverage; and

      vii. The correctness and completeness of the application;

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

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

f. CalOptima shall return an incomplete application to a Practitioner, and such incomplete application will not be processed until the Practitioner submits all the required information.

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

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

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

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

2. Upon receipt of a complete Credentialing application, CalOptima shall verify the information provided through primary verification using industry-recognized verification sources or a Credentialing Verification Organization. This information includes, but is not limited to:

a. A current, valid California license to practice in effect at the time of the Credentialing decision;

b. Board Certification, as applicable, unless exempt from the Board Certification requirement pursuant to CalOptima Policy GG.1633Δ: Board Certification Requirements for Physicians; and

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

3. CalOptima shall also collect and verify the following information from each Provider as applicable but need not verify this information through a primary source. (see Attachment B). This information includes, but is not limited to:

a. Work history, including all post-graduate activity in the last five (5) years (on initial Credentialing). The Practitioner shall provide, in writing, an explanation of any gaps of six (6) months, or more;

b. Written, or verbal, confirmation from the Practitioner's primary inpatient admitting facility that the Practitioner has privileges in good standing, or confirmation that the Practitioner refers patients to hospital-based Practitioners (Hospitalist), as applicable;

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

d. A valid DEA, or Controlled Dangerous Substances (CDS), certificate obtained through confirmation by National Technical Information Service (NTIS), if applicable, in effect at the time of the Credentialing decision; DEA certificate must show an address within the state of California;

e. A valid National Provider Identifier (NPI) number;

f. Current malpractice insurance or self-insurance (e.g., trust, escrow accounts coverage) in the minimum amounts of one million dollars ($1,000,000.00) per occurrence and three million dollars ($3,000,000.00) aggregate per year at the time of the Credentialing decision~~.~~ For Behavioral Health Services Providers, the minimum amounts shall be no less than one million dollars ($1,000,000.00) per incident and one million dollars ($1,000,000.00) aggregate per year at the time of the Credentialing decision.

g. Practitioner information entered in the National Practitioner Data Bank (NPDB), if applicable;

h. No exclusion, preclusion, suspension, or ineligibility to participate in any state and federal health care program at the time of the Credentialing decision;

i. A review of any Grievances, or quality cases, filed against a Practitioner in the last five (5) years;

j. No exclusion or preclusion from participation at any time in federal, or state, health care programs based on conduct within the last ten (10) years that supports a mandatory exclusion or preclusion under the Medicare program, as set forth in Title 42, United States Code, Section 1320a-7(a), as follows:

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

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

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

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

k. History of professional liability claims that resulted in settlements or judgments, paid by, or on behalf of, the Practitioner;

l. History of state sanctions, restrictions on licensure or limitations on scope of practice;

m. Human Immunodeficiency Virus (HIV) specialist attestation, if applicable;

n. Full or provisional California Children's Services (CCS)-paneled approval status, with a current active panel status;

~~o.~~ Current IRS Form W-9;

~~p.~~o. ~~———————————~~

~~q.~~p. Current (within last three (3) years) Full Scope FSR/MRR, and PARS, as applicable, pursuant to CalOptima Policy GG.1608Δ: Full Scope Site Reviews;

~~r.~~q. Active enrollment status with Medi-Cal, as required; and

~~s.~~r. ~~Absence from the~~Active enrollment status with Medicare ~~Preclusion List~~ for OneCare ~~and~~or OneCare Connect ~~Practitioners.~~ as required (i.e., has not Opted-Out of Medicare program).

B. Practitioner Recredentialing

1. CalOptima shall Recredential a Practitioner at least every three (3) years after initial Credentialing. At the time of Recredentialing, CalOptima shall:

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

   b. Incorporate the following data in the decision-making process, which shall have been reviewed no more than one hundred eighty (180) calendar days before the Recredentialing decision is made.

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

      ii. Information from quality review activities;

      iii. Board Certification, if applicable;

      iv. Member satisfaction, if applicable;

      v. Medical Record Reviews, if applicable;

      vi. FSR results and PARS results, if applicable; and

      vii. Compliance with the terms of the Practitioner's contract.

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

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

3. CalOptima shall ensure that all Practitioners maintain current California licensure, Drug Enforcement Agency (DEA) certification, and medical malpractice insurance in the interval between Credentialing cycles.

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

C. Practitioner Rights

1. New applicants for Credentialing will receive Practitioner rights included in the Addendum A of the credentialing application, as follows:

   a. Right to review information

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

   b. Right to correct erroneous information

      i. All Practitioners will be notified by certified mail when Credentialing information obtained from other sources varies substantially from that provided by the Practitioner;

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

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

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

         c) All submissions will be mailed to CalOptima's Quality Improvement Department using the following address:

            Attention: Quality Improvement Department – Credentialing
            CalOptima
            505 City Parkway West
            Orange, CA 92868

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

2. Documentation of receipt of corrections

   a. A Practitioner shall be notified within thirty (30) calendar days via a letter to document CalOptima's receipt of the identified erroneous information.

3. Right to be notified of application status

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

   b. Practitioners may request to review non-privileged information obtained from outside sources (e.g., malpractice insurance carriers and licensing boards).

   c. Practitioners can contact the Quality Improvement Department by phone, e-mail, or facsimile requesting the status of their application. The Quality Improvement Department will respond within one (1) business day of the status of the Practitioner's application with respect to outstanding information required to complete the application process.

D. Credentialing and Peer Review Committee (CPRC)

1. CalOptima shall designate a CPRC that uses a peer-review process to make recommendations and decisions regarding Credentialing and Recredentialing.

2. Such CPRC shall include representation from a range of Practitioners participating in the organization's network and shall be responsible for reviewing a Practitioner's Credentialing and Recredentialing files and determining the Practitioner's participation in CalOptima programs.

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

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

      i. A clean file shall be considered approved and effective on the date that the CMO or his or her physician Designee review and approve a Practitioner's Credentialing, or Recredentialing, file, and deem the file clean.

      ii. ~~Approved, clean~~Clean file lists approved by a Medical Director shall be presented at the CPRC for final approval and be reflected in the meeting minutes.

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

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

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

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

4. The CPRC shall make recommendations based on the Practitioners' ability to deliver care based on the Credentialing information collected from the file review process and shall be verified prior to making a Credentialing decision.

a. The Quality Improvement Department shall send the Practitioner a decision letter, within thirty (30) calendar days of the decision~~:~~ indicating:

i. Acceptance;

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

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

b. CalOptima shall render a final decision within one hundred eighty (180) calendar days from the date of licensure verification.

i. If CalOptima is unable to render a decision within one hundred eighty (180) calendar days from the date of licensure verification for any Practitioner, during the Practitioner's Credentialing or Recredentialing process, the application shall be considered expired.

E. CalOptima shall monitor and prevent discriminatory practices, to include, but not be limited to:

1. Monitoring

a. CalOptima shall conduct periodic audits of Credentialing files (in-process, denied, and approved files) to ensure that Practitioners are not discriminated against; and

b. Review Practitioner complaints to determine if there are complaints alleging discrimination.

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

2. Prevention

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

F. Upon acceptance of the Credentialing application, the CalOptima Quality Improvement Department shall generate a Provider profile and forward the Provider profile to the Contracting and Provider Data Management Service (PDMS) Departments. This Provider profile shall be generated from the Credentialing database to ensure that the information is consistent with data verified during the Credentialing process (i.e., education, training, Board Certification and specialty). The PDMS Department will enter the contract and Credentialing data into CalOptima's core business system, which updates pertinent information into the online provider directory.

IV. ATTACHMENT(S)

A. California Participating Physician Application (CPPA)
B. CalOptima Primary Source Verification Table
C. Council for Affordable Quality Healthcare Provider Application (CAQH)
D. HIV/AIDS Specialist Designation
E. Attestation Questions
F. Addendum A Practitioner Rights

V. REFERENCE(S)

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima 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. CalOptima PACE Program Agreements
E. CalOptima Contract for Health Care Services
F. NCQA Standards and Guidelines
G. CalOptima Policy GG.1406~~:~~Δ: Pharmacy Network: Credentialing and Access
H. CalOptima Policy GG.1602~~:~~Δ: Non-Physician Medical Practitioner (NMP) Scope of Practice
I. CalOptima Policy GG.1604Δ: Confidentiality of Credentialing Files
J. CalOptima Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities
K. CalOptima Policy GG.1607Δ: Monitoring Adverse ~~Activities~~Actions
L. CalOptima Policy GG.1608Δ: Full Scope Site Reviews
M. CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners
N. CalOptima Policy GG.1619: Delegation Oversight
O. CalOptima Policy GG.1633Δ: Board Certification Requirements for Physicians
P. CalOptima Policy GG.1643Δ: Minimum Physician Standards
Q. CalOptima Policy GG.1651Δ: ~~Credentialing and Recredentialing of a Healthcare Delivery Organization (HDO)~~Assessment and Re-Assessment of Organizational Providers
R. CalOptima Policy HH.1101: CalOptima Provider Complaint
S. CalOptima Policy MA.9006: Provider Complaint Process
T. Department of Health Care Services All Plan Letter (APL) 16-009: Adult Immunizations as a Pharmacy Benefit
U. Department of Health Care Services All Plan Letter (APL) 19-004: Provider Credentialing / Recredentialing and Screening / Enrollment
V. Department of Health Care Services All Plan Letter (APL) ~~18-023~~21-005: California Children's Services Whole Child Model Program
W. Title 42, Code of Federal Regulations, §§422.204(a), 422.205, 438.12, 438.214, 460.64 and 460.71
X. Title 42, Code of Federal Regulations, ~~§~~Part 455, Subpart E
Y. Title 42, United States Code, §1320a-7(a)
Z. Title XVIII and XIV of the Social Security Act
AA. California Business and Professions Code, §805 and §§3500-3502.3
BB. California Evidence Code, §1157
CC. Medicare Managed Care Manual, Chapter 6: Relationships with Providers

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
04/28/2015	Department of Health Care Services (DHCS)	Approved as Submitted
09/20/2018	Department of Health Care Services (DHCS)	Approved as Submitted
10/13/2020	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

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

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/01/1995	GG.1609	Health Network Practitioner Credentialing Program Standards	Medi-Cal
Revised	12/01/1995	GG.1609	Health Network Practitioner Credentialing Program Standards	Medi-Cal
Revised	12/01/1996	GG.1609	Health Network Practitioner Credentialing Program Standards	Medi-Cal
Revised	02/01/1998	GG.1609	Health Network Practitioner Credentialing Program Standards	Medi-Cal
Revised	01/01/1999	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	08/01/2000	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	02/01/2001	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	01/01/2006	MA.7009	Credentialing and Recredentialing	OneCare
Revised	07/01/2007	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	07/01/2009	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	09/01/2011	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	03/01/2012	MA.7009	Credentialing and Recredentialing	OneCare
Revised	02/01/2013	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	06/01/2014	GG.1609	Credentialing and Recredentialing	Medi-Cal
Retired	02/01/2015	MA.7009	Credentialing and Recredentialing	OneCare
Revised	02/01/2015	MA.1609	Credentialing and Recredentialing	OneCare OneCare Connect PACE
Retired	03/01/2015	MA.1609	Credentialing and Recredentialing	OneCare OneCare Connect PACE

Action	Date	Policy	Policy Title	Program(s)
Revised	03/01/2015	GG.1609Δ	Credentialing and Recredentialing	Medi-Cal OneCare OneCare Connect PACE
Retired	06/01/2017	GG.1609Δ	Credentialing and Recredentialing	Medi-Cal OneCare OneCare Connect PACE
Effective	06/01/2017	GG.1650Δ	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	01/01/2018	GG.1650Δ	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	09/06/2018	GG.1650Δ	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	02/01/2019	GG.1650Δ	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	10/01/2020	GG.1650Δ	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	TBD	GG.1650Δ	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Appeal	Medi-Cal: A ~~request~~review by CalOptima of an adverse benefit determination, which includes one of the ~~member~~following actions: 1. A denial or limited authorization of a requested service, including determinations based on the ~~member's Authorized Representative~~type or level of service, requirements for ~~review of any decision to deny, modify, or discontinue~~Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service~~.~~; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the timeframes provided in 42 CFR 438.408(b). OneCare: Any of the procedures that deal with the review of an adverse initial determination made by CalOptima on health care services or benefits under Part C or D the Member believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the Member), or on any amounts the Member must pay for a service or drug as defined in 42 CFR §422.566(b) and § 423.566(b). These procedures include reconsideration or redetermination , a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (MAC), and judicial review. OneCare Connect: In general, a Member's actions, both internal and external to CalOptima requesting review of CalOptima's denial, reduction or termination of benefits or services, from CalOptima. Appeals relating to Medi-Cal covered benefits and services shall proceed pursuant to the laws and regulations governing Medi-Cal Appeals. Appeals relating to Medicare covered benefits and services shall proceed pursuant to the laws and regulations governing Medicare Appeals. A Medi-Cal based Appeal is defined as review by CalOptima of an Adverse Benefit Determination. PACE: A Member's action taken with respect to the PACE organization's noncoverage of, modification of, or nonpayment for, a service including denials, reductions or termination of services, as defined by federal PACE regulation 42 CFR Section 460.122.
Behavioral Health Provider	A licensed practitioner including, but not limited to, physicians, nurse specialists, psychiatric nurse practitioners, licensed psychologists (PhD or PsyD), licensed clinical social worker (LCSW), marriage and family therapist (MFT or MFCC), professional clinical counselors and qualified autism service providers, furnishing covered services.
Board Certification/Certified	Certification of a physician by one (1) of the boards recognized by the American Board of Medical Specialties (ABMS), or American Osteopathic Association (AOA), as meeting the requirements of that board for certification.

Term	Definition
California Children's Services (CCS) Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible persons under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), sections 41515.2 through 41518.9.
California Children's Services (CCS)) - Eligible Condition	Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae as defined in Title 22, California Code of Regulations sections 41515.2 through 41518.9.
Continuity of Care	Medi-Cal & OneCare Connect: Services provided to a ~~member~~Member rendered by an out-of-network provider with whom the ~~member~~Member has pre-existing provider relationship. OneCare: Continuity of care refers to the continuous flow of care in a timely and appropriate manner. Continuity includes: 1. Linkages between primary and specialty care; 2. Coordination among specialists; 3. Appropriate combinations of prescribed medications; 4. Coordinated use of ancillary services; 5. Appropriate discharge planning; and ~~4.~~6. Timely placement at different levels of care including hospital, skilled nursing and home health care.
Credentialing	The process of obtaining, verifying, assessing, and monitoring the qualifications of a practitioner to provide quality and safe patient care services.
Credentialing and Peer Review Committee (CPRC)	The Credentialing and Peer Review (CPRC) Committee makes decisions, provides guidance, and provides peer input into the CalOptima provider selection process and determines corrective action necessary to ensure that all practitioners and providers who provide services to CalOptima Members meet generally accepted standards for their profession in the industry. The CPRC meets at least quarterly and reports to the CalOptima Quality Improvement (QI) Committee.
Credentialing Verification Organization	For purposes of this policy, an organization that collects and verifies credentialing information.
Delegate	An organization or entity granted authority to perform an activity on behalf of CalOptima within agreed-upon parameters. Any party that enters into an acceptable written arrangement below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Federally Qualified Health Center (FQHC)	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.

Term	Definition
Facility Site Review (FSR)	A DHCS tool utilized to assess the quality, safety and accessibility of PCPs and high-volume specialist physician offices.
Full Scope Site Review	An onsite inspection to evaluate the capacity or continuing capacity of a PCP Site to support the delivery of quality health care services using the Site Review Survey and Medical Record Review Survey.
Grievance	~~A Grievance is an~~ Medi-Cal: An oral or written expression of dissatisfaction about any matter other than an action that is an adverse benefit determination, as identified within the definition of an Appeal, and may include, but is not limited to: the quality of care or services provided, interpersonal relationships with a Provider or CalOptima's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima to make an authorization decision. OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. 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 ~~may~~ 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, and the beneficiary's right to dispute an extension of time proposed by the MCP to make an authorization decision.~~ Provider or employee, or failure to respect the Member's rights). Also~~,~~ called a "Complaint ~~from a Member related to Medi-Cal benefits and services pursuant to Welfare and Institutions Code~~." 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 ~~14450 and California Health and Safety Code Section 1368 and 1368.1.~~460.120.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to members assigned to that health network.
Long Term Support Services (LTSS) Provider	For purposes of this policy, a licensed practitioner such as physicians, Non-Physician Medical Practitioners (NMP), social workers, and nurse managers.
Medical Record Review (MRR)	A DHCS tool utilized to audit PCP medical records for format, legal protocols, and documented evidence of the provision of preventive care and coordination and continuity of care services.
Member	~~An enrollee~~ A beneficiary ~~of~~enrolled in a CalOptima program.
Minimum Physician Standards	Minimum standards that must be met in order for a Physician to be credentialed and contracted for participation in CalOptima programs.

Term	Definition
Non-Physician Medical Practitioner (NMP)	A licensed practitioner, including but not limited to, a Nurse Practitioner (NP), Certified Nurse Midwife (CNM), Licensed Midwife (LM), Certified Nurse Specialists (CNS), Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), Speech Therapist (ST), or Audiologist furnishing covered services.
Organized Health Care System	Includes a licensed clinic as described in Chapter 1 (commencing with Section 1200) of Division 2 of the Health and Safety Code, an outpatient setting as described in Chapter 1.3 (commencing with Section 1248) of Division 2 of the Health and Safety Code, a health facility as described in Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code, a county medical facility as described in Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code, an accountable care organization, a home health agency, a physician's office, a professional medical corporation, a medical partnership, a medical foundation, and any other entity that lawfully provides medical services and is in compliance with Article 18 (commencing with Section 2400) of Chapter 5.
Pharmacy Benefit Manager (PBM)	The entity that performs certain functions and tasks including, but not limited to, pharmacy credentialing, contracting, and claims processing in accordance with the terms and conditions of the PBM Services Agreement.
Physical Accessibility Review Survey (PARS)	A DHCS tool used to assess the level of physical accessibility of provider sites, including specialist and ancillary service providers.
Physician Practitioner	A licensed practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), furnishing covered services.
Practice Agreement	The writing, developed through collaboration among one or more physicians and surgeons and one or more physician assistants, that defines the medical services the physician assistant is authorized to perform pursuant to Section 3502 of the Business and Professions Code and that grants approval for physicians and surgeons on the staff of an Organized Health Care System to supervise one or more physician assistants in the Organized Health Care System. Any reference to a delegation of services agreement relating to physician assistants in any other law shall have the same meaning as a Practice Agreement.
Primary Care	For purposes of this policy, a basic level of health care usually rendered in an ambulatory setting by a Primary Care Provider (PCP).
Recredentialing	The process by which the qualifications of practitioners is verified in order to make determinations relating to their continued eligibility for participation in the CalOptima program.
Specialty Care	For purposes of this policy, specialty care given to members by referral by other than a Primary Care Provider (PCP).
Substance Use Disorder (SUD) Providers	Licensed, certified or registered by one (1) of the following: a physician licensed by the Medical Board of California, a psychologist licensed by the Board of Psychology, a clinical social worker or marriage and family therapist licensed by California Board of Behavioral Sciences, or an intern registered with California Board of Psychology or California Board of Behavioral sciences.

Term	Definition
Telehealth	The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a Member's health care while the Member is at the originating site, and the health care provider is at a distant site. Telehealth facilitates Member self-management and caregiver support for Members and includes synchronous interactions and asynchronous store and forward transfers.
Utilization Management (UM)	Requirements or limits on coverage. Utilization management may include, but is not limited to, prior authorization, quantity limit, or step therapy restrictions.

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Policy:	GG.1650Δ
Title:	**Credentialing and Recredentialing of Practitioners**
Department:	Medical Management
Section:	Quality Improvement
CEO Approval:	*/s/*
Effective Date:	06/01/2017
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE ☐ Administrative

I. PURPOSE

This policy defines the process by which CalOptima evaluates and determines whether to approve or decline practitioners (as described in Section II. of this Policy ("Practitioners")) for participation in CalOptima programs.

II. POLICY

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

B. CalOptima may delegate Credentialing and Recredentialing activities to a Health Network or other Delegate in accordance with CalOptima Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities. Delegated activities may include but are not limited to: Credentialing decisions, Credentialing verification, monitoring of sanctions, and processing of Credentialing applications.

1. A Health Network or Delegate shall establish policies and procedures to evaluate and approve Practitioners to participate in CalOptima programs that, at minimum, meet the requirements as outlined in this policy.

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

D. The CalOptima CPRC shall be responsible for reviewing a Practitioner's Credentialing information and determining such Practitioner's participation in CalOptima.

E. CalOptima shall credential and recredential the following Practitioners as provided in this Policy: Physicians, Non-Physicians Medical Practitioners, Behavioral Health Practitioners, Substance Use

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Disorder (SUD) Practitioners, and Long-Term Services and Supports (LTSS) Practitioners that provide care to CalOptima program Members, and are:

1. Licensed, certified, or registered by the state of California to practice independently;
2. Contracted with CalOptima to provide care under CalOptima's programs (including those Practitioners who render care in contracted Federally Qualified Health Centers (FQHC) and community clinics that perform Primary and Specialty Care services); and
3. Who provide care to Members under the organization's medical benefits.

F. Credentialing and recredentialing shall apply to Practitioners meeting the criteria in Section II.E. of this Policy, regardless of whether they provide care:

1. In individual or group practices;
2. In facilities; or
3. Through telemedicine/telehealth i.e., virtual care visit.

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

1. NMPs who provide services under the supervision of a practicing, licensed, and credentialed Physician Practitioner and have executed a signed agreement as required by the applicable state of California board with the NMP; or
2. NMPs who provide services as part of an Organized Health Care System that is credentialed with CalOptima and have a signed agreement as required by the applicable state of California board between the NMP and the Organized Health Care System; or
3. NMPs who are not PAs and who provide services under the employment agreement of a credentialed Provider.

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

I. CalOptima does not credential or recredential:

1. Practitioners that practice exclusively within the inpatient setting (e.g., Hospitalist) and provide care for a Member only as a result of the Member being directed to the hospital, or inpatient, setting;
2. Practitioners that practice exclusively within freestanding facilities, and provide care for a Member only as a result of the Member being directed to the facility (e.g. Diagnostic Radiologists, Urgent Care, Emergency Medicine);
3. Pharmacists who work for a Pharmacy Benefit Manager (PBM) to which CalOptima delegates Utilization Management (UM) functions (Credentialing of Pharmacies and its professional and technical staff shall be conducted by the PBM, in accordance with CalOptima Policy GG.1406Δ: Pharmacy Network Credentialing and Access);

4. Covering Practitioners (e.g., locum tenens) who do not have an independent relationship with CalOptima; and

5. Practitioners who do not provide care for a Member in a treatment setting (e.g., External Physician Reviewer).

J. CalOptima shall ensure that any provider for whose provider type has an enrollment pathway with Department of Health Care Services (DHCS) is enrolled with DHCS as a provider in accordance with DHCS All Plan Letter (APL) 19-004: Provider Credentialing / Recredentialing and Screening / Enrollment, Title 42, CFR, Section 455, and as described in Sections III.A. and III.B. of this Policy.

K. CalOptima shall recredential a Practitioner at least every three (3) years, utilizing a thirty-six (36)-month cycle to the month, not to the day.

L. CalOptima shall ensure that all Practitioners maintain current California licensure, Drug Enforcement Agency (DEA) certification, and medical malpractice insurance in the interval between Credentialing cycles and shall monitor various state, federal, boards, agencies and databanks for adverse activities in accordance with CalOptima Policy GG.1607Δ: Monitoring Adverse Actions.

M. If CalOptima declines to include a Practitioner in the CalOptima network, CalOptima shall notify, in writing, such Practitioner within thirty (30) calendar days of the date of the decision of the reason(s) for the denial.

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

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

2. Using different reimbursement amounts for different specialties, or for different Practitioners in the same specialty; and

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

O. CalOptima shall not discriminate against a Practitioner that serves high-risk populations or specializes in the treatment of costly conditions.

P. CalOptima shall not make, or decline, Credentialing and Recredentialing decisions based on a Practitioner's race, ethnicity, national identity, gender, age, sexual orientation, or the type of procedure, or patient, in which the Practitioner specializes.

Q. CalOptima shall monitor and prevent discriminatory Credentialing decisions as provided in this Policy.

R. CalOptima shall maintain the confidentiality of Credentialing files, in accordance with CalOptima Policy GG.1604Δ: Confidentiality of Credentialing Files.

S. CalOptima shall maintain Credentialing files that include documentation of required elements, as described in this Policy.

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

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

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

W. On an annual basis, the CalOptima Board of Directors shall review and approve this Policy.

III. PROCEDURE

A. Practitioner Initial Credentialing

1. In conjunction with the CalOptima Provider Relations and Contracting Departments, a Practitioner shall initiate the Credentialing process with CalOptima.

   a. Upon receipt of the request from the Practitioner, CalOptima shall send a notification electronically, explaining the expectations for completion and submission of the Credentialing application and required documents.

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

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

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

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

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

      iv. History of criminal convictions;

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

      vi. Current malpractice insurance coverage; and

      vii. The correctness and completeness of the application;

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

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

f. CalOptima shall return an incomplete application to a Practitioner, and such incomplete application will not be processed until the Practitioner submits all the required information.

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

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

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

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

2. Upon receipt of a complete Credentialing application, CalOptima shall verify the information provided through primary verification using industry-recognized verification sources or a Credentialing Verification Organization. This information includes, but is not limited to:

a. A current, valid California license to practice in effect at the time of the Credentialing decision;

b. Board Certification, as applicable, unless exempt from the Board Certification requirement pursuant to CalOptima Policy GG.1633Δ: Board Certification Requirements for Physicians; and

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

3. CalOptima shall also collect and verify the following information from each Provider as applicable but need not verify this information through a primary source (see Attachment B). This information includes, but is not limited to:

a. Work history, including all post-graduate activity in the last five (5) years (on initial Credentialing). The Practitioner shall provide, in writing, an explanation of any gaps of six (6) months, or more;

b. Written, or verbal, confirmation from the Practitioner's primary inpatient admitting facility that the Practitioner has privileges in good standing, or confirmation that the Practitioner refers patients to hospital-based Practitioners (Hospitalist), as applicable;

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

d. A valid DEA, or Controlled Dangerous Substances (CDS), certificate obtained through confirmation by National Technical Information Service (NTIS), if applicable, in effect at the time of the Credentialing decision; DEA certificate must show an address within the state of California;

e. A valid National Provider Identifier (NPI) number;

f. Current malpractice insurance or self-insurance (e.g., trust, escrow accounts coverage) in the minimum amounts of one million dollars ($1,000,000.00) per occurrence and three million dollars ($3,000,000.00) aggregate per year at the time of the Credentialing decision. For Behavioral Health Services Providers, the minimum amounts shall be no less than one million dollars ($1,000,000.00) per incident and one million dollars ($1,000,000.00) aggregate per year at the time of the Credentialing decision.

g. Practitioner information entered in the National Practitioner Data Bank (NPDB), if applicable;

h. No exclusion, preclusion, suspension, or ineligibility to participate in any state and federal health care program at the time of the Credentialing decision;

i. A review of any Grievances, or quality cases, filed against a Practitioner in the last five (5) years;

j. No exclusion or preclusion from participation at any time in federal, or state, health care programs based on conduct within the last ten (10) years that supports a mandatory exclusion or preclusion under the Medicare program, as set forth in Title 42, United States Code, Section 1320a-7(a), as follows:

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

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

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

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

k. History of professional liability claims that resulted in settlements or judgments, paid by, or on behalf of, the Practitioner;

l. History of state sanctions, restrictions on licensure or limitations on scope of practice;

m. Human Immunodeficiency Virus (HIV) specialist attestation, if applicable;

n. Full or provisional California Children's Services (CCS)-paneled approval status, with a current active panel status;

o. Current IRS Form W-9;

p. Current (within last three (3) years) Full Scope FSR/MRR, and PARS, as applicable, pursuant to CalOptima Policy GG.1608Δ: Full Scope Site Reviews;

q. Active enrollment status with Medi-Cal, as required; and

r. Active enrollment status with Medicare for OneCare or OneCare Connect as required (i.e., has not Opted-Out of Medicare program).

B. Practitioner Recredentialing

1. CalOptima shall Recredential a Practitioner at least every three (3) years after initial Credentialing. At the time of Recredentialing, CalOptima shall:

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

b. Incorporate the following data in the decision-making process, which shall have been reviewed no more than one hundred eighty (180) calendar days before the Recredentialing decision is made.

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

ii. Information from quality review activities;

iii. Board Certification, if applicable;

iv. Member satisfaction, if applicable;

v. Medical Record Reviews, if applicable;

vi. FSR results and PARS results, if applicable; and

vii. Compliance with the terms of the Practitioner's contract.

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

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

3. CalOptima shall ensure that all Practitioners maintain current California licensure, Drug Enforcement Agency (DEA) certification, and medical malpractice insurance in the interval between Credentialing cycles.

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

limit. If the reinstatement would be more than thirty (30) calendar days after termination, CalOptima must perform initial Credentialing of such Practitioner.

C. Practitioner Rights

1. New applicants for Credentialing will receive Practitioner rights included in the Addendum A of the credentialing application, as follows:

a. Right to review information

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

b. Right to correct erroneous information

i. All Practitioners will be notified by certified mail when Credentialing information obtained from other sources varies substantially from that provided by the Practitioner;

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

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

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

c) All submissions will be mailed to CalOptima's Quality Improvement Department using the following address:

Attention: Quality Improvement Department – Credentialing
CalOptima
505 City Parkway West
Orange, CA 92868

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

2. Documentation of receipt of corrections

a. A Practitioner shall be notified within thirty (30) calendar days via a letter to document CalOptima's receipt of the identified erroneous information.

3. Right to be notified of application status

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

b. Practitioners may request to review non-privileged information obtained from outside sources (e.g., malpractice insurance carriers and licensing boards).

c. Practitioners can contact the Quality Improvement Department by phone, e-mail, or facsimile requesting the status of their application. The Quality Improvement Department will respond within one (1) business day of the status of the Practitioner's application with respect to outstanding information required to complete the application process.

D. Credentialing and Peer Review Committee (CPRC)

1. CalOptima shall designate a CPRC that uses a peer-review process to make recommendations and decisions regarding Credentialing and Recredentialing.

2. Such CPRC shall include representation from a range of Practitioners participating in the organization's network and shall be responsible for reviewing a Practitioner's Credentialing and Recredentialing files and determining the Practitioner's participation in CalOptima programs.

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

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

i. A clean file shall be considered approved and effective on the date that the CMO or his or her physician Designee review and approve a Practitioner's Credentialing, or Recredentialing, file, and deem the file clean.

ii. Clean file lists approved by a Medical Director shall be presented at the CPRC for final approval and be reflected in the meeting minutes.

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

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

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

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

4. The CPRC shall make recommendations based on the Practitioners' ability to deliver care based on the Credentialing information collected from the file review process and shall be verified prior to making a Credentialing decision.

a. The Quality Improvement Department shall send the Practitioner a decision letter, within thirty (30) calendar days of the decision indicating:

i. Acceptance;

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

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

b. CalOptima shall render a final decision within one hundred eighty (180) calendar days from the date of licensure verification.

i. If CalOptima is unable to render a decision within one hundred eighty (180) calendar days from the date of licensure verification for any Practitioner, during the Practitioner's Credentialing or Recredentialing process, the application shall be considered expired.

E. CalOptima shall monitor and prevent discriminatory practices, to include, but not be limited to:

1. Monitoring

a. CalOptima shall conduct periodic audits of Credentialing files (in-process, denied, and approved files) to ensure that Practitioners are not discriminated against; and

b. Review Practitioner complaints to determine if there are complaints alleging discrimination.

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

2. Prevention

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

F. Upon acceptance of the Credentialing application, the CalOptima Quality Improvement Department shall generate a Provider profile and forward the Provider profile to the Contracting and Provider Data Management Service (PDMS) Departments. This Provider profile shall be generated from the Credentialing database to ensure that the information is consistent with data verified during the Credentialing process (i.e., education, training, Board Certification and specialty). The PDMS Department will enter the contract and Credentialing data into CalOptima's core business system, which updates pertinent information into the online provider directory.

IV. ATTACHMENT(S)

A. California Participating Physician Application (CPPA)
B. CalOptima Primary Source Verification Table
C. Council for Affordable Quality Healthcare Provider Application (CAQH)
D. HIV/AIDS Specialist Designation

E. Attestation Questions
F. Addendum A Practitioner Rights

V. REFERENCE(S)

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima 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. CalOptima PACE Program Agreements
E. CalOptima Contract for Health Care Services
F. NCQA Standards and Guidelines
G. CalOptima Policy GG.1406Δ: Pharmacy Network: Credentialing and Access
H. CalOptima Policy GG.1602Δ: Non-Physician Medical Practitioner (NMP) Scope of Practice
I. CalOptima Policy GG.1604Δ: Confidentiality of Credentialing Files
J. CalOptima Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities
K. CalOptima Policy GG.1607Δ: Monitoring Adverse Actions
L. CalOptima Policy GG.1608Δ: Full Scope Site Reviews
M. CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners
N. CalOptima Policy GG.1619: Delegation Oversight
O. CalOptima Policy GG.1633Δ: Board Certification Requirements for Physicians
P. CalOptima Policy GG.1643Δ: Minimum Physician Standards
Q. CalOptima Policy GG.1651Δ: Assessment and Re-Assessment of Organizational Providers
R. CalOptima Policy HH.1101: CalOptima Provider Complaint
S. CalOptima Policy MA.9006: Provider Complaint Process
T. Department of Health Care Services All Plan Letter (APL) 16-009: Adult Immunizations as a Pharmacy Benefit
U. Department of Health Care Services All Plan Letter (APL) 19-004: Provider Credentialing / Recredentialing and Screening / Enrollment
V. Department of Health Care Services All Plan Letter (APL) 21-005: California Children's Services Whole Child Model Program
W. Title 42, Code of Federal Regulations, §§422.204(a), 422.205, 438.12, 438.214, 460.64 and 460.71
X. Title 42, Code of Federal Regulations, Part 455, Subpart E
Y. Title 42, United States Code, §1320a-7(a)
Z. Title XVIII and XIV of the Social Security Act
AA. California Business and Professions Code, §805 and §§3500-3502.3
BB. California Evidence Code, §1157
CC. Medicare Managed Care Manual, Chapter 6: Relationships with Providers

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
04/28/2015	Department of Health Care Services (DHCS)	Approved as Submitted
09/20/2018	Department of Health Care Services (DHCS)	Approved as Submitted
10/13/2020	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

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

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/01/1995	GG.1609	Health Network Practitioner Credentialing Program Standards	Medi-Cal
Revised	12/01/1995	GG.1609	Health Network Practitioner Credentialing Program Standards	Medi-Cal
Revised	12/01/1996	GG.1609	Health Network Practitioner Credentialing Program Standards	Medi-Cal
Revised	02/01/1998	GG.1609	Health Network Practitioner Credentialing Program Standards	Medi-Cal
Revised	01/01/1999	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	08/01/2000	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	02/01/2001	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	01/01/2006	MA.7009	Credentialing and Recredentialing	OneCare
Revised	07/01/2007	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	07/01/2009	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	09/01/2011	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	03/01/2012	MA.7009	Credentialing and Recredentialing	OneCare
Revised	02/01/2013	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	06/01/2014	GG.1609	Credentialing and Recredentialing	Medi-Cal
Retired	02/01/2015	MA.7009	Credentialing and Recredentialing	OneCare
Revised	02/01/2015	MA.1609	Credentialing and Recredentialing	OneCare OneCare Connect PACE
Retired	03/01/2015	MA.1609	Credentialing and Recredentialing	OneCare OneCare Connect PACE
Revised	03/01/2015	GG.1609Δ	Credentialing and Recredentialing	Medi-Cal OneCare OneCare Connect PACE
Retired	06/01/2017	GG.1609Δ	Credentialing and Recredentialing	Medi-Cal OneCare OneCare Connect PACE
Effective	06/01/2017	GG.1650Δ	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE

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

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IX. GLOSSARY

Term	Definition
Appeal	Medi-Cal: A review by CalOptima of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the timeframes provided in 42 CFR 438.408(b). OneCare: Any of the procedures that deal with the review of an adverse initial determination made by CalOptima on health care services or benefits under Part C or D the Member believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the Member), or on any amounts the Member must pay for a service or drug as defined in 42 CFR §422.566(b) and § 423.566(b). These procedures include reconsideration or redetermination , a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (MAC), and judicial review. OneCare Connect: In general, a Member's actions, both internal and external to CalOptima requesting review of CalOptima's denial, reduction or termination of benefits or services, from CalOptima. Appeals relating to Medi-Cal covered benefits and services shall proceed pursuant to the laws and regulations governing Medi-Cal Appeals. Appeals relating to Medicare covered benefits and services shall proceed pursuant to the laws and regulations governing Medicare Appeals. A Medi-Cal based Appeal is defined as review by CalOptima of an Adverse Benefit Determination. PACE: A Member's action taken with respect to the PACE organization's noncoverage of, modification of, or nonpayment for, a service including denials, reductions or termination of services, as defined by federal PACE regulation 42 CFR Section 460.122.
Behavioral Health Provider	A licensed practitioner including, but not limited to, physicians, nurse specialists, psychiatric nurse practitioners, licensed psychologists (PhD or PsyD), licensed clinical social worker (LCSW), marriage and family therapist (MFT or MFCC), professional clinical counselors and qualified autism service providers, furnishing covered services.
Board Certification/Certified	Certification of a physician by one (1) of the boards recognized by the American Board of Medical Specialties (ABMS), or American Osteopathic Association (AOA), as meeting the requirements of that board for certification.
California Children's Services (CCS) Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible persons 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.

Term	Definition
California Children's Services (CCS)-Eligible Condition	Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae as defined in Title 22, California Code of Regulations sections 41515.2 through 41518.9.
Continuity of Care	Medi-Cal & OneCare Connect: Services provided to a Member rendered by an out-of-network provider with whom the Member has pre-existing provider relationship. OneCare: Continuity of care refers to the continuous flow of care in a timely and appropriate manner. Continuity includes: 1. Linkages between primary and specialty care; 2. Coordination among specialists; 3. Appropriate combinations of prescribed medications; 4. Coordinated use of ancillary services; 5. Appropriate discharge planning; and 6. Timely placement at different levels of care including hospital, skilled nursing and home health care.
Credentialing	The process of obtaining, verifying, assessing, and monitoring the qualifications of a practitioner to provide quality and safe patient care services.
Credentialing and Peer Review Committee (CPRC)	The Credentialing and Peer Review (CPRC) Committee makes decisions, provides guidance, and provides peer input into the CalOptima provider selection process and determines corrective action necessary to ensure that all practitioners and providers who provide services to CalOptima Members meet generally accepted standards for their profession in the industry. The CPRC meets at least quarterly and reports to the CalOptima Quality Improvement (QI) Committee.
Credentialing Verification Organization	For purposes of this policy, an organization that collects and verifies credentialing information.
Delegate	An organization or entity granted authority to perform an activity on behalf of CalOptima within agreed-upon parameters. Any party that enters into an acceptable written arrangement below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Federally Qualified Health Center (FQHC)	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.
Facility Site Review (FSR)	A DHCS tool utilized to assess the quality, safety and accessibility of PCPs and high-volume specialist physician offices.
Full Scope Site Review	An onsite inspection to evaluate the capacity or continuing capacity of a PCP Site to support the delivery of quality health care services using the Site Review Survey and Medical Record Review Survey.

Term	Definition
Grievance	Medi-Cal: An oral or written expression of dissatisfaction about any matter other than an action that is an adverse benefit determination, as identified within the definition of an Appeal, and may include, but is not limited to: the quality of care or services provided, interpersonal relationships with a Provider or CalOptima's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima to make an authorization decision. OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. 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." PACE: A complaint, either written or oral, expressing dissatisfaction with service delivery or the quality of care furnished, as defined by the federal PACE regulation 42 CFR Section 460.120.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to members assigned to that health network.
Long Term Support Services (LTSS) Provider	For purposes of this policy, a licensed practitioner such as physicians, Non-Physician Medical Practitioners (NMP), social workers, and nurse managers.
Medical Record Review (MRR)	A DHCS tool utilized to audit PCP medical records for format, legal protocols, and documented evidence of the provision of preventive care and coordination and continuity of care services.
Member	A beneficiary enrolled in a CalOptima program.
Minimum Physician Standards	Minimum standards that must be met in order for a Physician to be credentialed and contracted for participation in CalOptima programs.
Non-Physician Medical Practitioner (NMP)	A licensed practitioner, including but not limited to, a Nurse Practitioner (NP), Certified Nurse Midwife (CNM), Licensed Midwife (LM), Certified Nurse Specialists (CNS), Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), Speech Therapist (ST), or Audiologist furnishing covered services.

Term	Definition
Organized Health Care System	Includes a licensed clinic as described in Chapter 1 (commencing with Section 1200) of Division 2 of the Health and Safety Code, an outpatient setting as described in Chapter 1.3 (commencing with Section 1248) of Division 2 of the Health and Safety Code, a health facility as described in Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code, a county medical facility as described in Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code, an accountable care organization, a home health agency, a physician's office, a professional medical corporation, a medical partnership, a medical foundation, and any other entity that lawfully provides medical services and is in compliance with Article 18 (commencing with Section 2400) of Chapter 5.
Pharmacy Benefit Manager (PBM)	The entity that performs certain functions and tasks including, but not limited to, pharmacy credentialing, contracting, and claims processing in accordance with the terms and conditions of the PBM Services Agreement.
Physical Accessibility Review Survey (PARS)	A DHCS tool used to assess the level of physical accessibility of provider sites, including specialist and ancillary service providers.
Physician Practitioner	A licensed practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), furnishing covered services.
Practice Agreement	The writing, developed through collaboration among one or more physicians and surgeons and one or more physician assistants, that defines the medical services the physician assistant is authorized to perform pursuant to Section 3502 of the Business and Professions Code and that grants approval for physicians and surgeons on the staff of an Organized Health Care System to supervise one or more physician assistants in the Organized Health Care System. Any reference to a delegation of services agreement relating to physician assistants in any other law shall have the same meaning as a Practice Agreement.
Primary Care	For purposes of this policy, a basic level of health care usually rendered in an ambulatory setting by a Primary Care Provider (PCP).
Recredentialing	The process by which the qualifications of practitioners is verified in order to make determinations relating to their continued eligibility for participation in the CalOptima program.
Specialty Care	For purposes of this policy, specialty care given to members by referral by other than a Primary Care Provider (PCP).
Substance Use Disorder (SUD) Providers	Licensed, certified or registered by one (1) of the following: a physician licensed by the Medical Board of California, a psychologist licensed by the Board of Psychology, a clinical social worker or marriage and family therapist licensed by California Board of Behavioral Sciences, or an intern registered with California Board of Psychology or California Board of Behavioral sciences.
Telehealth	The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a Member's health care while the Member is at the originating site, and the health care provider is at a distant site. Telehealth facilitates Member self-management and caregiver support for Members and includes synchronous interactions and asynchronous store and forward transfers.

Term	Definition
Utilization Management (UM)	Requirements or limits on coverage. Utilization management may include, but is not limited to, prior authorization, quantity limit, or step therapy restrictions.

1

California Participating Practitioner Application

I. Instructions

This form should be typed. If more space is needed than provided on original, attach additional sheets and reference the question being answered. Please refer to cover page for a list of the required documents to be submitted with this application.

II. Identifying Information

Last Name: First Name: Middle:

Is there any other name under which you have been known? Name(s):

Home Mailing Address:

City: State: Zip Code:

Home Phone Number: ( ) - Fax Number: ( ) - Cell Numbe .( ) - Pager Number: ( ) -

Practitioner Email: Citizenship (If not a U.S. citizen, please provide a y of Alien Registration Card):

Birth Date: Social ecurity Number: - -

Birth Place: Gender Male Female

Driver's License State/Number: Race/Ethnicity (optional):

Your intent is to serve as a(n):

Primary Care Provider Specialist Urgent Care Hospitalist Hospital Based

Specialty:

Subspecialties:

III. Practice Information

Practice Name (if applicable): Department Name (if hospital based):

Primary Office Address:

City: State: Zip Code:

Telephone Number: ( ) - Fax Number: ( ) - Website (if applicable):

Office Administrator/Manager: Office Administrator/Manager Telephone Number: ( ) -

Office Administrator/Manager Email: Office Administrator/Manager Fax Number: ( ) -

Federal Tax ID Number: - Name Associated with Tax ID:

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III. Practice Information (Continued)

Please identify the physical accessibility of this office. ◯ Basic ◯ Limited ◯ None

Type of practice (check all that apply): ☐ Solo Practice ☐ Group Practice ☐ Urgent Care

☐ Single Specialty Group

☐ Multi Specialty Group

please type the working days and the working hours

Primary Office Hours of Operation

Languages spoken by Staff:

Languages spoken by Provider:

Group Medicare PTAN/UPIN #:

Group NPI #:

Secondary Practice Information

Practice Name (if applicable):

Depart[illegible] Name (if hospital based):

Secondary Office Address:

City: State: Zip Cod[illegible]: -

Telephone Number: ( ) - Fax Number: ( ) - Website (if applicable):

Office Administrator/Manager: Office Administrator/Manager Telephone Number:

Office Administrator/Manager Email: Office Administrator/Manager Fax Number: ( ) -

Federal Tax ID Number: - Name Associated with Tax ID:

Please identify the physical accessibili[illegible] of this office. ◯ Basic ◯ Limited ◯ None

Type of practice (check all that apply): ☐ Solo Practice ☐ Group Practice ☐ Urgent Care

☐ Single Specialty Group

☐ Multi Specialty Group

Secondary Office Hours of Operation

Languages spoken by Staff:

Languages spoken by Provider:

Group Medicare PTAN/UPIN #:

Group NPI #:

Tertiary Practice Information

Practice Name (if applicable): Department Name (if hospital based):

Tertiary Office Address:

City: State: Zip Code: -

Telephone Number: ( ) - Fax Number: ( ) - Website (if applicable):

Office Administrator/Manager: Office Administrator/Manager Telephone Number: ( ) -

Office Administrator/Manager Email: Office Administrator/Manager Fax Numb r: ( ) -

Federal Tax ID Number: - Name Associated with Tax ID:

Please identify the physical accessibility of this office. ◯ Basic ◯ Limited ◯ None

Type of practice (check all that apply): ☐ Solo Practice ☐ Group Practice ☐ Urgent Care

☐ Single Specialty Group

☐ Multi Sp cialty Group

Tertiary Office Hours of Operation

Languages spoken by Staff:

Languages spoken by Provider:

Group Medicare PTAN/UPIN #: Group NPI #:

Mailing Address

Which of your practices is your primary mailing address? ◯ Primary ◯ Secondary ◯ Tertiary ◯ Other

If your mailing address is ifferent from our practice address, please provide it:

IV. Billing Information

Which of your actic s handles your billing? ◯ Primary ◯ Secondary ◯ Tertiary If none, please provide billing information:

Billing Company

Billing Company Mailing Address:

City: State: Zip Code: -

Contact Person: Telephone Number: ( ) -

Federal Tax ID Number: - Name Associated with Tax ID:

V. Practice Description

Do you employ any allied health professionals (e.g. nurse practitioners, physician assistants, psychologist, etc.)? ◯ Yes ◯ No
If so, please list:

Name	Type of Provider	License Number

Physician Assistant Supervisor Name: License Number:

Do you personally employ any physicians (do not include physicians who are employed by the medical gr up)? ◯ Yes ◯ No
If so, please list:

Name	California Medical License Number	Primary/Secondary/Tertiary Practice
		☐ Pr ary ☐ Secondary ☐ Tertiary
		☐ Primary ☐ Secondary ☐ Tertiary
		☐ Primary ☐ Secondary ☐ Tertiary
		☐ Primary ☐ Secondary ☐ Tertiary

Please list any clinical services you perform that are not typically assoc ted with your specialty:

Which offices does this applies to: ☐ Primary ☐ Secondary ☐ Tertiary

Please list any clinical services you do **not** perform that are typically associated with your specialty:

Which offices does this applies to: ☐ Pri ary ☐ Secondary ☐ Tertiary

Is your practice limited to certain ages? ◯ Yes ◯ No If yes, specify limitation:

Which offices does this applies t ☐ Primary ☐ Secondary ☐ Tertiary

Coverage of Practice

List your answering servi e and c ering physicians by name. Attach additional sheets if necessary.

Answering Service Company

Answering Service ailing Address:

City: State: Zip Code: - Email:

Covering Physician's Name(s) / Phone Number / Which practices does their coverage apply (Primary, Secondary, Tertiary):

VI. Education, Training and Experience

Medical/Professional Education

Medical School/Professional: | Degree Received: | Graduation Date:

Mailing Address: | Website (if applicable):

City: | State: | Zip Code: - | Registrar's Phone Number: ( ) -

Internship/PGY-1

Institution: | Program Director:

Address | City | State | Zip -

Telephone Number: ( ) - | Fax Number: ( ) - | Website (if applicable):

Type of Internship: | From (mm/yyyy): | To (mm/yyyy):

Did you successfully complete the program? ◯ Yes ◯ No (If No, please explain on a separate sheet.)

Residencies/Fellowships

Include residencies, fellowships, and postgraduate education in chronological order. Use a separate sheet if necessary.

Institution: | Program Director:

Address | City | State | Zip -

Telephone Number: ( ) - | Fax Number: ( ) - | Website (if applicable):

Type of Training: | Specialty: | From (mm/yy):

Did you successfully complete the program? ◯ Yes ◯ No (Please explain on a separate sheet.) | To(mm/yy):

Institution: | Program Director:

Address | City | State | Zip -

Telephone Number: ( ) - | Fax Number: ( ) - | Website (if applicable):

Type of Training: | Specialty: | From (mm/yy):

Did you successfully complete the program? ◯ Yes ☒ No (Please explain on a separate sheet.) | To(mm/yy):

Institution: | Program Director:

Address | City | State | Zip -

Telephone Number: ( ) - | Fax Number: ( ) - | Website (if applicable):

Type of Training: | Specialty: | From (mm/yy):

Did you successfully complete the program? ◯ Yes ◯ No (Please explain on a separate sheet.) | To(mm/yy):

VII. Medical Licensure & Certifications

California State Medical License Number	Issue Date	Expiration Date

Drug Enforcement Agency (DEA) Registration Number	Schedules	Expiration Date

Controlled Dangerous Substances Certificate (CDS) (if applicable)	Expiration Date

ECFMG Number (applicable to foreign medical graduates)	Issue Date

Individual National Physician Identifier (NPI)	Medi-Cal/Medicaid Number	Individual Medicare PTAN Number

All Other State Medical Licenses

State	License Number	Issue Date	Expiration Date

Other Certifications (e.g., Fluoroscopy, Radio , ap. ACLS/BLS/PALS, etc.)

Type of Certification	License Number	Expiration Date

Board Certification(s)

Include certification by board(s) which are duly organized and recognized by:

- a member board of the American Board of Medical Specialties
- a member board of the American Osteopathic Association
- a board or association with equivalent requirements approved by the Medical Board of California
- a board or association with an Accreditation Council for Graduate Medical Education or American Osteopathic Association approved postgraduate training that provides complete training in that specialty or subspecialty.

Name of Issuing Board	Certificate Number	Date Certified/Recertified	Expiration Date (if any)

Board Certification(s) (Continued)

Have you applied for board certification other than those indicated on the prior page? ◯ Yes ◯ No

If so, list board(s) and date(s):

If not certified, describe your intent for certification, if any, and date of eligibility for certification below or in a separate sheet.

Specialty:

Board Name:

Exam Date:

Describe here:

VIII. Current Hospital and Other Institutional Affiliations

Please list in reverse chronological order (with the current affiliation(s) first) all institutions where you have current affiliations (A) and have had previous hospital privileges (B). This includes hospitals, surgery centers, institutions, corporations, military assignments, or government agencies. If more space is needed, attach additional sheet(s).

A. Current Affiliations

Hospital Name: Department Name : Status (active, provisional, courtesy, temporary, etc.):

Primary Hospital Address:

City: State: Zip Code: - From (mm/yy):

Medical Staff Phone: ( ) - Medical Staff Fax: ( ) - To (mm/yy):

Hospital Name: Department Name : Status (active, provisional, courtesy, temporary, etc.):

Secondary Hospital Address:

City: State: Zip Code: - From (mm/yy):

Medical Staff Phone: ( ) - Medical Staff Fax: ( ) - To (mm/yy):

Hospital Name: Department Name : Status (active, provisional, courtesy, temporary, etc.):

Other Institution Address:

City: State: Zip Code: - From (mm/yy):

Medical Staff Phone: ( ) - Medical Staff Fax: ( ) - To (mm/yy):

Hospital Name: Department Name : Status (active, provisional, courtesy, temporary, etc.):

Other Institution Address:

City: State: Zip Code: - From (mm/yy):

Medical Staff Phone: ( ) - Medical Staff Fax: ( ) - To (mm/yy):

A. Current Affiliations (continued)

If you do not have hospital privileges, please explain (physicians without hospital privileges must provide written plan for continuity of care):

B. Previous Hospital and Other Institution Affiliations

Name and Address of Affiliation:

Department:

From (mm/yy):

To (mm/yy):

Reason for leaving:

Name and Address of Affiliation:

Department:

From (mm/yy):

To (mm/yy):

Reason for leaving:

Name and Address of Affiliation:

Department:

From (mm/yy):

To (mm/yy):

Reason for leaving:

Name and Address of Affiliation:

Department:

From (mm/yy):

To (mm/yy):

Reason for leaving:

Name and Address of Affiliation:

Department:

From (mm/yy):

To (mm/yy):

Reason for leaving:

IX. Peer References

List three professional references, preferably from your specialty area, not including relatives, current partners or associates in practice. If possible, include at least one member from the Medical Staff of each facility at which you have privileges.

NOTE: References must be from individuals who are directly familiar with your work, either via direct clinical observation or through close working relations. **At least one reference must be from someone with the same credentials, for example, a MD must list a reference from another MD or a DPM must list one reference from another DPM.**

Name of Reference: Specialty:

Address City State Zip

Telephone Number: ( ) - Fax Number: ( ) - Email Address:

Name of Reference: Specialty:

Address City State Zip

Telephone Number: ( ) - Fax Number: ( ) - Email Address:

Name of Reference: Specialty:

Address City State Zip

Telephone Number: ( ) - Fax Number: ( ) - Email Address:

X. Work History

Chronologically list all work history activities since completion of postgraduate training (use extra sheets if necessary). This information must be complete. Curriculum vitae are not sufficient. Please explain any gaps on a separate page.

Current Practice: Contact Name:

Address City State Zip

Telephone Number: ( ) - Fax Number: ( ) - From (mm/yy): To (mm/yy):

Name of Practice/Employer: Contact Name:

Address City State Zip

Telephone Number: ( ) - Fax Number: ( ) - From (mm/yy): To (mm/yy):

Name of Practice/Employer: Contact Name:

Address City State Zip

Telephone Number: ( ) - Fax Number: ( ) - From (mm/yy): To (mm/yy):

XI. Professional Liability

Please list all of your professional liability carriers for the past five years, listing the most recent first. If more space is needed, attach additional sheet(s).

Name of Current Insurance Carrier: Policy Number:

Address City State Zip -

Telephone Number: ( ) - Fax Number: ( ) - Website (if applicable):

Email Address: Tail Coverage? Yes No Per Claim Amount:

Original Effective Date: Expiration Date: Aggregate Amount:

Name of Carrier: Policy Number:

Address City State Zip -

Telephone Number: ( ) - Fax Number: ( ) - Website (if applicable):

Email Address: Tail Coverage? Yes No Per Claim Amount:

Original Effective Date: Expiration Date: Aggregate Amount:

Name of Carrier: Policy Number:

Address City State Zip -

Telephone Number: ( ) - Fax Number: ( ) - Website (if applicable):

Email Address: Tail Coverage? Yes No Per Claim Amount:

Original Effective Date: Expiration Date: Aggregate Amount:

XII. Professional and Practice Services

Are you a Certified Qualified Medical Examiner (QME) of the State Industrial Medical Council? Yes No

What type of anesthesia do you provide in your group/office?

Local Regional Conscious Sedation General None Other (please specify)

If you provide direct laboratory services, please indicate the TIN utilized and provide Clinical Laboratory Information Act (CLIA) information. Attach a copy of your CLIA certificate or waiver.

Federal Tax ID: Type of Service Provided: Do you have a CLIA certificate? Yes No

Billing Name: Do you have a CLIA waiver? Yes No

CLIA Certificate Number: CLIA Certificate Expiration Date:

XII. Professional and Practice Services (continued)

Have you or your office received any of the following accreditations, certificates or licensures?

- ☐ American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)
- ☐ Institute for Medical Quality-Accreditation Association for Ambulatory Health Care (IMQ-AAAHC)
- ☐ Medicare Certification
- ☐ The Medical Quality Commission (TMQC)
- ☐ Child Health and Disability Prevention Program (CHDP)
- ☐ Comprehensive Perinatal Services Program (CPSP)
- ☐ California Children Services (CCS)
- ☐ Family Planning
- ☐ Other

Please list international, state and/or national medical societies or other professional organizations or societies of which you are a member or applicant. Use the drop-down list to select your membership status.

Organization Name	Membership Status

Do you participate in electronic data interchange (EDI)? ○ Yes ○ No If so, which Network?

Do you use a practice management system/software? ○ Yes ○ No If so, which one?

Continue to the Next Page for HIV/AIDS Specialist Designation

HIV/AIDS SPECIALIST DESIGNATION

This legislation requires standing referrals to HIV/AIDS specialists for patients who need continued care for their HIV/AIDS. The Department of Managed Health Care (DMHC) recently defined an HIV/AIDS specialist under Regulation LS - 34 -01.

In order to comply with this regulation, we need to identify appropriately qualified specialists within our network who meet the definition of an HIV/AIDS specialist.

We will use your information for internal referral procedures and for publication listing in the Provider Directory.

As always, if information about your practice changes, please notify us promptly.

☐ No, I do not wish to be designated as an HIV/AIDS specialist.

☐ Yes, I do wish to be designated as an HIV/AIDS specialist based on the below criteria:

☐ I am credentialed as an "HIV Specialist" by the American Academy of HIV Medicine. **OR**

☐ I am board certified in HIV Medicine or have earned a Certificate of Added Qualification in the field of HIV Medicine granted by a member board of the American Board of Medical Specialties. **OR**

☐ I am board certified in Infectious Disease by a member board of the American Board of Medical Specialties and meet the following qualifications:

1. In the immediately preceding 12 months, I have clinically managed medical care to a minimum of 5 patients who are infected with HIV; **AND**
2. In the immediately preceding 12 months, I have successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment or both of HIV-infected patients, including a minimum of 5 hours related to antiretroviral therapy per year; **OR**

☐ In the immediately preceding 24 months, I have clinically managed medical care to a minimum of 20 patients who are infected with HIV; **AND**

1. In the immediately preceding 12 months, I have obtained board certification or re-certification in the field of Infectious Disease from a member board of the American Board of Medical Specialties; **OR**
2. In the immediately preceding 12 months, I have successfully completed a minimum of 30 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment or both, of HIV-infected patients; **OR**
3. In the immediately preceding 12 months, I have successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment or both, of HIV-infected patients Medicine and successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV Medicine.

Continue to the Next Page for Attestation Questions

ATTESTATION QUESTIONS

INSTRUCTIONS: Please answer the following questions "Yes" or "No". If your answer to any of the following questions is "**Yes**", please provide full details on a separate sheet of paper.

1. Has your license to practice medicine, Drug Enforcement Administration (DEA) registration or an applicable narcotic registration in any jurisdiction ever been denied, limited, restricted, suspended, revoked, not renewed, or subject to probationary conditions, or have you voluntarily or involuntarily relinquished any such license or registration or voluntarily or involuntarily accepted any such actions or conditions or have you been fined or received a letter of reprimand or is such action pending? ◯ Yes ◯ No

2. Have you ever been charged, suspended, fined, disciplined, or otherwise sanctioned, subjected to probationary conditions, restricted or excluded, or have you voluntarily or involuntarily relinquished eligibility to provide services or accepted conditions on your eligibility to provide services, for reasons relating to possible incompetence or improper professional conduct, or breach of contract or program conditions by Medicare, Medicaid, or any federal program or is any such action pending? ◯ Yes ◯ No

3. Have your clinical privileges, membership, contractual participation or employment by any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with (public) federal programs), or other health delivery entity or system), ever been denied, suspended, restricted, reduced, subject to probationary conditions, revoked or not renewed for possible incompetence, improper professional conduct or breach of contract, or is any such action pending? ◯ Yes ◯ No

4. Have you ever surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership or clinical privileges, terminated contractual participation or employment, or resigned from any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), or other health delivery entity or system) while under investigation for possible incompetence or improper professional conduct, or breach of contract, or in return for such an investigation not being conducted, or is any such action pending? ◯ Yes ◯ No

5. Have you ever surrendered, voluntarily withdrawn, or been requested or compelled to relinquish your status as a student in good standing in any internship, residency, fellowship, preceptorship, or other clinical education program? ◯ Yes ◯ No

6. Have you ever been denied certification/recertification by a specialty board? ◯ Yes ◯ No

7. Have you ever chosen not to recertify or voluntarily surrender your board certification while under investigation? ◯ Yes ◯ No

8. a. Have you ever been convicted of, or pled guilty to a criminal offense (e.g., felony or misdemeanor) and/or placed on deferred adjudication or probation for a criminal offense other than a misdemeanor traffic offense? ◯ Yes ◯ No
   b. Are any such actions pending? ◯ Yes ◯ No

9. Have any judgments been entered against you, or settlements been agreed to by you within the last seven (7) years, in professional liability cases? If **YES**, please complete Addendum B. ◯ Yes ◯ No

10. Are there any professional liability lawsuits/arbitrations against you that have been dismissed or currently pending? If **YES**, please complete Addendum B. ◯ Yes ◯ No

11. Has your professional liability insurance ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged, or have you ever been denied professional liability insurance, or has any professional liability carrier provided you with written notice of any intent to deny, cancel, not renew, or limit your professional liability insurance or its coverage of any procedures? ◯ Yes ◯ No

12. Do you have any physical or mental condition which would prevent or limit your ability to perform the essential functions of the position and/or privileges for which your qualifications are being evaluated in accordance with accepted standards of professional performance, with or without reasonable accommodations? If **YES**, please describe on a separate sheet any accommodations that could reasonably be made to facilitate your performance of such functions without risk of compromise. ◯ Yes ◯ No

Continue to the Next Page for Additional Attestation Questions

ATTESTATION QUESTIONS (Continued)

INSTRUCTIONS: Please answer the following questions "Yes" or "No". If your answer to any of the following questions is "**Yes**", please provide full details on a separate sheet of paper.

13. Have you ever rendered professional medical services as an employee of a staff model HMO, an entity insured by the federal government (such as the military or a Federally Qualified Health Center) or an academic institution. ◯ Yes ◯ No

    If **YES**, have you, in the past seven (7) years, been named as a defendant in a lawsuit (whether or not you were later dismissed from the matter)? ◯ Yes ◯ No

14. Is your current ability to practice impaired by chemical dependency or substance abuse, including present use of illegal drugs? ◯ Yes ◯ No

15. Within the last three (3) years, has your membership, privileges, participation or affiliation with any healthcare organization (e.g., a hospital or HMO), been terminated, suspended or restricted; or have you taken a leave of absence from a health care organization for reasons related to the abuse of, or dependency on, alcohol or drugs? ◯ Yes ◯ No

I hereby affirm that the information submitted in this Section, Attestation Questions, Application, and any addenda thereto is current, correct, and complete to the best of my knowledge and belief and in good faith. I understand that material omissions or misrepresentations may result in denial of my application or termination of my privileges, employment or physician participation agreement.

APPLICANT SIGNATURE (Stamp is Not Acceptable) | **PRINTED NAME** | **DATE**

Continue to the Next Page for Information Release/Acknowledgements

INFORMATION RELEASE/ACKNOWLEDGEMENTS

I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials and qualifications and performance ("credentialing information") by and between "this Healthcare Organization" and other Healthcare Organizations (e.g., hospital medical staffs, medical groups, independent practice associations (IPAs), health care service plans, health maintenance organizations (HMOs), preferred provider organizations (PPOs), other health delivery systems or entities, medical societies, professional associations, medical school faculty positions, training programs, professional liability insurance companies {with respect to certification of coverage and claims history}, licensing authorities, and businesses and individuals acting as their agents - collectively "Healthcare Organizations,") for the purpose of evaluating this application and any recredentialing application regarding my professional training, experience, character, conduct and judgment, ethics, and ability to work with others. In this regard, the utmost care shall be taken to safeguard the privacy of patients and the confidentiality of peer records, and to protect peer review information from being further disclosed.

I am informed and acknowledge that federal and state laws provide immunity protections to certain individuals and entities for their acts and/or communications in connection with evaluating the qualifications of healthcare providers. I hereby release all persons and entities, including this Healthcare Organization, engaged in quality assessment, peer review and credentialing on behalf of this Healthcare Organization, and all persons and entities providing credentialing information to such representatives of this Healthcare Organization, from any liability they might incur for their acts and/or communications in connection with evaluation of my qualifications for participation in this Healthcare Organization, to the extent that those acts and/or communications are protected by state or federal law.

I understand that I shall be afforded such fair procedures with respect to my participation in this Healthcare Organization as may be required by state and federal law and regulation, including, but not limited to, California Business and Professions Code Section 809 et seq., if applicable.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubt about such qualifications.

During such time as this application is being processed, I agree to update the application should there be any change in the information provided.

In addition to any notice required by any contract with a Healthcare Organization, I agree to notify this Healthcare Organization immediately in writing of the occurrence of any of the following: (i) the unstayed suspension, revocation or nonrenewal of my license to practice medicine in California; (ii) any suspension, revocation or nonrenewal of my DEA or other controlled substances registration; or (iii) any cancellation or nonrenewal of my professional liability insurance coverage.

I further agree to notify this Healthcare Organization in writing, within fourteen (14) days from the occurrence of any of the following: (i) receipt of written notice of any adverse action against me, by the Medical Board of California taken or pending, including, but not limited to, any accusation filed, temporary restraining order or imposition of any interim suspension, probation or limitations affecting my license to practice medicine; or (ii) any adverse action against me by any Healthcare Organization, which has resulted in the filing of a Section 805 report (or any subsections) with the Medical Board of California, appropriate licensing board or a report with the National Practitioner Data Bank; or (iii) the denial, revocation, suspension, reduction limitation, nonrenewal or voluntary relinquishment by resignation of my medical staff membership or clinical privileges at any Healthcare Organization; or (iv) any material reduction in my professional liability insurance coverage; or (v) my receipt of written notice of any legal action against me, including, without limitation, any filed and served malpractice suit or arbitration action; or (vi) my conviction of any crime (excluding any minor traffic violations); or (vii) my receipt of written notice of any adverse action against me under the Medicare or Medicaid programs, including, but not limited to, fraud and abuse proceedings or convictions.

I pledge to provide continuous care for my patients.

I hereby affirm that the information submitted in this application and any addenda thereto (including my curriculum vitae if attached) is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that material omissions or misrepresentations may result in denial of my application or termination of my privileges, employment or physician participation agreement.

A photocopy of this document shall be as effective as the original.

APPLICANT SIGNATURE (Stamp is Not Acceptable) | **PRINTED NAME** | **DATE**

Addenda Submitting :

☐ Addendum B: Professional Liability Action Explanation

This application and Addenda A and B were created and are endorsed by:
- California Association of Health Plans (916) 552-2910
- California Association of Physician Groups (916) 443-2274

The CPPA has been completed. Please be sure you have signed the last two pages (pages 15 and 16) before submission.

California Participating Practitioner Application

Addendum A

Practitioner Rights

Right to Review

The practitioner has the right to review information obtained by the Healthcare Organization for the purpose of evaluating that practitioner's credentialing or recredentialing application. This includes non-privileged information obtained from any outside source (e.g., malpractice insurance carriers, state licensing boards), but does not extend to review of information, references or recommendations protected by law from disclosure.

The practitioner may request to review such information at any time by sending a written request, via certified letter, to the Credentialing Department at the Healthcare Organization's offices. The Credentialing Department of the Healthcare Organization's offices will notify the practitioner within 72 hours of the date and time when such information will be available for review at the Credentialing Department office.

Right to be Informed of the Status of Credentialing/Recredentialing Application

Practitioners may request to be informed of the status of their credentialing/recredentialing application. The practitioner may request this information by sending a written request by letter, email or fax to the Credentialing Department of the Healthcare Organization's offices.

The provider will be notified in writing by fax, email or letter no more than seven working days of the current status of your application with respect to outstanding information required to complete the application process.

Notification of Discrepancy

Practitioners will be notified in writing via fax, email or certified letter, when information obtained by primary sources varies substantially from information provided on the practitioner's application. Examples of information that substantial variance include reports of practitioner's malpractice claims history, actions taken against a practitioner's license/certificate, suspension or termination of hospital privileges or board certification expiration when one or more of these examples have not been self-reported by the practitioner on his/her application form. Practitioners will be notified of the discrepancy at the time of primary source verification. Sources will not be revealed if information obtained is not intended for verification of credentialing elements or is protected from disclosure by law.

Correction of Erroneous Information

If a practitioner believes that erroneous information has been supplied to Healthcare Organization by primary sources, the practitioner may correct such information by submitting written notification to the Credentialing Department. Practitioners must submit a written notice, via certified letter, along with a detailed explanation to the Credentialing Department at the Healthcare Organization, within 48 hours of the Healthcare Organization's notification to the practitioner of a discrepancy or within 24 hours of a practitioner's review of his/her credentials file.

Upon receipt of notification from the practitioner, the Healthcare Organization will re-verify the primary source information in dispute. If the primary source information has changed, correct will be made immediately to the practitioner's credentials file. The practitioner will be notified in writing, via certified letter, that the correction has been made to his/her credentials file. If, upon review, primary source information remains inconsistent with practitioner's notification, the Credentialing Department will so notify the practitioner via certified letter. The practitioner may then provide proof of correction by the primary source body to Healthcare Organization's Credentialing Department via certified letter at the address below within 10 working days. The Credentialing Department will re-verify primary source information if such documentation is provided.

Healthcare Organization's Credentialing Department Address:

Address:	5[illegible]5 City [illegible] arkway West				
City:	Orange	ST:	CA	Zip:	92868

APPLICANT SIGNATURE (Stamp is Not Acceptable) ✖

PRINTED NAME ✖

DATE ✖

California Participating Practitioner Application

Addendum B

Professional Liability Action Explained

This Addendum is submitted to _____ herein, this Healthcare Organization

Please complete this form for each pending, settled or otherwise conclude professional liability lawsuit or arbitration filed and served against you, in which you were named a party in the past seven (7) years, whether the lawsuit or arbitration is pending, settled or otherwise co[illegible] whether or not any payment was made on your behalf by any insurer, company, hospital or other entity. All questions must be answered [illegible]etely in order to avoid delay in expediting your application. If there is more than one professional liability lawsuit or arbitration action, please photocopy this Addendum B prior to completing, and complete a separate form for each lawsuit.

☐ *Please check here if there are no pending/ settled claims to report (and sign below to attest).*

I. Practioner Identifying Information

Last Name: _____ First Name: _____ Middle: _____

II. Case Information

Patient's Name: _____ Patient Gender ◯ Male ◯ Female Patient DOB: _____

City, County, State where lawsuit filed: _____ Court Ca[illegible]mber, if known: _____ Date of alleged incident serving as basis for the lawsuit/ arbitration: _____ Date suit filed: _____

Location of incident:
☐ Hospital ☐ My Office ☐ Other doctor's office ☐ Surgery Center ☐ Other (specify) _____

Relationship to patient (Attending physician, Surgeon, Assistant, Consultant, etc.) _____

Allegation

_____

Is/was there an insurance company or other liability protection company or organization providing coverage/defense of the lawsuit or arbitration action? ◯ Yes ◯ No

If yes, please provide company name, contact person, phone number, location and carrier's claim identification number, or other liability protection company or organization.

_____

If you would like us to contact your attorney regarding any of the above, please provide attorney(s) name(s) and phone number(s). Please fax this document to your attorney as this will serve as your authorization:

Name: _____ Telephone Number: ( ) - Fax Number: ( ) -

III. Status of Lawsuit/Arbitration (check one)

- ☐ Lawsuit/arbitration still ongoing, unresolved.
- ☐ Judgment rendered and payment was made on my behalf. Amount paid on my behalf: _____
- ☐ Judgment rendered and I was found not liable.
- ☐ Lawsuit/arbitration settled and payment made on my behalf. Amount paid on my behalf: _____
- ☐ Lawsuit/arbitration settled/dismissed, no judgment rendered, no payment made on my behalf.

Summarize the circumstances giving rise to the action. If the action involves patient care, provide a narrative, with adequate clinical detail, including your description of your care and treatment of the patient. If more space is needed, attach additional sheets.

Please include:
1. Condition and diagnosis at the time of incident,
2. Dates and description of treatment rendered, and
3. Condition of patient subsequent to treatment.

SUMMARY

I certify that the information in this document and any attached documents is true and correct. I agree that "this Healthcare Organization", its representatives, and any individuals or entities providing information to this Healthcare Organization in good faith shall not be liable, to the fullest extent provided by law, for any act or occasion related to the evaluation or verification contained in this document, which is part of the California Participating Practitioner Application. In order for the participating healthcare organizations to evaluate my application for participation in and/or my continued participation in those organizations, I hereby give permission to release to this Healthcare Organization about my medical malpractice insurance coverage and malpractice claims history. This authorization is expressly contingent upon my understanding that the information provided will be maintained in a confidential manner and will be shared only in the context of legitimate credentialing and peer review activities. This authorization is valid unless and until it is revoked by me in writing. I authorize the attorney(s) listed on Page 1 to discuss any information regarding this case with "this Healthcare Organization".

APPLICANT SIGNATURE (Stamp is Not Acceptable) ✖ **PRINTED NAME** ✖ **DATE** ✖

CalOptima Primary Source Verification Table

Primary Source Verification – Licensure

Licensure	Source of Verification	Method of Verification
MD – Medical Board of California	https://search.dca.ca.gov/ https://www.mbc.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
DO- Osteopathic Board of California	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
DC- California Board of Chiropractic	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
DDS- Dental Board of California	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
DPM- California Board of Podiatric Medicine	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
California Board of Psychology	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
California Board of Behavioral Sciences	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
Department of Consumer Affairs Acupuncture Board	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

Department of Consumer Affairs CA State Board of Optometry	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
California Board of Registered Nursing	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
California Department of Consumer Affairs; Physician Assistant Board	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
Physical Therapy Board of California	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
Department of Consumer Affairs California Board of Occupational Therapy	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
Department of Consumer affairs Speech-Language Pathology & Audiology & Hearing Aid Dispensers Board	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

Primary Source Verification – DEA

DEA	Source of Verification	Method of Verification
	https://www.deadiversion.usdoj.gov/ https://apps.deadiversion.usdoj.gov/webforms2/spring/timedout.xhtml	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	Copy of current DEA certificate	Visual inspection of certificate and stored in Credentialing database.

CalOptima Primary Source Verification Table

Primary Source Verification – Board Certification

Certification	Source of Verification	Method of Verification
~~Board Certification~~	~~https://www.boardcertifieddocs.com/~~	~~Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.~~
	~~https://www.aoaprofiles.org/~~ ~~American Board of Podiatric Surgery~~	~~Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.~~
Board Certification	American Board of Medical Specialties https://certifacts.abms.org/~~https://www.abms.prg/~~	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	American Osteopathic Association (AOA) https://osteopathic.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	American Board of Professional Psychology https://www.abpp.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated
	American Board of Foot and Ankle Surgery (ABFAS) https://www.abfas.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	American Board of Oral and Maxillofacial Surgery (ABOMS) https://www.aboms.org/	Verified sources are reviewed and stored in Credentialing database. All sources

		are electronically tracked and dated.
Nursing Board	**Nursing Board Certification for Nurse Practitioners/Advance Practice Nurses** American Academy of Nurse Practitioners Certification Board (AANPCB) www.aanpcert.org/ American Nursing Credentialing Center (ANCC) https://www.nursingworld.org/ancc/ National Certification Corporation (NCC) www.nccwebsite.org Pediatric Nursing Certification Board (PNCB) www.pncb.org American Association of Critical Care Nurses (AACN) www.aacn.org	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	National Commission on Certification of PA's (NCCPA) https://portal.nccpa.net/verifypac	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

Primary Source Verification – Education & Training

Education	Source of Verification	Method of Verification
Education & Training	Board certification by ABMS or AOIA in practicing specialty	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	American Board of Multiple Specialties in Podiatry. http://abmsp.org/	Verified sources are reviewed and stored in Credentialing database. All sources are

		electronically tracked and dated.
	AMA Physician Master File https://www.ama-assn.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	AOIA Official Osteopathic Physician Profile Report https://www.aoaprofiles.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	Contact the training institution to verify the highest level of training; or State Licensing Agency, as applicable.	Letter from institution is reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	National Student Clearing House http://nscverifications.org/welcome-to-verification-serives/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	National Board of Physicians and Surgeons (NBPAS) https://nbpas.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

CalOptima Primary Source Verification Table

Primary Source Verification – Malpractice History

Malpractice Information	Source of Verification	Method of Verification
Malpractice History	National Practitioner Data Bank (NPDB) https://www.npdb.hrsa.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

Primary Source Verification –Sanctions and other sources

Sanction Information	Source of Verification	Method of Verification
State & Federal Sanctions and Other Sources	National Practitioner Data Bank (-NPDB) https://www.npdb.hrsa.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	System for Award Management-SAM https://sam.gov/search/?index=_all&page=1&sort=modifiedDate&sfm%5Bstatus%5D%5Bis_active%5D=truehttps://www.sam.gov/SAM/pages/public/searchRecords/search.jsf	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	Office of Inspector General https://exclusions.oig.hhs.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	Medi-Cal Suspended & Ineligible List https://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	CMS Preclusion List https://portal.cms.gov/wps/portal/unauthportal/home/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	Drug Code Limitation Listing of practitioners and/or medical groups placed on P/DCL sanction,	Verified sources are reviewed and stored in Credentialing database. All sources are

	https://files.medi-cal.ca.gov/pubsdoco/pdcl_home.aspx	electronically tracked and dated.
	Department of Health Care Service (DHCS)- Restricted Provider Database	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	CMS.gov Centers for Medicare & Medicaid Services – Medicare Opt-Out Physicians https://www.cms.gov/Medicare/Provider-Enrollment-andCertification/MedicareProviderSupEnroll/OptOutAffidavits.html For a listing of all physicians and practitioners that are currently opted out of Medicare: https://data.cms.gov/tools/provider-opt-out-affidavits-look-up-tool	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
Other Sanction Sources	AMA Physician Master File	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	AOIA Physician Profile report	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

CalOptima Primary Source Verification Table

Primary Source Verification – Licensure

Licensure	Source of Verification	Method of Verification
MD – Medical Board of California	https://search.dca.ca.gov/ https://www.mbc.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
DO- Osteopathic Board of California	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
DC- California Board of Chiropractic	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
DDS- Dental Board of California	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
DPM- California Board of Podiatric Medicine	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
California Board of Psychology	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
California Board of Behavioral Sciences	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
Department of Consumer Affairs Acupuncture Board	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

Department of Consumer Affairs CA State Board of Optometry	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
California Board of Registered Nursing	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
California Department of Consumer Affairs; Physician Assistant Board	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
Physical Therapy Board of California	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
Department of Consumer Affairs California Board of Occupational Therapy	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
Department of Consumer affairs Speech-Language Pathology & Audiology & Hearing Aid Dispensers Board	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

Primary Source Verification – DEA

DEA	Source of Verification	Method of Verification
	https://www.deadiversion.usdoj.gov/ https://apps.deadiversion.usdoj.gov/webforms2/spring/timedout.xhtml	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	Copy of current DEA certificate	Visual inspection of certificate and stored in Credentialing database.

CalOptima Primary Source Verification Table

Primary Source Verification – Board Certification

Certification	Source of Verification	Method of Verification
Board Certification	American Board of Medical Specialties https://certifacts.abms.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	American Osteopathic Association (AOA) https://osteopathic.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	American Board of Professional Psychology https://www.abpp.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated
	American Board of Foot and Ankle Surgery (ABFAS) https://www.abfas.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	American Board of Oral and Maxillofacial Surgery (ABOMS) https://www.aboms.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
Nursing Board	**Nursing Board Certification for Nurse Practitioners/Advance Practice Nurses** American Academy of Nurse Practitioners Certification Board (AANPCB) www.aanpcert.org/ American Nursing Credentialing Center (ANCC) https://www.nursingworld.org/ancc/ National Certification Corporation (NCC) www.nccwebsite.org	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

	Pediatric Nursing Certification Board (PNCB) www.pncb.org American Association of Critical Care Nurses (AACN) www.aacn.org	
	National Commission on Certification of PA's (NCCPA) https://portal.nccpa.net/verifypac	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

Primary Source Verification – Education & Training

Education	Source of Verification	Method of Verification
Education & Training	Board certification by ABMS or AOIA in practicing specialty	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	American Board of Multiple Specialties in Podiatry. http://abmsp.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	AMA Physician Master File https://www.ama-assn.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	AOIA Official Osteopathic Physician Profile Report https://www.aoaprofiles.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	Contact the training institution to verify the highest level of training; or	Letter from institution is reviewed and stored in

	State Licensing Agency, as applicable.	Credentialing database. All sources are electronically tracked and dated.
	National Student Clearing House http://nscverifications.org/welcome-to-verification-serives/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	National Board of Physicians and Surgeons (NBPAS) https://nbpas.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

Primary Source Verification – Malpractice History

Malpractice Information	Source of Verification	Method of Verification
Malpractice History	National Practitioner Data Bank (NPDB) https://www.npdb.hrsa.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

Primary Source Verification –Sanctions and other sources

Sanction Information	Source of Verification	Method of Verification
State & Federal Sanctions and Other Sources	National Practitioner Data Bank (NPDB) https://www.npdb.hrsa.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	System for Award Management-SAM https://sam.gov/search/?index=_all&page=1&sort=modifiedDate&sfm%5Bstatus%5D%5Bis_active%5D=true	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	Office of Inspector General https://exclusions.oig.hhs.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

CalOptima Primary Source Verification Table

	Medi-Cal Suspended & Ineligible List https://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	CMS Preclusion List https://portal.cms.gov/wps/portal/unauthportal/home/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	Drug Code Limitation Listing of practitioners and/or medical groups placed on P/DCL sanction, https://files.medi-cal.ca.gov/pubsdoco/pdcl_home.aspx	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	Department of Health Care Service (DHCS)- Restricted Provider Database	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	CMS.gov Centers for Medicare & Medicaid Services – Medicare Opt-Out Physicians https://www.cms.gov/Medicare/Provider-Enrollment-andCertification/MedicareProviderSupEnroll/OptOutAffidavits.html For a listing of all physicians and practitioners that are currently opted out of Medicare: https://data.cms.gov/tools/provider-opt-out-affidavits-look-up-tool	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
Other Sanction Sources	AMA Physician Master File	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	AOIA Physician Profile report	Verified sources are reviewed and stored in Credentialing database. All sources are

		electronically tracked and dated.

Provider Application

CORRECT NUMBERS AND LETTERS: A B C 1 2 3 | CORRECT MARK: X | INCORRECT MARKS: ✓ •

CAQH AUTOMATICALLY APPLIES MIXED-CASE FORMATTING, COMMON ABBREVIATIONS, AND ZIP CODE MATCHING. PLEASE MAKE CORRECTIONS ONLINE OR CALL THE HELP DESK.

Instructions

Read all instructions carefully prior to submitting your application.

Tips to avoid processing delays

1. Complete only this application and its supplemental forms. **Do not use another provider's application.**
2. Use a blue or black ink ball-point pen only. Do not use a pencil or a felt-tip pen.
3. Print legibly and inside the boxes provided based upon the examples given above.
4. Do not enter more than 1 character per box. If necessary, write outside the provided spaces.
5. Complete all sections that are applicable to you.
6. Some fields use "codes" to help you easily report information (e.g., schools, languages). Code lists are found on pages 36 - 43.

NOTE: Fields with asterisks (*) indicate that a response is required. All other fields will be considered not applicable if left blank.

SECTION 1 Personal Information and Professional IDs

Provider Type

Code list is found on page 36. Enter the associated 3-digit code in the space provided.*

YES NO

DO YOU PRACTICE EXCLUSIVELY WITHIN THE INPATIENT SETTING?* (E.G. PATHOLOGISTS, ANESTHESIOLOGISTS, ER PHYSICIANS, NURSE PRACTITIONER, RADIOLOGISTS, PHYSICIAN ASSISTANT, ETC.)

Name

Do not use nicknames or initials, unless they are part of your legal name.

LAST NAME* SUFFIX (JR, III)

FIRST NAME* MIDDLE NAME

HAVE YOU EVER USED ANOTHER NAME?* YES NO IF YES, PLEASE LIST ALL OTHER NAMES USED AND THEIR DATES OF USE BELOW.

OTHER LAST NAME SUFFIX (JR, III)

OTHER FIRST NAME OTHER MIDDLE NAME

DATE STARTED USING OTHER NAME (M M D D Y Y Y Y) DATE STOPPED USING OTHER NAME (M M D D Y Y Y Y)

General Information

Only enter a Foreign National Identification Number if you do not have a SSN. Do not enter National Provider Identification (NPI) Number here.

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

GENDER* MALE FEMALE DATE OF BIRTH* (M M D D Y Y Y Y)

CITY OF BIRTH STATE OF BIRTH COUNTRY OF BIRTH

SSN* FOREIGN NATIONAL IDENTIFICATION NUMBER (FNIN) FNIN COUNTRY OF ISSUE

ENTER ALL NON-ENGLISH LANGUAGES YOU SPEAK

LANGUAGE CODE LANGUAGE CODE LANGUAGE CODE LANGUAGE CODE LANGUAGE CODE

Home Address

NUMBER STREET APT NUMBER

CITY STATE ZIP CODE

TELEPHONE

NOTE CAQH will use this method for application follow-up.

E-MAIL

FAX PREFERRED METHOD OF CONTACT* E-MAIL FAX

3076

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESS NG DELAYS AND REQU RE FOLLOW-UP.

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESS NG DELAYS AND REQUIRE FOLLOW-UP.

Section 1 — Personal Information and Professional IDs (Continued)

Professional IDs

Include all state licenses, DEA Registration and State Controlled Dangerous Substance (CDS) certification numbers.

Provide all current and previous licenses/ certifications.

Non-licensed professionals should enter certification/ registration number in the space provided for license number.

If you have additional Professional IDs to report, use the Professional IDs Supplemental Form on page 19.

FEDERAL DEA NUMBER

DEA ISSUE DATE (M M D D Y Y Y Y)

DEA STATE OF REGISTRATION

DEA EXPIRATION DATE (M M D D Y Y Y Y)

CDS CERTIFICATE NUMBER

CDS ISSUE DATE (M M D D Y Y Y Y)

CDS STATE OF REGISTRATION

CDS EXPIRATION DATE (M M D D Y Y Y Y)

STATE LICENSE NUMBER

LICENSE ISSUING STATE

LICENSE ISSUE DATE (M M D D Y Y Y Y)

IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? YES NO

LICENSE EXPIRATION DATE (M M D D Y Y Y Y)

LICENSE STATUS CODE — Code list is found on page 36 use license status codes. Enter 3-digit code in space provided.

LICENSE TYPE — Code list is found on page 36 use provider type codes. Enter 3-digit code in space provided.

STATE LICENSE NUMBER

LICENSE ISSUING STATE

LICENSE ISSUE DATE (M M D D Y Y Y Y)

IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? YES NO

LICENSE EXPIRATION DATE (M M D D Y Y Y Y)

LICENSE STATUS CODE — Code list is found on page 36 use license status codes. Enter 3-digit code in space provided.

LICENSE TYPE — Code list is found on page 36 use provider type codes. Enter 3-digit code in space provided.

Other ID Numbers

If you have additional Professional IDs to report, use the Professional IDs Supplemental Form on page 19.

ARE YOU A PARTICIPATING MEDICARE PROVIDER?* YES NO

MEDICARE NUMBER

UPIN

ARE YOU A PARTICIPATING MEDICAID PROVIDER?* YES NO

MEDICAID NUMBER

MEDICAID STATE

NATIONAL PROVIDER IDENTIFICATION (NPI) NUMBER

USMLE NUMBER (WITHOUT HYPHENS)

WORKERS COMPENSATION NUMBER

0 — — —

ECFMG NUMBER (NON-U.S./CANADIAN GRADUATE ONLY)

ECFMG CERTIFICATE ISSUE DATE (NON-U.S./CANADIAN GRADUATE ONLY) (M M D D Y Y Y Y)

Section 2 — Education and Training

Undergraduate School(s)

Provide the appropriate information for the school that issued your undergraduate degree and all schools attended.

Professional School(s)

Provide the appropriate information for the school that issued your professional degree.

Fifth Pathway Graduates please complete the following sections: U.S. School that issued your certificate, the Non-U.S. School where you attended, and he Fifth Pathway institution where you completed your training on Supplemental Page 20.

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

If you have additional Undergraduate or Professional Schools to report, use the Education Supplemental Form on page 20.

UNDERGRADUATE SCHOOL

OFFICIAL NAME OF UNDERGRADUATE SCHOOL

ADDRESS

CITY | STATE | ZIP/POSTAL CODE

COUNTRY CODE | TELEPHONE | FAX

START DATE (MMYYYY) | END DATE (GRADUATION DATE) (MMYYYY) | DEGREE AWARDED

DID YOU COMPLETE YOUR UNDERGRADUATE EDUCATION AT THIS SCHOOL? ☐ YES ☐ NO

GRADUATE TYPE*:

☐ U.S. OR CANADIAN GRADUATE ☐ NON-U.S./CANADIAN GRADUATE ☐ FIFTH PATHWAY GRADUATE

U.S. OR CANADIAN SCHOOL

SCHOOL CODE (U.S./ CANADIAN ONLY) | NAME OF U.S./ CANADIAN SCHOO

START DATE* (MMYYYY) | END DATE (GRADUATION DATE)* (MMYYYY) | DEGREE AWARDED

DID YOU COMPLETE YOUR GRADUATE EDUCATION AT THIS SCHOOL? ☐ Y S ☐ NO

NON - U.S. OR CANADIAN SCHOOL

OFFICIAL NAME OF NON-U.S. PROFESSIONAL SCHOOL

ADDRES

CIT | COUNTRY CODE | POSTAL CODE

START DATE* (MMYYYY) | END DATE (GRADUATION DATE)* (MMYYYY) | DEGREE AWARDED

DID YOU COMPLETE YOUR GRADUATE EDUCATION AT THIS SCHOOL? ☐ YES ☐ NO

Section 2 Education and Training (Continued)

Training

List all training programs you attended. Use one section per institution.

If you have additional post-graduate training programs, use the Supplemental Training Form on page 21.

Please explain on the Supplemental Professional / Work History Gap Form on page 33 any training gap(s) of three (3) months or greater, or any gap(s) of a shorter duration if required by he organization for which you are being credentialed.

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

INSTITUTION/HOSPITAL NAME (USE BOTH LINES IF REQUIRED)

SCHOOL CODE (E.G., AFFILIATED MEDICAL SCHOOL)

NUMBER STREET SUITE/BUILDING

CITY STATE ZIP/POSTAL CODE

COUNTRY CODE TELEPHONE FAX

DID YOU COMPLETE THIS TRAINING PROGRAM AT THIS INSTITUTION? YES NO

(IF NOT, PLEASE USE THE SPACE BELOW TO EXPLAIN.)

List each department separately, if applicable.

List Internship/ Residency, Fellowship and Other programs separately.

INTERNSHIP/ RESIDENCY FELLOWSHIP OTHER M M Y Y Y Y M M Y Y Y Y

START DATE END DATE

DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)

NAME OF DIRECTOR

INTERNSHIP/ RESIDENCY FELLOWSHIP OTHER M M Y Y Y Y M M Y Y Y Y

START DATE END DATE

DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)

NAME OF DIRECTOR

INTERNSHIP/ RESIDENCY FELLOWSHIP OTHER M M Y Y Y Y M M Y Y Y Y

START DATE END DATE

DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)

NAME OF DIRECTOR

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESS NG DELAYS AND REQUIRE FOLLOW-UP.

Section 3 — Professional / Medical Specialty Information

Primary Specialty

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

SPECIALTY CODE

BOARD CERTIFIED? YES NO

CERTIFYING BOARD CODE

INITIAL CERTIFICATION DATE M M D D Y Y Y Y

RECERTIFICATION DATE (IF APPLICABLE) M M D D Y Y Y Y

EXPIRATION DATE (IF APPLICABLE) M M D D Y Y Y Y

DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?

HMO YES NO

PPO YES NO

POS YES NO

IF NOT BOARD CERTIFIED (SELECT ONE)

I HAVE TAKEN EXAM, RESULTS PENDING FOR

CERTIFYING BOARD CODE

I INTEND TO SIT FOR AN EXAM ON M M D D Y Y Y Y

I DO NOT INTEND TO TAKE A CERTIFYING BOARD EXAM.

IF YOU INDICATED THAT YOU DID NOT INTEND TO TAKE A CERTIFYING BOARD EXAM, PLEASE USE THE FOLLOWING SPACE TO EXPLAIN, OTHERWISE LEAVE THE SPACE BLANK.

Secondary Specialty

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

If you have additional Professional / Medical Specialties to report, use the Additional Specialties Supplemental Form on page 22.

SPECIALTY CODE

BOARD CERTIFIED? YES NO

CERTIFYING BOARD CODE

INITIAL CERTIFICATION DATE M M D D Y Y Y Y

RECERTIFICATION DATE (IF APPLICABLE) M M D D Y Y Y Y

EXPIRATION DATE (IF APPLICABLE) M M D D Y Y Y Y

DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?

HMO YES NO

PPO YES NO

POS YES NO

IF NOT BOARD CERTIFIED (SELECT ONE)

I HAVE TAKEN EXAM, RESULTS PENDING FOR

CERTIFYING BOARD CODE

I INTEND TO SIT FOR AN EXAM ON M M D D Y Y Y Y

I DO NOT INTEND TO TAKE A CERTIFYING BOARD EXAM.

IF YOU INDICATED THAT YOU DID NOT INTEND TO TAKE A CERTIFYING BOARD EXAM, PLEASE USE THE FOLLOWING SPACE TO EXPLAIN, OTHERWISE LEAVE THE SPACE BLANK.

Section 3 — Professional / Medical Specialty Information (Continued)

Certifications

Do you hold the following certifica ions? If yes, provide expiration dates.

Certification	YES	NO	EXPIRATION DATE	Certification	YES	NO	EXPIRATION DATE
BASIC LIFE SUPPORT?*	YES	NO	M M D D Y Y Y Y	ADV LIFE SUPPORT IN OB?*	YES	NO	M M D D Y Y Y Y
CPR?*	YES	NO	M M D D Y Y Y Y	ADV TRAUMA LIFE SUPPORT?*	YES	NO	M M D D Y Y Y Y
ADV CARDIAC LIFE SPT?*	YES	NO	M M D D Y Y Y Y	PEDIATRIC ADVANCED LIFE SPT?*	YES	NO	M M D D Y Y Y Y
NEONATAL ADVANCED LIFE SPT?*	YES	NO	M M D D Y Y Y Y				

Practice Interests

Provide additional areas of professional practice interest, procedures, activities, diagnoses or populations.

Primary Credentialing Contact

CHECK HERE TO USE THE OFFICE MANAGER AND ADDRESS OF THE PRIMARY PRACTICE LOCATION AS THE CREDENTIALING INFORMATION.

LAST NAME

FIRST NAM_ M.I.

NUMBER STREET SUITE/BUILDING

CITY STATE ZIP CODE

TELEPHONE FAX

E-MAIL ADDRESS

NOTE:

Even if you checked the boxes above, please provide the e-mail address, if available.

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESS NG DELAYS AND REQUIRE FOLLOW-UP.

Section 4 — Practice Location Information

Primary Practice Location

If you have additional practice locations, use the Supplemental Practice Location Information Form on pages 25-29.

NOTE: "General Correspondence" refers to any correspondence that might be sent to the provider that does not solely relate to credentialing or billing information.

TIP Your Individual Tax ID is assumed to be your Primary Tax ID unless you specify otherwise to the right.

NOTE IF YOU INDICATED THAT YOU PRACTICE EXCLUSIVELY WITHIN THE INPATIENT SETTING ON PAGE 1, YOU ARE ONLY REQUIRED TO COMPLETE THE CREDENTIALING CONTACT QUESTION ABOVE. SECTION 4 MAY BE LEFT BLANK. YOU MAY PROCEED TO SECTION 5 ON PAGE 11.

CURRENTLY PRACTICING AT THIS ADDRESS?* ☐ YES ☐ NO

IF NO, WHAT IS YOUR EXPECTED START DATE? M M D D Y Y Y Y

PHYSICIAN GROUP / PRACTICE NAME TO APPEAR IN DIRECTORY (DO NOT ABBREVIATE)*

GROUP / CORPORATE NAME AS IT APPEARS ON W-9, IF DIFFERENT FROM ABOVE (DO NOT ABBREVIATE)

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

SEND GENERAL CORRESPONDENCE HERE?* ☐ YES ☐ NO

TELEPHONE* FAX

OFFICE E-MAIL ADDRESS

INDIVIDUAL TAX ID GROUP TAX ID

PRIMARY TAX ID (ONE ONLY)* ☐ USE INDIVIDUAL TAX ID ☐ USE GROUP TAX ID

Office Manager or Business Office Staff Contact

List each contact separately. You may use the check boxes below for convenience. Do not write instructions like "see above". These responses will be rejected and will require follow-up.

LAST NAME*

FIRST NAME* M.I.

TELEPHONE* FAX

E-MAIL ADDRESS

Billing Contact

CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS BILLING INFORMATION ☐

NOTE:

Even if you checked the box above, please provide the E-mail Address of the Billing Contact.

LAST NAME*

FIRST NAME* M.I.

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

TELEPHONE* FAX

E-MAIL ADDRESS

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESS NG DELAYS AND REQUIRE FOLLOW-UP.

Section 4 — Practice Location Information (Continued)

Payment and Remittance

ELECTRONIC BILLING CAPABILITIES?* ☐ YES ☐ NO

BILLING DEPARTMENT (IF HOSPITAL-BASED)

YOUR "CHECK PAYABLE TO" INFORMATION SHOULD BE CONSISTENT WITH YOUR W-9.

CHECK PAYABLE TO*

CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS PAYEE INFORMATION ☐

LAST NAME*

FIRST NAME* M.I.

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

NOTE:

Even if you checked the box above, please provide the E-mail Address of the Payee Contact.

TELEPHONE* FAX

E-MAIL ADDRESS

Office Hours

(USE HHMM FORMAT AND ROUND TO THE NEAREST HALF-HOUR)

	START	A=AM P=PM	END	A=AM P=PM		START	A=AM P=PM	END	A=AM P=PM
MONDAY					FRIDAY				
TUESDAY					SATURDAY				
WEDNESDAY					SUNDAY				
THURSDAY									

NOTE:

After hours back office telephone will be used only by the health plan and will not be published under any circumstances.

24/7 PHONE COVERAGE? ☐ YES ☐ NO IF YES ☐ ANSWERING SERVICE ☐ VOICE MAIL WITH INSTRUCTIONS TO CALL ANSWERING SERVICE ☐ VOICE MAIL WITH OTHER INSTRUCTIONS

AFTER HOURS BACK OFFICE TELEPHONE

Open Practice Status

ACCEPT NEW PATIENTS INTO THIS PRACTICE?* ☐ YES ☐ NO

ACCEPT ALL NEW PATIENTS?* ☐ YES ☐ NO

ACCEPT EXISTING PATIENTS WITH CHANGE OF PAYOR?* ☐ YES ☐ NO

ACCEPT NEW MEDICARE PATIENTS?* ☐ YES ☐ NO

ACCEPT NEW PATIENTS WITH PHYSICIAN REFERRAL?* ☐ YES ☐ NO

ACCEPT NEW MEDICAID PATIENTS?* ☐ YES ☐ NO

IF ANY OF THE ABOVE INFORMATION VARIES BY PLAN, EXPLAIN (USE BOTH LINES IF REQUIRED)

ARE THERE ANY PRACTICE LIMITATIONS?* ☐ YES ☐ NO IF YES

GENDER LIMITATIONS ☐ MALE ONLY ☐ FEMALE ONLY ☐ NONE

AGE LIMITATIONS ☐☐ MINIMUM AGE ☐☐ MAXIMUM AGE

LIST OTHER LIMITATIONS

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESS NG DELAYS AND REQU RE FOLLOW-UP.

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESS NG DELAYS AND REQUIRE FOLLOW-UP.

Section 4 Practice Location Information (Continued)

Mid-Level Practitioners

DO MID-LEVEL PRACTITIONERS (NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, ETC.) CARE FOR PATIENTS IN YOUR PRACTICE?* ☐ YES ☐ NO

(IF YES, PLEASE PROVIDE THE INFORMATION BELOW)

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME | M.I. | PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER | PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME | M.I. | PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER | PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME | M.I. | PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER | PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME | M.I. | PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER | PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME | M.I. | PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER | PRACTITIONER STATE

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESS NG DELAYS AND REQUIRE FOLLOW-UP.

Section 4 — Practice Location Information (Continued)

Languages

Code lists are found on pages 37. Enter the associated 3-digit code in the space provided.

LANGUAGES

NON-ENGLISH LANGUAGES SPOKEN BY OFFICE PERSONNEL — LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE

INTERPRETERS AVAILABLE?* YES NO

LANGUAGES INTERPRETED — LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE

Accessibilities

DOES THIS OFFICE MEET ADA ACCESSIBILITY REQUIREMENTS?* YES NO

DOES THIS SITE OFFER HANDICAPPED ACCESS FOR THE FOLLOWING

- BUILDING?* YES NO
- PARKING?* YES NO
- RESTROOM?* YES NO

OTHER HANDICAPPED ACCESS

DOES THIS SITE OFFER OTHER SERVICES FOR THE DISABLED?* YES NO

- TEXT TELEPHONY (TTY)* YES NO
- AMERICAN SIGN LANGUAGE* YES NO
- MENTAL/PHYSICAL IMPAIRMENT SERVICES* YES NO

OTHER DISABILITY SERVICES

ACCESSIBLE BY PUBLIC TRANSPORTATION?* YES NO

- BUS* YES NO
- SUBWAY* YES NO
- REGIONAL TRAIN* YES NO

OTHER TRANSPORTATION ACCESS

Services

Does this location provide any of the following services?

- LABORATORY SERVICES? YES NO — IF YES, PROVIDE ACCREDITING/ CERTIFYING PROGRAM (E.G., CLIA, COLA, MLE)
- RADIOLOGY SERVICES? YES NO — IF YES, PROVIDE X-RAY CERTIFICATION TYPE

EKGS? YES NO	ALLERGY INJECTIONS? YES NO	ALLERGY SKIN TESTING? YES NO	ROUTINE OFFICE GYNECOLOGY (PELVIC/PAP)? YES NO
DRAWING BLOOD? YES NO	AG - APPROPRIATE IMMUNIZATIONS? YES NO	FLEXIBLE SIGMOIDOSCOPY? YES NO	TYMPANOMETRY/ AUDIOMETRY SCREENING? YES NO
ASTHMA TREATMENT? YES NO	OSTEOPATHIC MANIPULATION? YES NO	IV HYDRATION/ TREATMENT? YES NO	CARDIAC STRESS TEST? YES NO
PULMONARY FUNCTION TESTING? YES NO	PHYSICAL THERAPY? YES NO	CARE OF MINOR LACERATIONS? YES NO	

IS ANESTHESIA ADMINISTERED IN YOUR OFFICE? YES NO — IF YES, WHAT CLASS/CATEGORY DO YOU USE?

IF YES, WHO ADMINISTERS IT? LAST NAME FIRST NAME

TYPE OF PRACTICE (SELECT ONE ONLY)* SOLO PRACTICE | SINGLE SPECIALTY GROUP | MULTI-SPECIALTY GROUP

ADDITIONAL OFFICE PROCEDURES PROVIDED (INCLUDING SURGICAL PROCEDURES)

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESS NG DELAYS AND REQU RE FOLLOW-UP.

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESS NG DELAYS AND REQUIRE FOLLOW-UP.

Section 4 — Practice Location Information (Continued)

Partners/ Associates

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

If you have additional partners/associates at THIS location, use the Partner/Associate Supplemental Form on page 23. Photocopy as necessary. Be certain to check "Primary Location" at the top of he page.

LIST ALL PARTNERS/ASSOCIATES AT THIS PRACTICE

LAST NAME | FIRST NAME | M.I. | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)? | PROVIDER TYPE (CODE PG 36)

LAST NAME | FIRST NAME | M.I. | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)? | PROVIDER TYPE (CODE PG 36)

LAST NAME | FIRST NAME | M.I. | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)? | PROVIDER TYPE (CODE PG 36)

Covering Colleagues

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

If you have additional covering colleagues that are not partners at THIS location, use the Covering Colleagues Supplemental Form on page 24. Photocopy as necessary. Be certain to check "Primary Location" at the top of the page.

LIST ALL COVERING COLLEAGUES THAT ARE NOT PARTNERS/ASSOCIATES AT THIS PRACTICE

LAST NAME | FIRST NAME | M.I. | SPECIALTY CODE | PROVIDER TYPE (CODE PG 36)

LAST NAME | FIRST NAME | M.I. | SPECIALTY CODE | PROVIDER TYPE (CODE PG 36)

LAST NAME | FIRST NAME | M.I. | SPECIALTY CODE | PROVIDER TYPE (CODE PG 36)

Section 5 — Hospital Affiliations

Admitting Arrangements

DO YOU HAVE HOSPITAL PRIVILEGES?* YES NO

IF YOU DO NOT ADMIT PATIENTS, WHAT TYPE OF ADMITTING ARRANGEMENTS DO YOU HAVE?

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESS NG DELAYS AND REQUIRE FOLLOW-UP.

Section 5 — Hospital Affiliations (Continued)

Hospital Privileges

If applicable, list all hospital affiliations. List primary hospital, then other current affiliations, followed by previous affiliations in chronological order.

If you have additional hospital privileges, use he Supplemental Hospital Privileges Form on page 30.

TIP Be certain your admission percentages add up to 100% for current hospitals. Otherwise, you will have to correct this error.

PRIMARY HOSPITAL

HOSPITAL NAME

NUMBER | STREET | SUITE/BUILDING

CITY | STATE | ZIP CODE

TELEPHONE | FAX

DEPARTMENT NAME

DEPARTMENT DIRECTOR'S LAST NAME

DEPARTMENT DIRECTOR'S FIRST NAME | M.I.

AFFILIATION START DATE (M M Y Y Y Y) | AFFILIATION END DATE (M M Y Y Y Y) | FULL UNRESTRICTED PRIVILEGES? YES NO | ARE PRIVILEGES TEMPORARY? YES NO

ADMITTING PRIVILEGE STATUS (E.G. NONE, FULL UNRESTRICTED, PROVISIONAL, TEMPORARY) | OF YOUR TOTAL ANNUAL ADMISSIONS, WHAT PERCENTAGE IS TO THIS HOSPITAL? %

OTHER HOSPITAL

HOSPITAL NAME

NUMBER | STREET | SUITE/BUILDING

CITY | STATE | ZIP CODE

TELEPHONE | FAX

DEPARTMENT NAME

DEPARTMENT DIRECTOR'S LAST NAME

DEPARTMENT DIRECTOR'S FIRST NAME | M.I.

AFFILIATION START DATE (M M Y Y Y Y) | AFFILIATION END DATE (M M Y Y Y Y) | FULL, UNRESTRICTED PRIVILEGES? YES NO | ARE PRIVILEGES TEMPORARY? YES NO

ADMITTING PRIVILEGE STATUS (E.G. NONE, FULL UNRESTRICTED, PROVISIONAL, TEMPORARY) | OF YOUR TOTAL ANNUAL ADMISSIONS, WHAT PERCENTAGE IS TO THIS HOSPITAL? %

PLEASE EXPLAIN TERMINATED AFFILIATION

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESS NG DELAYS AND REQUIRE FOLLOW-UP.

Section 6 — Professional Liability Insurance Carrier

Professional Liability Insurance Carrier

IMPORTANT
IF YOU DO NOT CARRY MALPRACTICE INSURANCE, CHECK THIS BOX AND SKIP THIS SECTION. ☐

SELF-INSURED?* ☐ YES ☐ NO

CARRIER OR SELF-INSURED NAME*

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

ORIGINAL EFFECTIVE DATE* (M M Y Y Y Y) EFFECTIVE DATE* (M M Y Y Y Y) EXPIRATION DATE (M M Y Y Y Y)

TYPE OF COVERAGE?* ☐ INDIVIDUAL ☐ SHARED

DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER?* ☐ YES ☐ NO

$ AMOUNT OF COVERAGE PER OCCURRENCE $ AMOUNT OF COVERAGE AGGREGATE

POLICY INCLUDES TAIL COVERAGE? ☐ YES ☐ NO

POLICY NUMBER*

Professional Liability Insurance Carrier

List other current, future, or previous carrier(s) if current carrier is less than ten (10) years.

NOTE: A longer period may be required by your healthcare entity.

If you have additional Insurance, use the Supplemental Insurance Form on page 31.

SELF-INSURED? ☐ YES ☐ NO

CARRIER OR SELF-INSURED NAME

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

ORIGINAL EFFECTIVE DATE* (M M Y Y Y Y) EFFECTIVE DATE* (M M Y Y Y Y) EXPIRATION DATE (M M Y Y Y Y)

TYPE OF COVERAGE?* ☐ INDIVIDUAL ☐ SHARED

DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER? ☐ YES ☐ NO

$ AMOUNT OF COVERAGE PER OCCURRENCE $ AMOUNT OF COVERAGE AGGREGATE

POLICY INCLUDES TAIL COVERAGE? ☐ YES ☐ NO

POLICY NUMBER*

Section 7 — Work History and References

Military Duty

Are you currently on active military duty or military reserve?* ☐ YES ☐ NO

Work History

Include a chronological work history for the past 10 years.

A longer period may be required by your healthcare entity.

If you have additional work history, use the Supplemental Work History Form on page 32.

WORK HISTORY

PRACTICE / EMPLOYER NAME

NUMBER STREET SUITE/BUILDING

CITY STATE ZIP/POSTAL CODE

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESS NG DELAYS AND REQUIRE FOLLOW-UP.

Section 7 — Work History and References (Continued)

Work History

Do not list current positions. Those should be listed in Section 4.

Include a chronological work history for the past 10 years.

A longer period may be required by your heal hcare entity

If you have additional work history, use the Supplemental Work History Form on page 32.

TELEPHONE — FAX

COUNTRY CODE — START DATE (M M Y Y Y Y) — END DATE (M M Y Y Y Y)

REASON FOR DEPARTURE (IF APPLICABLE)

WORK HISTORY

PRACTICE / EMPLOYER NAME

NUMBER — STREET — SUITE/BUILDING

CITY — STATE — ZIP/POSTAL CODE

TELEPHONE — FAX

COUNTRY CODE — START DATE (M M Y Y Y Y) — END DATE (M M Y Y Y Y)

REASON FOR DEPARTURE (IF APPLICABLE)

WORK HISTORY

PRACTICE / EMPLOYER NAME

NUMBER — STREET — SUITE/BUILDING

CITY — STATE — ZIP/POSTAL CODE

TELEPHONE — FAX

COUNTRY CODE — START DATE (M M Y Y Y Y) — END DATE (M M Y Y Y Y)

REASON FOR DEPARTURE (IF APPLICABLE)

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESS NG DELAYS AND REQUIRE FOLLOW-UP.

Section 7 — Work History and References (Continued)

Gaps in Professional / Work History

If you have additional professional / work history gaps, use the Supplemental Professional Work History Gaps Form on page 33.

PLEASE EXPLAIN ANY TIME PERIODS OR GAPS IN TRAINING OR WORK HISTORY THAT HAVE OCCURRED SINCE GRADUATION FROM PROFESSIONAL SCHOOL AND ARE LONGER THAN THREE MONTHS IN DURATION OR OF A SHORTER DURATION IF REQUIRED BY THE ORGANIZATION FOR WHICH YOU ARE BEING CREDENTIALED.

GAP START DATE M M Y Y Y Y GAP END DATE M M Y Y Y Y

Professional References

Provide three professional references to whom you are not related or are not partners in your practice.

Code lists are found on pages 36-43. Enter the associated 3-digit code for provider type.

NOTE:

You are required to provide exactly 3 references. Your application will not be complete without this information.

Please check with credentialing entity for any special requirements.

Reference 1

LAST NAME*

FIRST NAME* PROVIDER TYPE (CODE PG 36)

NUMBER* STREET* APT/SUITE/BUILDING

CITY* STATE* ZIP CODE*

TELEPHONE FAX

Reference 2

LAST NAME*

FIRST NAME* PROVIDER TYPE (CODE PG 36)

NUMBER* STREET* APT/SUITE/BUILDING

CITY* STATE* ZIP CODE*

TELEPHONE FAX

Reference 3

LAST NAME*

FIRST NAME* PROVIDER TYPE (CODE PG 36)

NUMBER* STREET* APT/SUITE/BUILDING

CITY* STATE* ZIP CODE*

TELEPHONE FAX

Section 8 — Disclosure Questions

Disclosure Questions

Answer all questions. For any "Yes" response, provide an explanation on the Supplemental Disclosure Question Explanation Form on page 34.

Allied Health Providers

If you are an Allied Health Provider and you do not believe a question is applicable to you, you should answer the question "NO".

LICENSURE

1. ☐ YES ☐ NO Has your license, registration or certification to practice in your profession, ever been voluntarily or involuntarily relinquished, denied, suspended, revoked, restricted, or have you ever been subject to a fine, reprimand, consent order, probation or any conditions or limitations by any state or professional licensing, registration or certification board?*
2. ☐ YES ☐ NO Has there been any challenge to your licensure, registration or certification?*

HOSPITAL PRIVILEGES AND OTHER AFFILIATIONS

3. ☐ YES ☐ NO Have your clinical privileges or medical staff membership at any hospital or healthcare institution, voluntarily or involuntarily, ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical record when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board?*
4. ☐ YES ☐ NO Have you voluntarily or involuntarily surrendered, limited your privileges or not reapplied for privileges while under inves igation?*
5. ☐ YES ☐ NO Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)?*

EDUCATION, TRAINING AND BOARD CERTIFICATION

6. ☐ YES ☐ NO Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign?*
7. ☐ YES ☐ NO Have you ever, while under investigation or to avoid an investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program?*
8. ☐ YES ☐ NO Have any of your board certifications or eligibility ever been revoked?*
9. ☐ YES ☐ NO Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation?*

DEA OR STATE CONTROLLED SUBSTANCE REGISTRATION

10. ☐ YES ☐ NO Have your Federal DEA and/or State Controlled Dangerous Substances (CDS) certificate(s) or authorization(s) ever been challenged, denied, suspended, revoked, restricted, denied renewal, or voluntarily or involuntarily relinquished?*

MEDICARE, MEDICAID OR OTHER GOVERNMENTAL PROGRAM PARTICIPATION

11. ☐ YES ☐ NO Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental healthcare plans or programs?*

OTHER SANCTIONS OR INVESTIGATIONS

12. ☐ YES ☐ NO Are you currently the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program or a defendant in any civil action that is reasonably related to your qualifications, competence, functions, or duties as a medical professional for alleged fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?*
13. ☐ YES ☐ NO To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank?*
14. ☐ YES ☐ NO Have you ever received sanctions from or are you currently the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)?*
15. ☐ YES ☐ NO Have you ever been convicted of, pled guilty to, pled nolo contendere to, sanctioned, reprimanded, restricted, disciplined or resigned in exchange for no investigation or adverse action within the last ten years for sexual harassment or other illegal misconduct?*
16. ☐ YES ☐ NO Are you currently being investigated or have you ever been sanctioned, reprimanded, or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation or in exchange for no investigation by a hospital or healthcare facility of any military agency?*

PROFESSIONAL LIABILITY INSURANCE INFORMATION AND CLAIMS HISTORY

17. ☐ YES ☐ NO Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history?*
18. ☐ YES ☐ NO Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional liability insurance carrier, based on your individual liability history?*

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESS NG DELAYS AND REQUIRE FOLLOW-UP.

Section 8 — Disclosure Questions (Continued)

Disclosure Questions

Answer all questions. For any "Yes" response, provide an explanation on the Supplemental Disclosure Question Explanation Form on page 34.

IMPORTANT
If you answered "Yes" to **question #19**, you must complete the Supplemental Malpractice Claims Explanation Form on page 35 for each malpractice claim.

MALPRACTICE CLAIMS HISTORY

19. ☐ YES ☐ NO Have you had any professional liability actions (pending, settled, arbitrated, mediated or litigated) within the past 10 years?* If yes, provide information for each case.

CRIMINAL/CIVIL HISTORY

20. ☐ YES ☐ NO Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony?*

21. ☐ YES ☐ NO In the past ten years have you been convicted of, pled guilty to, or pled nolo contendere to any misdemeanor (excluding minor traffic violations) or been found liable or responsible for any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical professional, or for fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?*

22. ☐ YES ☐ NO Have you ever been court-martialed for actions related to your duties as a medical professional?*

Note: A criminal record will not necessarily be a bar to acceptance. Decisions will be made by each health plan or credentialing organization based upon all the relevant circumstances, including the nature of the crime.

ABILITY TO PERFORM JOB

23. ☐ YES ☐ NO Are you currently engaged in the illegal use of drugs?*
("Currently" means sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on one's ability to practice medicine. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. § 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.)

24. ☐ YES ☐ NO Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety?*

25. ☐ YES ☐ NO Do you have any reason to believe that you would pose a risk to the safety or well being of your patients?*

26. ☐ YES ☐ NO Are you unable to perform the essential functions of a practitioner in your area of practice even with reasonable accommodation?*

Standard Authorization, Attestation and Release

(Not for Use for Employment Purposes)

I understand and agree that, as part of the credentialing application process for participation, membership and/or clinical privileges (hereinafter, referred to as "Participation") at or with each healthcare organization indicated on the "List of Authorized Organizations" that accompanies this Provider Application (hereinafter, each healthcare organization on the "List of Authorized Organizations" is individually referred to as the "Entity"), and any of the Entity's affiliated entities, I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, clinical competence, health status, character, ethics, and any other criteria used by the Entity for determining initial and ongoing eligibility for Participation. Each Entity and its representatives, employees, and agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law.

I acknowledge that each Entity has its own criteria for acceptance, and I may be accepted or rejected by each independently. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that any Entity will grant me clinical privileges or contract with me as a provider of services. I understand that my application for Participation with the Entity is not an application for employment with the Entity and that acceptance of my application by the Entity will not result in my employment by the Entity.

Authorization of Investigation Concerning Application for Participation. I authorize the following individuals including, without limitation, the Entity, its representatives, employees, and/or designated agent(s); the Entity's affiliated entities and their representatives, employees, and/or designated agents; and the Entity's designated professional credentials verification organization (collectively referred to as "Agents"), to investigate information, which includes both oral and written statements, records, and documents, concerning my application for Participation. I agree to allow the Entity and/or its Agent(s) to inspect and copy all records and documents relating to such an investigation.

Authorization of Third-Party Sources to Release Information Concerning Application for Participation. I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to the Entity and/or its Agent(s), information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation in, or with, the Entity. I authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

Authorization of Release and Exchange of Disciplinary Information. I hereby further authorize any third party at which I currently have Participation or had Participation and/or each third party's agents to release "Disciplinary Information," as defined below, to the Entity and/or its Agent(s). I hereby further authorize the Agent(s) to release Disciplinary Information about any disciplinary action taken against me to its participating Entities at which I have Participation, and as may be otherwise required by law. As used herein, "Disciplinary Information" means information concerning (i) any action taken by such health care organizations, their administrators, or their medical or other committees to revoke, deny, suspend, restrict, or condition my Participation or impose a corrective action plan; (ii) any other disciplinary action involving me, including, but not limited to, discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges, but after I have knowledge that such formal charges were being (or are being) contemplated and/or were (or are) in preparation.

Release from Liability. I release from all liability and hold harmless any Entity, its Agent(s), and any other third party for their acts performed in good faith and without malice unless such acts are due to the gross negligence or willful misconduct of the Entity, its Agent(s), or other third party in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation and Release. I further agree not to sue any Entity, any Agent(s), or any other third party for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of such Entity, Agent(s) or third party in connection with the credentialing process. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities. In this Authorization, Attestation and Release, all references to the Entity, its Agent(s), and/or other third party include their respective employees, directors, officers, advisors, counsel, and agents. The Entity or any of its affiliates or agents retains the right to allow access to the application information for purposes of a credentialing audit to customers and/or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer and/or their auditor executes an appropriate confidentiality agreement. I understand and agree that this Authorization, Attestation and Release is irrevocable for any period during which I am an applicant for Participation at an Entity, a member of an Entity's medical or health care staff, or a participating provider of an Entity. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. I understand that my failure to promptly provide another consent may be grounds for termination or discipline by the Entity in accordance with the applicable bylaws, rules, and regulations, and requirements of the Entity, or grounds for my termination of Participation at or with the Entity. I agree that information obtained in accordance with the provisions of this Authorization, Attestation and Release is not and will not be a violation of my privacy.

I certify that all information provided by me in my application is current, true, correct, accurate and complete to the best of my knowledge and belief, and is furnished in good faith. I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information (including any changes/challenges to licenses, DEA, insurance, malpractice claims, NPDP/HIPDB reports, discipline, criminal convictions, etc.) I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of Participation by the Entity, and must be submitted online or in writing, and must be dated and signed by me (may be a written or an electronic signature). I acknowledge that the Entity will not process an application until they deem it to be a complete application and that I am responsible to provide a complete application and to produce adequate and timely information for resolving questions that arise in the application process. I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Participation; and/or immediate suspension or termination of Participation. This action may be disclosed to the Entity and/or its Agent(s). I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release and that I have access to the bylaws of applicable medical staff organizations and agree to abide by these bylaws, rules and regulations. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

Signature*

Name (print)*

M M D D Y Y Y Y

DATE SIGNED*

3094

Professional IDs Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQU RE FOLLOW-UP.

Section 1 — Personal Information and Professional IDs

Professional IDs

Include all additional state licenses, DEA Registration and State Controlled Dangerous Substance (CDS) certification numbers.

Provide all current and previous licenses/ certifications.

If you need to report additional Professional IDs, photocopy this page as needed and submit as instructed.

FEDERAL DEA NUMBER

DEA ISSUE DATE (M M D D Y Y Y Y)

DEA STATE OF REGISTRATION

DEA EXPIRATION DATE (M M D D Y Y Y Y)

FEDERAL DEA NUMBER

DEA ISSUE DATE (M M D D Y Y Y Y)

DEA STATE OF REGISTRATION

DEA EXPIRATION DATE (M M D D Y Y Y Y)

CDS CERTIFICATE NUMBER

CDS ISSUE DATE (M M D D Y Y Y Y)

CDS STATE OF REGISTRATION

CDS EXPIRATION DATE (M M D D Y Y Y Y)

CDS CERTIFICATE NUMBER

CDS ISSUE DATE (M M D D Y Y Y Y)

CDS STATE OF REGISTRATION

CDS EXPIRATION DATE (M M D D Y Y Y Y)

STATE LICENSE NUMBER

LICENSE ISSUING STATE

LICENSE ISSUE DATE (M M D D Y Y Y Y)

IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS S ATE? ☐ YES ☐ NO

LICENSE EXPIRATION DATE (M M D D Y Y Y Y)

LICENSE STATUS CODE — Code list is found on page 36 use license status codes. Enter 3-digit code in space provided.

LICENSE TYPE — Code list is found on page 36 use provider type codes. Enter 3-digit code in space provided.

STATE LICENSE NUMBER

LICENSE ISSUING STATE

LICENSE ISSUE DATE (M M D D Y Y Y Y)

IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? ☐ YES ☐ NO

LICENSE EXPIRATION DATE (M M D D Y Y Y Y)

LICENSE STATUS CODE — Code list is found on page 36 use license status codes. Enter 3-digit code in space provided.

LICENSE TYPE — Code list is found on page 36 use provider type codes. Enter 3-digit code in space provided.

Other Relevant Education
Supplemental Form

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESS NG DELAYS AND REQUIRE FOLLOW-UP.

Section 2 | **Education and Training**

Fifth Pathway Education

FIFTH PATHWAY GRADUATES ONLY

INSTITUTION/HOSPITAL WHERE U.S. CLINICAL TRAINING WAS PERFORMED (DO NOT ABBREVIATE)

ADDRESS

CITY | STATE | ZIP CODE

TELEPHONE | FAX

DID YOU COMPLETE YOUR EDUCATION AT THIS SCHOOL? YES NO

START DATE (MMYYYY) | END DATE (GRADUATION DATE) (MMYYYY)

Other Relevant Education

If you need to report additional Education, photocopy this page as needed and submit as instructed.

INSTITUTION/SCHOOL ISSUING DEGREE (DO NOT ABBREVIATE)

NUMBER | STREET | SUITE/BUILDING

CITY | STATE | ZIP/POSTAL CODE

TELEPHONE | FAX

COUNTRY CODE | START DATE (MMYYYY) | END DATE (GRADUATION DATE) (MMYYYY) | DEGREE AWARDED

DID YOU COMPLETE YOUR EDUCATION AT THIS SCHOOL? YES NO

INSTITUTION/SCHOOL ISSUING DEGREE (DO NOT ABBREVIATE)

NUMBER | STREET | SUITE/BUILDING

CITY | STATE | ZIP/POSTAL CODE

TELEPHONE | FAX

COUNTRY CODE | START DATE (MMYYYY) | END DATE (GRADUATION DATE) (MMYYYY) | DEGREE AWARDED

DID YOU COMPLETE YOUR EDUCATION AT THIS SCHOOL? YES NO

Other Training Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQU RE FOLLOW-UP.

Section 2 Education and Training

Training

List all postgraduate training programs you attended. Use one section per institution.

If you need to report additional Training, photocopy this page as needed and submit as instructed.

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

INSTITUTION / HOSPITAL NAME (USE BOTH LINES IF REQUIRED)

SCHOOL CODE (E.G., AFFILIATED MEDICAL SCHOOL)

NUMBER

STREET

SUITE/BUILDING

CITY

STATE

ZIP/POSTAL CODE

COUNTRY CODE

TELEPHONE

FAX

DID YOU COMPLETE THIS TRAINING PROGRAM AT THIS INSTITUTION? YES NO

(IF NOT, PLEASE USE THE SPACE BELOW TO EXPLAIN.)

List each department separately, if applicable.

List Internship/ Residency, Fellowship and Other programs separately.

INTERNSHIP/ RESIDENCY FELLOWSHIP OTHER

M M Y Y Y Y START DATE

M M Y Y Y Y END DATE

DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)

NAME OF DIRECTOR

INTERNSHIP/ RESIDENCY FELLOWSHIP OTHER

M M Y Y Y Y START DATE

M M Y Y Y Y END DATE

DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)

NAME OF DIRECTOR

INTERNSHIP/ RESIDENCY FELLOWSHIP OTHER

M M Y Y Y Y START DATE

M M Y Y Y Y END DATE

DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE)

NAME OF DIRECTOR

3096

Additional Specialty
Supplemental Form

* REQUIRED RESPONSE (F THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQU RE FOLLOW-UP.

Section 3 — Professional / Medical Specialty Information

Additional Specialty

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

SPECIALTY CODE

BOARD CERTIFIED? YES NO

CERTIFYING BOARD CODE

INITIAL CERTIFICATION DATE M M D D Y Y Y Y

RECERTIFICATION DATE (IF APPLICABLE) M M D D Y Y Y Y

EXPIRATION DATE (IF APPLICABLE) M M D D Y Y Y Y

DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?

HMO YES NO

PPO YES NO

POS YES NO

IF NOT BOARD CERTIFIED (SELECT ONE)

I HAVE TAKEN EXAM, RESULTS PENDING FOR

CERTIFYING BOARD CODE

I INTEND TO SIT FOR AN EXAM ON M M D D Y Y Y Y

I DO NOT INTEND TO TAKE A CERTIFYING BOARD EXAM

IF YOU INDICATED THAT YOU DID NOT INTEND TO TAKE A CERTIFYING BOARD EXAM, PLEASE USE THE FOLLOWING SPACE TO EXPLAIN, OTHERWISE LEAVE THE SPACE BLANK.

Additional Specialty

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

If you need to report additional Specialties, photocopy this page as needed and submit as instructed.

SPECIALTY CODE

BOARD CERTIFIED? YES NO

CERTIFYING BOARD CODE

INITIAL CERTIFICATION DATE M M D D Y Y Y Y

RECERTIFICATION DATE (IF APPLICABLE) M M D D Y Y Y Y

EXPIRATION DATE (IF APPLICABLE) M M D D Y Y Y Y

DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?

HMO YES NO

PPO YES NO

POS YES NO

IF NOT BOARD CERTIFIED (SELECT ONE)

I HAVE TAKEN EXAM, RESULTS PENDING FOR

CERTIFYING BOARD CODE

I INTEND TO SIT FOR AN EXAM ON M M D D Y Y Y Y

I DO NOT INTEND TO TAKE A CERTIFYING BOARD EXAM.

IF YOU INDICATED THAT YOU DID NOT INTEND TO TAKE A CERTIFYING BOARD EXAM, PLEASE USE THE FOLLOWING SPACE TO EXPLAIN, OTHERWISE LEAVE THE SPACE BLANK.

Partners/Associates Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQU RE FOLLOW-UP.

Section 4 — Practice Location Information

Partner/ Associates

Use this page to report additional partners/associates at the designated practice location.

IMPORTANT

In he box provided, indicate to which practice location this page belongs.

Check "Covering Colleague?" if he/she provides coverage for you at THIS location.

Code lists are found on pages 36-43. Enter he associated 3-digit code in the space provided.

If you need to report additional partners/associates, photocopy this page as needed and submit as instructed.

SPECIFY PRACTICE LOCATION INDICATE THE PRACTICE LOCATION TO WHICH YOU ARE ASSOCIATING THESE PROVIDERS.

LOCATION # ☐☐ ☐ PRIMARY PRACTICE

PRACTICE NAME

PRACTICE ADDRESS

LAST NAME		SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?
FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)	
LAST NAME		SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?
FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)	
LAST NAME		SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?
FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)	
LAST NAME		SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?
FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)	
LAST NAME		SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?
FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)	
LAST NAME		SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?
FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)	
LAST NAME		SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?
FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)	
LAST NAME		SPECIALTY CODE	COVERING COLLEAGUE (Y/N)?
FIRST NAME	M.I.	PROVIDER TYPE (CODE PG 36)	

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* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Back To Item Back to Agenda

Covering Colleagues
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQU RE FOLLOW-UP.

Section 4 | **Practice Location Information**

Covering Colleagues

Include all colleagues providing regular coverage and his/her specialty, including if he/she is a partner in one or more of your practice locations.

IMPORTANT

In he box provided, indicate to which practice location this page belongs.

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

If you need to report additional Covering Colleagues, photocopy his page as needed and submit as instructed.

SPECIFY PRACTICE LOCATION INDICATE THE PRACTICE LOCATION TO WHICH YOU ARE ASSOCIATING THESE PROVIDERS.

LOCATION # ☐☐ ☐ PRIMARY PRACTICE

PRACTICE NAME

PRACTICE ADDRESS

LAST NAME | SPECIALTY CODE
FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

LAST NAME | SPECIALTY CODE
FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

LAST NAME | SPECIALTY CODE
FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

LAST NAME | SPECIALTY CODE
FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

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FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

LAST NAME | SPECIALTY CODE
FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

LAST NAME | SPECIALTY CODE
FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

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Practice Location Information
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQU RE FOLLOW-UP.

Section 4 | **Practice Location Information - Page 1 of 5**

Additional Practice Location

IMPORTANT

In he box provided, indicate to which practice location this page belongs.

For example, if you practice at three locations, the primary location is reported in the main application and remaining locations would be reported on Supplemental Forms as Location 2 and Location 3.

TIP Your Individual Tax ID is assumed to be your Primary Tax ID unless you specify otherwise to the right.

LOCATION* #

CURRENTLY PRACTICING AT THIS ADDRESS?* YES NO

IF NO, WHAT IS YOUR EXPECTED START DATE? M M D D Y Y Y Y

PHYSICIAN GROUP / PRACTICE NAME TO APPEAR IN DIRECTORY (DO NOT ABBREVIATE)*

GROUP / CORPORATE NAME AS IT APPEARS ON W-9, IF DIFFERENT FROM ABOVE (DO NOT ABBREVIATE)

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

SEND GENERAL CORRESPON-DENCE HERE?* YES NO

TELEPHONE* FAX

OFFICE E-MAIL ADDRESS

INDIVIDUAL TAX ID GROUP TAX ID

PRIMARY TAX ID (ONE ONLY)* USE INDIVIDUAL TAX ID USE GROU TAX ID

Office Manager or Business Office Contact

List each contact separately. You may use the check boxes below for convenience. Do not write instructions like “see above”. These responses will be rejected and will require follow-up.

LAST NAME*

FIRST NAME* M.I.

TELEPHONE* FAX

E-MAIL ADDRESS

Billing Contact

CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS BILLING INFORMATION

NOTE:

Even if you checked the boxes above, please provide the e-mail address of the Billing Contact, if available.

LAST NAME*

FIRST NAME* M.I.

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

TELEPHONE* FAX

E-MAIL ADDRESS

3100

Practice Location Information
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQU RE FOLLOW-UP.

Section 4 | **Practice Location Information - Page 2 of 5**

Add'l Practice Location (Cont.)

LOCATION* #

Payment and Remittance

ELECTRONIC BILLING CAPABILITIES?* YES NO

BILLING DEPARTMENT (IF HOSPITAL-BASED)

YOUR "CHECK PAYABLE TO" INFORMATION SHOULD BE CONSISTENT WITH YOUR W-9.

CHECK PAYABLE TO*

CHECK HERE TO USE OFFICE MANAGER AND OFFICE ADDRESS AS BILLING INFORMATION

LAST NAME*

FIRST NAME* M.I.

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

TELEPHONE* FAX

E-MAIL ADDRESS

NOTE:

Even if you checked he boxes above, please provide the E-mail Address, Department Name, Electronic Billing and Check Payable To, if applicable.

Office Hours

(USE HHMM FORMAT AND ROUND TO THE NEAREST HALF HOUR)

	START	A=AM P=PM	END	A=AM P=PM		START	A=AM P=PM	END	A=AM P=PM
MONDAY					FRIDAY				
TUESDAY					SATURDAY				
WEDNESDAY					SUNDAY				
THURSDAY									

24/7 PHONE COVERAGE?* YES NO IF YES ANSWERING SERVICE VOICE MAIL WITH INSTRUCTIONS TO CALL ANSWERING SERVICE VOICE MAIL WITH OTHER INSTRUCTIONS

AFTER HOURS BACK OFFICE TELEPHONE

NOTE:

After hours back office telephone will be used only by the health plan and will not be published under any circumstances.

Open Practice Status

ACCEPT NEW PATIENTS INTO THIS PRACTICE?* YES NO

ACCEPT ALL NEW PATIENTS?* YES NO

ACCEPT EXISTING PATIENTS WITH CHANGE OF PAYOR?* YES NO

ACCEPT NEW MEDICARE PATIENTS?* YES NO

ACCEPT NEW PATIENTS WITH PHYSICIAN REFERRAL?* YES NO

ACCEPT NEW MEDICAID PATIENTS?* YES NO

IF ANY OF THE ABOVE VARIES BY PLAN, EXPLAIN

ARE THERE ANY PRACTICE LIMITATIONS?* YES NO IF YES

GENDER LIMITATIONS: MALE ONLY NONE FEMALE ONLY

AGE LIMITATIONS: MINIMUM AGE MAXIMUM AGE

LIST OTHER LIMITATIONS

3101

Practice Location Information
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQU RE FOLLOW-UP.

Section 4 | **Practice Location Information - Page 3 of 5**

Additional Practice Location
(Continued)

IMPORTANT

In the box provided, indicate to which practice location this page belongs.

LOCATION* #

Mid-Level Practitioners

DO MID-LEVEL PRACTITIONERS (NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, ETC.) CARE FOR PATIENTS IN YOUR PRACTICE?* ☐ YES ☐ NO

(IF YES, PLEASE PROVIDE THE INFORMATION BELOW)

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME | M.I. | PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER | PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME | M.I. | PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER | PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME | M.I. | PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER | PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME | M.I. | PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER | PRACTITIONER STATE

PRACTITIONER LAST NAME

PRACTITIONER FIRST NAME | M.I. | PRACTITIONER TYPE (E.G., PA, CNP, NP)

PRACTITIONER LICENSE / CERTIFICATE NUMBER | PRACTITIONER STATE

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* REQUIRED RESPONSE (F THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESS NG DELAYS AND REQU RE FOLLOW-UP.

Practice Location Information
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQU RE FOLLOW-UP.

Section 4 | **Practice Location Information - Page 4 of 5**

Additional Practice Location (Continued)

IMPORTANT

In the box provided, indicate to which practice location this page belongs.

→ **LOCATION* #**

LANGUAGES

NON-ENGLISH LANGUAGES SPOKEN BY OFFICE PERSONNEL — LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE

INTERPRETERS AVAILABLE?* YES NO

LANGUAGES INTERPRETED — LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE

Accessibilities

DOES THIS OFFICE MEET ADA ACCESSIBILITY REQUIREMENTS?* YES NO

DOES THIS SITE OFFER HANDICAPPED ACCESS FOR THE FOLLOWING

- BUILDING?* YES NO
- PARKING?* YES NO
- RESTROOM?* YES NO

DOES THIS SITE OFFER OTHER SERVICES FOR THE DISABLED?* YES NO

- TEXT TELEPHONY (TTY)* YES NO
- AMERICAN SIGN LANGUAGE* YES NO
- MENTAL/PHYSICAL IMPAIRMENT SERVICES* YES NO

ACCESSIBLE BY PUBLIC TRANSPORTATION?* YES NO

- BUS* YES NO
- SUBWAY* YES NO
- REGIONAL TRAIN* YES NO

OTHER HANDICAPPED ACCESS

OTHER DISABILITY SERVICES

OTHER TRANSPORTATION ACCESS

Services

Does this location provide any of the following services?

LABORATORY SERVICES? YES NO — IF YES, PROVIDE ACCREDITING/CERTIFYING PROGRAM (E.G., CLIA, COLA, ME)

RADIOLOGY SERVICES? YES NO — IF YES, PROVIDE X-RAY CERTIFICATION TYPE

EKGS? YES NO	ALLERGY INJECTIONS? YES NO	ALLERGY SKIN TESTING? YES NO	ROUTINE OFFICE GYNECOLOGY (PELVIC/PAP)? YES
DRAWING BLOOD? YES NO	AGE APPROPRIATE IMMUNIZATIONS? YES NO	FLEXIBLE SIGMOIDOSCOPY? YES NO	TYMPANOMETRY/ AUDIOMETRY SCREENING? YES
ASTHMA TREATMENT? YES NO	OSTEOPATHIC MANIPULATION? YES NO	IV HYDRATION/ TREATMENT? YES NO	CARDIAC STRESS TEST? YES
PULMONARY FUNCTION TESTING? YES NO	PHYSICAL THERAPY? YES NO	CARE OF MINOR LACERATIONS? YES NO	

IS ANESTHESIA ADMINISTERED IN YOUR OFFICE? YES NO — IF YES, WHAT CLASS/CATEGORY DO YOU USE?

IF YES, WHO ADMINISTERS IT? LAST NAME FIRST NAME

TYPE OF PRACTICE (SELECT ONE ONLY)* SOLO PRACTICE | SINGLE SPECIALTY GROUP | MULTI-SPECIALTY GROUP

ADDITIONAL OFFICE PROCEDURES PROVIDED (INCLUDING SURGICAL PROCEDURES)

Practice Location Information
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4 | **Practice Location Information - Page 5 of 5**

Additional Practice Location
(Continued)

IMPORTANT

In the box provided, indicate to which practice location this page belongs.

If you have additional partners/associates at THIS location, use the Partner/Associate Supplemental Form on page 23. Photocopy as necessary. Be certain to indicate the Practice Location Number at the top of the page.

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

LOCATION* #

LIST ALL PARTNERS/ASSOCIATES AT THIS PRACTICE

LAST NAME | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)?
FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

LAST NAME | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)?
FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

LAST NAME | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)?
FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

LAST NAME | SPECIALTY CODE | COVERING COLLEAGUE (Y/N)?
FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

Covering Colleagues

Code lists are found on pages 36-43. Enter the associated 3-digit code in the space provided.

If you have additional covering colleagues that are not partners at THIS location, use the Covering Colleagues Supplemental Form on page 24. Photocopy as necessary. Be certain to indicate the Practice Location Number at the top of the page.

LIST ALL COVERING COLLEAGUES THAT ARE NOT PARTNERS/ASSOCIATES AT THIS PRACTICE

LAST NAME | SPECIALTY CODE
FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

LAST NAM | SPECIALTY CODE
FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

LAST NAME | SPECIALTY CODE
FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

LAST NAME | SPECIALTY CODE
FIRST NAME | M.I. | PROVIDER TYPE (CODE PG 36)

3104

Hospital Privileges (Current)
Supplemental Form

* REQU RED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQU RE FOLLOW-UP.

Section 5 | **Hospital Affiliations**

Hospital Privileges

Use this form to continue listing hospitals where you currently have privileges.

If you need to report additional space for Hospital Privileges, photocopy this page as needed and submit as instructed.

TIP Be certain your admission percentages add up to 100% for current hospitals. Otherwise, you will have to correct this error.

OTHER HOSPITAL

HOSPITAL NAME

NUMBER | STREET | SUITE/BUILDING

CITY | STATE | ZIP CODE

TELEPHONE | FAX

DEPARTMENT NAME

DEPARTMENT DIRECTOR'S LAST NAME

DEPARTMENT DIRECTOR'S FIRST NAME | M.I.

AFFILIATION START DATE (MMYYYY) | AFFILIATION END DATE (MMYYYY) | FULL, UNRESTRICTED PR VILEG S? YES NO | ARE PRIVILEGES TEMPORARY? YES NO

ADMITTING PRIVILEGE STATUS (E.G. NONE, FULL UNRESTRICTED, ROVISIONAL, TEMPORARY) | OF YOUR TOTAL ANNUAL ADMISSIONS, WHAT PERCENTAGE IS TO THIS HOSPITAL? %

PLEASE EXPLAIN TERMINATED AFFILIATION

THIS SPACE HAS BEEN PURPOSELY LEFT BLANK

Professional Liability Insurance Carrier
Supplemental Form

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 6 | **Professional Liability Insurance Carrier**

Other Professional Liability Insurance Carrier

List secondary / second layer / future or previous carrier(s).

For second layer coverage list name of hospital/organization providing coverage

CARRIER OR SELF-INSURED NAME | SELF-INSURED? YES NO

NUMBER* | STREET* | SUITE/BUILDING

CITY* | STATE* | ZIP CODE*

ORIGINAL EFFECTIVE DATE* (M M Y Y Y Y) | EFFECTIVE DATE* (M M Y Y Y Y) | EXPIRATION DATE (M M Y Y Y Y) | TYPE OF COVERAGE?* INDIVIDUAL SHARED

DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER? YES NO | $ AMOUNT OF COVERAGE PER OCCURRENCE | $ AMOUNT OF COVERAGE AGGREGATE

POLICY INCLUDES TAIL COVERAGE? YES NO

POLICY NUMBER*

Other Professional Liability Insurance Carrier

List secondary / second layer / future or previous carrier(s).

For second layer coverage list name of hospital/organization providing coverage

If you need additional space for Insurance Coverage, photocopy this page as needed and submit as instructed.

CARRIER OR SELF-INSURED NAME | SELF-INSURED? YES NO

NUMBER* | STREET* | SUITE/BUILDING

CITY* | STATE* | ZIP CODE*

ORIGINAL EFFECTIVE DATE* (M M Y Y Y Y) | EFFECTIVE DATE* (M M Y Y Y Y) | EXPIRATION DATE (M M Y Y Y Y) | TYPE OF COVERAGE?* INDIVIDUAL SHARED

DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER? YES NO | $ AMOUNT OF COVERAGE PER OCCURRENCE | $ AMOUNT OF COVERAGE AGGREGATE

POLICY INCLUDES TAIL COVERAGE? YES NO

POLICY NUMBER*

Work History
Supplemental Form

* REQUIRED RESPONSE (F THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQU RE FOLLOW-UP.

Section 7 | **Work History**

Work History

Use this form to continue listing work history.

If you need additional space for Work History, photocopy this page as needed and submit as instructed.

WORK HISTORY

PRACTICE / EMPLOYER NAME

NUMBER | STREET | SUITE/BUILDING

CITY | STATE | ZIP/POSTAL CODE

TELEPHONE | FAX

COUNTRY CODE | START DATE (M M Y Y Y Y) | END DATE (M M Y Y Y Y)

REASON FOR DEPARTURE (IF APPLICABLE)

WORK HISTORY

PRACTICE / EMPLOYER NAME

NUMBER | STREET | SUITE/BUILDING

CITY | STATE | ZIP/POSTAL CODE

TELEPHONE | FAX

COUNTRY CODE | START DATE (M M Y Y Y Y) | END DATE (M M Y Y Y Y)

REASON FOR DEPARTURE (IF APPLICABLE)

Professional Training / Work History Gaps
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQU RE FOLLOW-UP.

Section 7 | **Professional Training / Work History Gaps**

Professional Training / Work History Gaps

Please explain any time periods or gaps in training or work history hat have occurred since graduation from professional school and are longer than three month in duration or of a shorter duration if required by the organization for which you are being credentialed.

GAP START DATE M M Y Y Y Y GAP END DATE M M Y Y Y Y

GAP START DATE M M Y Y Y Y GAP END DATE M M Y Y Y Y

GAP START DATE M M Y Y Y Y GAP END DATE M M Y Y Y Y

GAP START DATE M M Y Y Y Y GAP END DATE M M Y Y Y Y

GAP START DATE M M Y Y Y Y GAP END DATE M M Y Y Y Y

Disclosure Questions
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQU RE FOLLOW-UP.

Section 8 | **Disclosure Questions**

Disclosure Questions

Use this form to report any "Yes" response to one or more of the Disclosure Questions in Section 8. Your response should not exceed the spaces provided.

Record the question number in the first column, then your explanation in the second column.

If you need additional space to explain a Yes response, photocopy his page as needed and submit as instructed.

QUESTION #	EXPLANATION

QUESTION #	EXPLANATION

QUESTION #	EXPLANATION

Malpractice Claims Explanation
Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQU RE FOLLOW-UP.

Section 8 | **Malpractice Claims Explanation**

Malpractice Claims Explanation

Use this form to report any "Yes" response to Disclosure Question #19.

If you need additional space to explain a Yes response, photocopy his page as needed and submit as instructed.

DATE OF OCCURRENCE* M M D D Y Y Y Y

DATE CLAIM WAS FILED* M M D D Y Y Y Y

STATUS OF CLAIM* (NOTE: IF CASE IS PENDING, SELECT OPEN)

☐ OPEN ☐ CLOSED

IF SETTLED, ENTER DATE CLAIM WAS SETTLED M M D D Y Y Y Y

PROFESSIONAL LIABILITY CARRIER INVOLVED* (USE BOTH LINES IF NECESSARY)

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

TELEPHONE POLICY NUMBER

$, , AMOUNT OF AWARD OR SETTLEMENT*

METHOD OF RESOLUTION?* ☐ DISMISSED ☐ SETTLED ☐ MEDIATION ☐ ARBITRATION ☐ JUDGMENT FOR DEFENDANT(S) ☐ JUDGMENT FOR PLAINTIFF(S)

DESCRIPTION OF ALLEGATIONS* (USE ALL FOUR LINES BELOW, IF NECESSARY)

WERE YOU THE PRIMARY DEFENDANT OR CO-DEFENDANT?* ☐ PRIMARY DEFENDANT ☐ CO-DEFENDANT

NUMBER OF OTHER CO-DEFENDANTS (IF ANY)

YOUR INVOLVEMENT IN CASE* (ATTENDING, CONSULTING, ETC)

DESCRIPTION OF ALLEGED INJURY TO THE PATIENT (USE ALL FOUR LINES BELOW, IF NECESSARY)

DID THE ALLEGED INJURY RESULT IN DEATH? ☐ YES ☐ NO

TO THE BEST OF YOUR KNOWLEDGE, IS THE CASE INCLUDED IN THE NATIONAL PRACTITIONER DATA BANK (NPDB)?* ☐ YES ☐ NO

Code Lists

Provider Type Codes

001 Medical Doctor (MD)
002 Doctor of Dental Surgery (DDS)
003 Doctor of Dental Medicine (DMD)
004 Doctor of Podiatric Medicine (DPM)
005 Doctor of Chiropractic (DC)
007 Osteopathic Doctor (DO)

020 Acupuncturist
021 Alcohol/Drug Counselor
022 Audiologist
023 Biofeedback Technician
024 Certified Registered Nurse Anesthetist
025 Christian Science Practitioner
026 Clinical Nurse Specialist
027 Clinical Psychologist
028 Clinical Social Worker
029 Dietician
030 Licensed Practical Nurse
031 Marriage/Family Therapist
032 Massage Therapist
033 Naturopath
034 Neuropsychologist
035 Midwife
036 Nurse Midwife
037 Nurse Practitioner
038 Nutritionist
039 Occupational Therapist
040 Optician
041 Optometrist
042 Pharmacist
043 Physical Therapist
044 Physician Assistant
045 Professional Counselor
046 Registered Nurse
047 Registered Nurse First Assistant
048 Respiratory Therapist
049 Speech Pathologist

License Status Codes

001 Active
002 Canceled
003 Denied
004 Expired
005 Inactive
006 Lapsed
007 Limited
008 Pending
009 Probation
010 Provisional
011 Restricted
012 Revoked
013 Suspended
014 Surrendered
015 Temporary
016 Terminated
017 Time Limited
018 Unrestricted
019 Other

Country Codes

004 Afghanistan
008 Albania
012 Algeria
016 American Samoa
020 Andorra
024 Angola
660 Anguilla
010 Antarctica
028 Antigua and Barbuda
032 Argentina
051 Armenia
533 Aruba
036 Australia
040 Austria
031 Azerbaijan
044 Bahamas
048 Bahrain
050 Bangladesh
052 Barbados
112 Belarus
056 Belgium
084 Belize
204 Benin
060 Bermuda
064 Bhutan
068 Bolivia
070 Bosnia and Herzegovina
072 Botswana
074 Bouvet Island
076 Brazil
086 British Indian Ocean Territory
096 Brunei Darussalam
100 Bulgaria
854 Burkina Faso
108 Burundi
116 Cambodia
120 Cameroon
124 Canada
132 Cape Verde
136 Cayman Islands
140 Central African Republic
148 Chad
152 Chile
156 China
162 Christmas Island
166 Cocos (Keeling) Islands
170 Colombia
174 Comoros
178 Congo
180 Congo, Democratic Republic of the
184 Cook Islands
188 Costa Rica
384 Cote d'Ivoire
191 Croatia
192 Cuba
196 Cyprus
203 Czech Republic
208 Denmark
262 Djibouti
212 Dominica
214 Dominican Republic
626 East Timor (provisional)
218 Ecuador
818 Egypt
222 El Salvador
226 Equatorial Guinea
232 Eritrea
233 Estonia
231 Ethiopia
238 Falkland Islands (Malvinas)
234 Faroe Islands
242 Fiji
246 Finland
250 France
249 France, Metropolitan
254 French Guiana
258 French Polynesia
260 French Southern Territories
266 Gabon
270 Gambia
268 Georgia
276 Germany
288 Ghana
292 Gibraltar
300 Greece
304 Greenland
308 Grenada
312 Guadaloupe
316 Guam
320 Guatemala
324 Guinea
624 Guinea-Bissau
328 Guyana
332 Haiti
334 Heard Island and McDonald Islands
340 Honduras
344 Hong Kong
348 Hungary
352 Iceland
356 India
360 Indonesia
364 Iran
368 Iraq
372 Ireland
376 Israel
380 Italy
388 Jamaica
392 Japan
400 Jordan
398 Kazakhstan
404 Kenya
296 Kiribati
408 Korea, North
410 Korea, South
414 Kuwait
417 Kyrgyzstan
418 Laos
428 Latvia
422 Lebanon
426 Lesotho
430 Liberia
434 Libya
438 Liechtenstein
440 Lithuania
442 Luxembourg
446 Macau
807 Macedonia
450 Madagascar
454 Malawi
458 Malaysia
462 Maldives
466 Mali
470 Malta
584 Marshall Islands
474 Martinique
478 Mauritania
480 Mauritius
175 Mayotte
484 Mexico
583 Micronesia
498 Moldova
492 Monaco
496 Mongolia
500 Montserrat
504 Morocco
508 Mozambique
104 Myanmar
516 Namibia
520 Nauru
524 Nepal
528 Netherlands
530 Netherlands Antilles
540 New Caledonia
554 New Zealand
558 Nicaragua
562 Niger
566 Nigeria
570 Niue
574 Norfolk Island
580 Northern Mariana Islands
578 Norway
512 Oman
586 Pakistan
585 Palau
591 Panama
598 Papua New Guinea
600 Paraguay
604 Peru
608 Philippines
612 Pitcairn
616 Poland
620 Portugal
630 Puerto Rico
634 Qatar
638 Réunion
642 Romania
643 Russian Federation
646 Rwanda
654 Saint Helena
659 Saint Kitts and Nevis
662 Saint Lucia
666 Saint Pierre and Miquelon
670 Saint Vincent and the Grenadines

Code Lists

Country Codes (continued)

882 Samoa
674 San Marino
678 São Tomé and Príncipe
682 Saudi Arabia
683 Scotland
686 Senegal
690 Seychelles
694 Sierra Leone
702 Singapore
703 Slovakia
705 Slovenia
090 Solomon Islands
706 Somalia
710 South Africa
239 South Georgia and the South Sandwich Islands
724 Spain
144 Sri Lanka
736 Sudan
740 Suriname
744 Svalbard and Jan Mayen
748 Swaziland
752 Sweden
756 Switzerland
760 Syria
158 Taiwan
762 Tajikistan
834 Tanzania
764 Thailand
768 Togo
772 Tokelau
776 Tonga
780 Trinidad and Tobago
788 Tunisia
792 Turkey795 Turkmenistan
796 Turks and Caicos Islands
798 Tuvalu
800 Uganda
804 Ukraine
784 United Arab Emirates
826 United Kingdom
840 United States
581 U.S. Minor Outlying Islands
858 Uruguay
860 Uzbekistan
548 Vanuatu
336 Vatican City State (Holy See)
862 Venezuela
704 Viet Nam
092 Virgin Islands, British
850 Virgin Islands, U.S.
876 Wallis and Fortuna Islands
732 Western Sahara (provisional)
887 Yemen
891 Yugoslavia
894 Zambia
716 Zimbabwe

Language Codes

001 Abkhazian
002 Afan (Oromo)
003 Afar
004 Afrikaans
005 Albanian
006 Amharic
007 Arabic
008 Armenian
009 Assamese
010 Zerbaijani
011 Bashkir
012 Basque
013 Bengali;Bangla
014 Bhutani
015 Bihari
016 Bislama
017 Breton
018 Bulgarian
019 Burmese
020 Byelorussian
021 Cambodian
022 Catalan
023 Chinese
024 Corsican
025 Croatian
026 Czech
027 Danish
028 Dutch
140 English
030 Esperonto
031 Estonian
032 Faroese
033 Fiji
034 Finnish
035 French
036 Frisian
037 Galican
038 Georgian
039 German
040 Greek
041 Greenlandic
042 Guarani
043 Gujarati
044 Hausa
045 Hebrew
046 Hindi
047 Hungarian
048 Icelandic
049 Indonesian
050 Interlingua
051 Interlingue
052 Inuktitut
053 Inupiak
054 Irish
055 Italian
056 Japanese
057 Javanese
058 Kannada
059 Kashmiri
060 Kazakh
061 Kinyarwanda
062 Kirghiz
063 Kurundi
064 Korean
065 Kurdish
066 Laothian
067 Latin
068 Latvian;Lettish
069 Lingala
070 Lithuanian
071 Macedonian
072 Malagasy
073 Malay
074 Malayalam
075 Maltese
076 Maori
077 Marathi
078 Moldavian
079 Mongolian
080 Nauru
081 Nepali
082 Norwegian
083 Occitan
084 Oriya
085 Pashto;Pus,to
086 Persian (Farsi)
087 Polish
088 Portuguese
089 unjabi
090 Quechua
091 Rhaeto-Romance
092 Roman'an
093 Rus'ian
094 S' moan
095 Sangho
09 Sanskrit
097 Scot Gaelic
098 Serbian
099 Serbo-Croatian
100 Sesotho
101 Setswana
102 Shona
103 Sindhi
104 Singhalese
105 Siswati
106 Slovak
107 Slovenian
108 Somali
109 Spanish
110 Sundanese
111 Swahili
112 Swedish
113 Tagalog
114 Tajik
115 Tamil
116 Tatar
117 Telugu
118 Thai
119 Tibetan
120 Tigrinya
121 Tonga
122 Tsonga
123 Turkish
124 Turkmen
125 Twi
126 Uigur
127 Ukrainian
128 Urdu
129 Uzbek
130 Vietnamese
131 Vol puk
132 Welsh
133 Wolof
1 4 Xhosa
135 Yiddish
136 Yoru a
10 Zerbaijani
137 Zhuang
138 Zulu

Code Lists

U.S. / Canadian Professional School Codes

Alabama
300 University of Alabama School of Dentistry
001 University of Alabama School of Medicine
002 University of South Alabama College of Medicine

Arkansas
003 University of Arkansas College of Medicine

Arizona
500 Arizona College of Osteopathic Medicine
004 University of Arizona College of Medicine

California
801 California College of Podiatric Medicine
400 Cleveland Chiropractic College of Los Angele
005 Keck School of Medicine
401 Life Chiropractic College West
301 Loma Linda University School of Dentistry
006 Loma Linda University School of Medicine
402 Los Angeles College of Chiropractic
403 Palmer College of Chiropractic West
404 Quantum University/SCCC
007 Stanford University School of Medicine
501 Touro University College of Osteopathic Medicine
008 UCLA School of Medicine
009 University of California
010 University of California, Irvine, College of Medicine
302 University of California, Los Angeles School of Dentistry
011 University of California, San Diego, School of Medicine
303 University of California, San Francisco, School of Dentistry
012 University of California, San Francisco, School of Medicine
304 University of Southern California School of Dentistry
305 University of the Pacific School of Dentistry
502 Western University of Health Sciences, College of Osteopathic Medicine of the Pacific

Colorado
306 University of Colorado School of Dentistry
013 University of Colorado School of Medicine

Connecticut
405 University of Bridgeport College of Chiropractic
307 University of Connecticut School of Dental Medicine
014 University of Connecticut School of Medicine
015 Yale University School of Medicine

District of Columbia
016 George Washington University
017 Georgetown University School of Medicine
308 Howard University College of Dentistry
018 Howard University College of Medicine

Florida
800 Barry University School of Graduate Medical Sciences
309 Nova Southeastern University College of Dentistry
503 Nova Southeastern University College of Osteopathic Medicine
310 University of Florida College of Dentistry
019 University of Florida College of Medicine
020 University of Miami School of Medicine
021 University of South Florida College of Medicine

Georgia
022 Emory University School of Medicine
406 Life Chiropractic College
311 Medical College of Georgia School of Dentistry
023 Medical College of Georgia School of Medicine
024 Mercer University School of Medicine
025 Morehouse School of Medicine

Hawaii
026 John A. Burns School of Medicine

Iowa
802 College of Podiatric Medicine and Surgery Des Moines University
504 Des Moines University, Osteopathic Medical Center, College of Osteopathic Medicine and Surgery
407 Palmer College of Chiropractic
312 University of Iowa College of Dentistry
027 University of Iowa College of Medicine

Illinois
028 Chicago Medical School, Finch University of Health Sciences
029 Loyola University Chicago, Stritch School of Medicine
505 Midwestern University, Chicago College of Osteopathic Medicine
408 National College of Chiropractic
313 Northwestern University Dental School
030 Northwestern University Medical School
031 Rush Medical College of Rush University
804 Scholl College of Podiatric Medicine at Finch University
314 Southern Illinois University School of Dental Medicine
032 Southern Illinois University School of Medicine
033 University of Chicago, The Pritzker School of Medicine
315 University of Illinois at Chicago College of Dentistry
034 University of Illinois College of Medicine

Indiana
316 Indiana University School of Dentistry
035 Indiana University School of Medicine

Kansas
036 University of Kansas School of Medicine

Kentucky
506 Pikeville College, School of Osteopathic Medicine
317 University of Kentucky College of Dentistry
037 University of Kentucky College of Medicine
318 University of Louisville School of Dentistry
038 University of Louisville School of Medicine

Louisiana
319 Louisiana State University School of Dentistry
039 Louisiana State University School of Medicine in New Orleans
040 Louisiana State University School of Medicine in Shreveport
041 Tulane University School of Medicine

Massachusetts
042 Boston University School of Medicine
320 Boston University, Goldman School of Dental Medicine
043 Harvard Medical School
321 Harvard School of Dental Medicine
322 Tufts University School of Dental Medicine
044 Tufts University School of Medicine
045 University of Massachusetts Medical School

Maryland
046 Johns Hopkins University School of Medicine
047 Uniformed Services University of the Health Sciences
048 University of Maryland School of Medicine
323 University of Maryland, Baltimore, College of Dental Surgery

Maine
507 University of New England, College of Osteopathic Medicine

Michigan
049 Michigan State University College of Human Medicine
508 Michigan State University, College of Osteopathic Medicine
324 University of Detroit Mercy School of Dentistry
050 University of Michigan Medical School
325 University of Michigan School of Dentistry
051 Wayne State University School of Medicine

Minnesota
052 Mayo Medical School
409 Northwestern College of Chiropractic
053 University of Minnesota, Duluth School of Medicine
054 University of Minnesota Medical School, Twin Cities
326 University of Minnesota School of Dentistry

Missouri
410 Cleveland Chiropractic College of Kansas City
509 Kirksville College of Osteopathic Medicine
411 Logan Chiropractic College
055 Saint Louis University School of Medicine
510 University of Health Sciences, College of Osteopathic Medicine

056 University of Missouri, Columbia School of Medicine
327 University of Missouri Kansas City School of Dentistry
057 University of Missouri Kansas City School of Medicine
058 Washington University in St. Louis School of Medicine

Code Lists

U.S. / Canadian Professional School Codes (continued)

Mississippi
328 University of Mississippi School of Dentistry
059 University of Mississippi School of Medicine

North Carolina
060 Duke University School of Medicine
061 The Brody School of Medicine at East Carolina University
329 University of North Carolina at Chapel Hill School of Dentistry
062 University of North Carolina at Chapel Hill School of Medicine
063 Wake Forest University School of Medicine

North Dakota
064 University of North Dakota School of Medicine and Health Sciences

Nebraska
330 Creighton University School of Dentistry
065 Creighton University School of Medicine
066 University of Nebraska College of Medicine
331 University of Nebraska Medical Center, College of Dentistry

New Hampshire
067 Dartmouth Medical School

New Jersey
068 Robert Wood Johnson Medical School
069 University of Medicine and Dentistry of New Jersey (UMDNJ)
332 UMDNJ, New Jersey Dental School
511 UMDNJ, School of Osteopathic Medicine

New Mexico
070 University of New Mexico School of Medicine

Nevada
071 University of Nevada School of Medicine

New York
072 Albany Medical College
073 Albert Einstein College of Medicine
074 Columbia University College of Physicians and Surgeons
333 Columbia University School of Dental and Oral Surgery
075 Joan & Sanford I. Weill Medical College of Cornell University
076 Mount Sinai School of Medicine of New York University
412 New York Chiropractic College
512 NY College of Osteopathic Medicine of the NY Institute of Technology
077 New York Medical College
334 New York University Kriser Dental Center
078 New York University School of Medicine
335 State University of New York at Buffalo School of Dental Medicine
082 State University of New York at Buffalo School of Medicine
336 State University of New York at Stony Brook School of Dental Medicine
081 State University of New York at Stony Brook School of Medicine
079 State University of New York College of Medicine
080 State University of New York Upstate Medical University
083 University of Rochester School of Medicine and Dentistry

Ohio
337 Case Western Reserve University School of Dentistry
084 Case Western Reserve University School of Medicine
085 Medical College of Ohio
086 Northeastern Ohio Universities College of Medicine
803 Ohio College of Podiatric Medicine
338 Ohio State University College of Den istry
087 Ohio State University College of Medicine and Public Health
513 Ohio University College of Osteopathic Medicine
088 University of Cincinnati College of Medicine
089 Wright State University School of Medicine

Oklahoma
514 Oklahoma State University, College of Osteopathic Medicine
339 University of Oklahoma College of Dentistry
090 University of Oklahoma College of Medicine

Oregon
091 Oregon Health & Science University School of Medicine
340 Oregon Health Sciences University School of Dentistry
413 Western States Chiropractic College

Pennsylvania
092 Jefferson Medical College of Thomas Jefferson University
515 Lake Erie College of Osteopathic Medicine
093 MCP Hahnemann University School of Medicine
094 Pennsylvania State University College of Medicine
516 Philadelphia College of Osteopathic Medicine
341 Temple University School of Dentistry
095 Temple University School of Medicine
805 Temple University School of Podiatric Medicine
342 University of Pennsylvania School of Dental Medicine
096 University of Pennsylvania School of Medicine
343 University of Pittsburgh School of Dental Medicine
097 University of Pittsburgh School of Medicine

Puerto Rico
098 Ponce School of Medicine
099 Universidad Central del Caribe School of Me icine
100 University of Puerto Rico School of Medi ne
344 University of Puerto Rico School of De tistry

Rhode Island
101 Brown Medical School

South Carolina
345 Medical University of outh Carolina ollege of Dental Medicine
102 Medical University of South Carolina College of Medicine
414 Sherman Colleg of Chiropractic
103 University of outh Carolina S hool of Medicine

South Dakota
104 University of South Dakota School of Medicine

Tenne see
105 ast Tenness e State University
3 o M harry M dical College School of Dentistry
106 Meharry Medical College School of Medicine
347 Uni rsity of Tennessee College of Dentistry
107 Un ersity of Tennessee College of Medicine
108 anderbilt University School of Medicine

Texas
348 Baylor College of Dentistry
109 Baylor College of Medicine
415 Parker College of Chiropractic
416 Texas Chiropractic College
110 Texas Tech University Health Sciences Center School of Medicine
111 The Texas A & M University System College of Medicine
517 UNT Health Sciences Center, Texas College of Osteopathic Medicine
349 University of Texas Health Science Center at Houston Dental School
350 University of Texas Health Science Center at San Antonio Dental School
112 University of Texas Medical Branch at Galveston
113 University of Texas Medical School at Houston
114 University of Texas Medical School at San Antonio
115 UT Southwestern Medical Center at Dallas Southwestern Medical School

Utah
116 University of Utah School of Medicine

Virginia
117 Eastern VA Medical School of the Medical College of Hampton Roads
118 University of Virginia School of Medicine Health System
351 Virginia Commonwealth University School of Dentistry
119 Virginia Commonwealth University School of Medicine

Vermont
120 University of Vermont College of Medicine

Washington
352 University of Washington School of Dentistry
121 University of Washington School of Medicine

Wisconsin
353 Marquette University School of Dentistry
122 Medical College of Wisconsin
123 University of Wisconsin Medical School

West Virginia
124 Joan C. Edwards School of Medicine at Marshall University
518 West Virginia School of Osteopathic Medicine
354 West Virginia University School of Dentistry
125 West Virginia University School of Medicine

Code Lists

U.S. / Canadian Professional School Codes (continued)

Canada

355 Dalhousie University Faculty of Dentistry
126 Dalhousie University Faculty of Medicine
357 Laval University Faculty of Dentistry
127 Laval University Faculty of Medicine
356 McGill University Faculty of Dentistry
128 McGill University Faculty of Medicine
129 McMaster University School of Medicine
130 Memorial University of Newfoundland Faculty of Medicine
131 Queen's University Faculty of Health Sciences
132 The University of Western Ontario Faculty of Medicine & Dentistry
133 Universite de Montreal Faculty of Medicine
134 Universite de Sherbrooke Faculty of Medicine
358 University of Alberta Faculty of Dentistry
135 University of Alberta Faculty of Medicine
359 University of British Columbia Faculty of Dentistry
136 University of British Columbia Faculty of Medicine
137 University of Calgary Faculty of Medicine
360 University of Manitoba Faculty of Dentistry
138 University of Manitoba Faculty of Medicine
361 University of Montreal Faculty of Dentistry
139 University of Ottawa Faculty of Medicine
362 University of Saskatchewan College of Dentistry
140 University of Saskatchewan College of Medicine
363 University of Toronto Faculty of Dentistry
141 University of Toronto Faculty of Medicine
364 University of Western Ontario Faculty of Dentistry

Specialty Codes - MD / DO Only

NOTE THIS LIST IS FROM THE NATIONAL HEALTH CARE PROVIDER TAXONOMY CODE LIST, PUBLISHED IN COOPERATION WITH THE NATIONAL UNIFORM CLAIM COMMITTEE (NUCC).

247 Allergy & Immunology
246 Allergy & Immunology, Allergy
291 Allergy & Immunology, Clinical & Laboratory Immunology
249 Anesthesiology
235 Anesthesiology, Addiction Medicine
258 Anesthesiology, Critical Care Medicine
126 Anesthesiology, Pain Medicine
363 Clinical Pharmacology
367 Colon & Rectal Surgery
263 Dermatology
292 Dermatology, Clinical & Laboratory Dermatological Immunology
444 Dermatology, Dermatological Surgery
266 Dermatology, Dermatopathology
264 Dermatology, MOHS-Micrographic Surgery
443 Dermatology, Pediatric Dermatology
268 Emergency Medicine
445 Emergency Medicine, Emergency Medical Services
427 Emergency Medicine, Medical Toxicology
348 Emergency Medicine, Pediatric Emergency Medicine
395 Emergency Medicine, Sports Medicine
446 Emergency Medicine, Undersea and Hyperbaric Medicine
391 Facial Plastic Surgery
272 Family Prac ice
447 Family Practice, Addiction Medicine
237 Family Practice, Adolescent Medicine
448 Family Practice, Adult Medicine
282 Family Practice, Geriatric Medicine
396 Family Practice, Sports Medicine
225 General Practice
479 Hospitalist
301 Internal Medicine
449 Internal Medicine, Addiction Medicine
236 Internal Medicine, Adolescent Medicine
248 Internal Medicine, Allergy & Immunology
255 Internal Medicine, Cardiovascular Disease
294 Internal Medicine, Clinical & Laboratory Immunology
253 Internal Medicine, Clinical Cardiac Electrophysiology
257 Internal Medicine, Critical Care Medicine
267 Internal Medicine, Endocrinology, Diabetes & Metabolism
275 Internal Medicine, Gastroenterology
285 Internal Medicine, Geriatric Medicine
287 Internal Medicine, Hematology
288 Internal Medicine, Hematology & Oncology
450 Internal Medicine, Hepatology
299 Internal Medicine, Infectious Disease
451 Internal Medicine, Interven ional Cardiology
453 Internal Medicine, Magnetic Resonance Imaging (MRI)
325 Internal Medicine, Medical Oncology
309 Internal Medicine, Nephrology
378 Internal Medicine, Pulmonary Disease
390 Internal Medicine, Rheumatology
397 Internal Medicine, Sports Medicine
4 3 Laboratories, Clinical Medical Laboratory
481 Legal M dicine
278 Medical Genetics, Clinical Biochemical Genetics
261 Medical Genetics, Clinical Cytogenetic
277 Medical Genetics, Clinical Genetics (M.D.)
280 Medical Genetics, Clinical Molecular Genetics
455 Medical Genetics, Molecular Genetic Pathology
454 Medical Genetics, Ph.D. Medical Genetics
306 Neonatal-Perinatal Medicine
308 Neopathology
409 Neurological Surgery
330 Neuromusculoskeletal Medicine & OMM
440 Neuromusculoskeletal Medicine, Sports Medicine
317 Nuclear Medicine
318 Nuclear Medicine, In Vivo & In Vitro Nuclear Medicine
315 Nuclear Medicine, Nuclear Cardiology
316 Nuclear Medicine, Nuclear Imaging & Therapy
321 Obstetrics & Gynecology
260 Obstetrics & Gynecology, Critical Care Medicine
326 Obstetrics & Gynecology, Gynecologic Oncology
286 Obstetrics & Gynecology, Gynecology
303 Obstetrics & Gynecology, Maternal & Fetal Medicine
320 Obstetrics & Gynecology, Obstetrics
271 Obstetrics & Gynecology, Reproductive Endocrinology
328 Ophthalmology
441 Oral & Maxillofacial Surgery
411 Orthopaedic Surgery
412 Orthopaedic Surgery, Adult Reconstructive Orthopaedic Surgery
456 Orthopaedic Surgery, Foot and Ankle Orthopaedics
406 Orthopaedic Surgery, Hand Surgery
415 Orthopaedic Surgery, Orthopaedic Surgery of the Spine
416 Orthopaedic Surgery, Orthopaedic Trauma
457 Orthopaedic Surgery, Sports Medicine
119 Orthopedic
331 Otolaryngology
458 Otolaryngology, Otolaryngic Allergy
459 Otolaryngology, Otolaryngology/ Facial Plastic Surgery
332 Otolaryngology, Otology & Neurotology
357 Otolaryngology, Pediatric Otolaryngology
417 Otolaryngology, Plastic Surgery within the Head & Neck
480 Pain Medicine, Interventional Pain Medicine
337 Pain Medicine
338 Pathology, Anatomic Pathology
340 Pathology, Anatomic Pathology & Clinical Pathology
250 Pathology, Blood Banking & Transfusion Medicine
344 Pathology, Chemical Pathology
302 Pathology, Clinical Pathology/Laboratory Medicine
262 Pathology, Cytopathology
265 Pathology, Dermatopathology
273 Pathology, Forensic Pathology
290 Pathology, Hematology
298 Pathology, Immunopathology
305 Pathology, Medical Microbiology
461 Pathology, Molecular Genetic Pathology
312 Pathology, Neuropathology
358 Pathology, Pediatric Pa hology
244 Pediatrics
239 Pediatrics, Adolescent Medicine
295 Pediatrics, Clinical & Laboratory Immunology
462 Pediatrics, Developmental – Behavioral Pediatrics
354 Pediatrics, Medical Toxicology
356 Pediatrics, Neurodevelopmental Disabilities
345 Pediatrics, Pediatric Allergy & Immunology
346 Pediatrics, Pediatric Cardiology
347 Pediatrics, Pediatric Critical Care Medicine
463 Pediatrics, Pediatric Emergency Medicine
349 Pediatrics, Pediatric Endocrinology

Code Lists

Specialty Codes - MD/DO Only

350	Pediatrics, Pediatric Gastroenterology
351	Pediatrics, Pediatric Hematology-Oncology
352	Pediatrics, Pediatric Infectious Diseases
355	Pediatrics, Pediatric Nephrology
359	Pediatrics, Pediatric Pulmonology
361	Pediatrics, Pediatric Rheumatology
398	Pediatrics, Sports Medicine
365	Physical Medicine & Rehabilitation
468	Physical Medicine & Rehabilitation, Pain Medicine
389	Physical Medicine & Rehabilitation, Pediatric Rehabilitation Medicine
466	Physical Medicine & Rehabilitation, Spinal Cord Injury Medicine
469	Physical Medicine & Rehabilitation, Sports Medicine
419	Plastic Surgery
470	Plastic Surgery, Plastic Surgery Within the Head and Neck
407	Plastic Surgery, Surgery of the Hand
242	Preventive Medicine, Aerospace Medicine
429	Preventive Medicine, Medical Toxicology
112	Preventive Medicine, Occupational Medicine
471	Preventive Medicine, Sports Medicine
431	Preventive Medicine, Undersea and Hyperbaric Medicine
114	Preventive Medicine/Occupational Environmental Medicine
370	Psychiatry & Neurology, Addiction Medicine
473	Psychiatry & Neurology, Addiction Psychiatry
371	Psychiatry & Neurology, Child & Adolescent Psychiatry
313	Psychiatry & Neurology, Clinical Neurophysiology
274	Psychiatry & Neurology, Forensic Psychiatry
373	Psychiatry & Neurology, Geriatric Psychiatry
472	Psychiatry & Neurology, Neurodevelopmental Disabilities
100	Psychiatry & Neurology, Neurology
311	Psychiatry & Neurology, Neurology with Special Qualifications in Child Neurology
474	Psychiatry & Neurology, Pain Medicine
368	Psychiatry & Neurology, Psychiatry
475	Psychiatry & Neurology, Sports Medicine
476	Psychiatry & Neurology, Vascular Neurology
366	Public Health & General Preventive Medicine
252	Radiology, Body Imaging
173	Radiology, Diagnostic Radiology
430	Radiology, Diagnostic Ultrasound
314	Radiology, Neuroradiology
319	Radiology, Nuclear Radiology
360	Radiology, Pediatric Radiology
380	Radiology, Radiation Oncology
477	Radiology, Radiological Physics
381	Radiology, Therapeutic Radiology
384	Radiology, Vascular & Interventional Radiology
434	Supplier
399	Surgery
418	Surgery, Pediatric Surgery
420	Surgery, Plastic and Reconstructive Surgery
405	Surgery, Surgery of the Hand
425	Surgery, Surgical Cri ical Care
413	Surgery, Surgical Oncology
423	Surgery, Trauma Surgery
400	Surgery, Vascular Surgery
421	Thoracic Surgery (Cardiothoracic Vascular Surgery)
442	Transplant Surgery
424	Urology

Specialty Codes - DDS / DMD / DPM / DC

NOTE THIS LIST IS FROM THE NATIONAL HEALTH CARE PROVIDER TAXONOMY CODE LIST, PUBLISHED IN COOPERATION WITH THE NATIONAL UNIFORM CLAIM COMMITTEE (NUCC).

DDS / DMD

2	Dentist
13	Dentist, Dental Public Health
14	Dentist, Endodontics
438	Dentist, General Practice
16	Dentist, Oral and Maxillofacial Pathology
439	Dentist, Oral and Maxillofacial Radiology
20	Dentist, Oral and Maxillofacial Surgery
15	Dentist, Orthodontics and Dentofacial Orthopedics
17	Dentist, Pediatric Dentistry
18	Dentist, Periodontics
19	Dentist, Prosthodontics

DPM

3	Podiatrist
231	Podiatrist, Foot & Ankle Surgery
230	Podiatrist, Foot Surgery
225	Podiatrist, General Practice
227	Podiatrist, Primary Podiatric Medicine
226	Podiatrist, Public Medicine
228	Podiatrist, Radiology
229	Podiatrist, Sports Medicine

DC

1	Chiropractor
5	Chiropractor, Internist
6	Chiropractor, Neurology
7	Chiropractor, Nutrition
8	Chiropractor, Occupational Medicine
9	Chiropractor, Orthopedic
10	Chiropractor, Radiology
11	Chiropractor, Sports Physician
12	Chiropractor, Thermography

Specialty Codes - Allied Providers

NOTE THIS LIST IS FROM THE NATIONAL HEALTH CARE PROVIDER TAXONOMY CODE LIST, PUBLISHED IN COOPERATION WITH THE NATIONAL UNIFORM CLAIM COMMITTEE (NUCC).

501	Acupuncturist
503	Audiologist
504	Audiologist, Assistive Technology Practitioner
505	Audiologist, Assistive Technology Supplier
531	Chris ian Science Practitioner
727	Clinical Nurse Specialist
728	Clinical Nurse Specialist, Acute Care
729	Clinical Nurse Specialist, Adult Health
730	Clinical Nurse Specialist, Chronic Care
731	Clinical Nurse Specialist, Community Health/Public Health
732	Clinical Nurse Specialist, Critical Care Medicine
733	Clinical Nurse Specialist, Emergency
734	Clinical Nurse Specialist, Ethics
735	Clinical Nurse Specialist, Family Health
736	Clinical Nurse Specialist, Gerontology
737	Clinical Nurse Specialist, Holistic
738	Clinical Nurse Specialist, Home Health
739	Clinical Nurse Specialist, Informatics
740	Clinical Nurse Specialist, Long-Term Care
741	Clinical Nurse Specialist, Medical-Surgical
742	Clinical Nurse Specialist, Neonatal
743	Clinical Nurse Specialist, Neuroscience
744	Clinical Nurse Specialist, Occupational Health
745	Clinical Nurse Specialist, Oncology
746	Clinical Nurse Specialist, Oncology, Pediatrics
747	Clinical Nurse Specialist, Pediatrics
748	Clinical Nurse Specialist, Perinatal
749	Clinical Nurse Specialist, Perioperative
750	Clinical Nurse Specialist, Psychiatric/Mental Health
751	Clinical Nurse Specialist, Psychiatric/Mental Health, Adult
752	Clinical Nurse Specialist, Psychiatric/Mental Health, Child & Adolescent
753	Clinical Nurse Specialist, Psychiatric/Mental Health, Child & Family
754	Clinical Nurse Specialist, Psychiatric/Mental Health, Chronically Ill
755	Clinical Nurse Specialist, Psychiatric/Mental Health, Community
756	Clinical Nurse Specialist, Psychiatric/Mental Health, Geropsychiatric
757	Clinical Nurse Specialist, Rehabilita ion
759	Clinical Nurse Specialist, School
758	Clinical Nurse Specialist, Transplantation
760	Clinical Nurse Specialist, Women's Health
513	Counselor
514	Counselor, Addiction (Substance Use Disorder)
515	Counselor, Mental Health
516	Counselor, Professional
533	Dietitian, Registered
536	Dieti ian, Registered, Nutri ion, Metabolic
534	Dietitian, Registered, Nutrition, Pediatric
535	Dietitian, Registered, Nutrition, Renal
651	Licensed Prac ical Nurse
517	Marriage & Family Therapist
547	Massage Therapist
549	Midwife, Certified
652	Midwife, Certified Nurse
551	Naturopath
553	Neuropsychologist
653	Nurse Anesthetist, Certified Registered
654	Nurse Prac itioner
655	Nurse Practitioner, Acute Care
656	Nurse Practitioner, Adult Health
658	Nurse Practitioner, Community Health
657	Nurse Practitioner, Critical Care Medicine
659	Nurse Practitioner, Family

Code Lists

Specialty Codes - Allied Providers (continued)

660 Nurse Practitioner, Gerontology
661 Nurse Practitioner, Neonatal
662 Nurse Practitioner, Neonatal, Critical Care
670 Nurse Practitioner, Obstetrics & Gynecology
671 Nurse Practitioner, Occupational Health
663 Nurse Practitioner, Pediatrics
664 Nurse Practitioner, Pediatrics, Critical Care
666 Nurse Practitioner, Perinatal
667 Nurse Practitioner, Primary Care
665 Nurse Practitioner, Psych/Mental Health
668 Nurse Practitioner, School
669 Nurse Practitioner, Women's Health
537 Nutritionist
538 Nutritionist, Nutrition, Education
555 Occupational Therapist
556 Occupational Therapist, Ergonomics
557 Occupational Therapist, Hand
558 Occupational Therapist, Human Factors
559 Occupational Therapist, Neurorehabilitation
560 Occupational Therapist, Pediatrics
561 Occupational Therapist, Rehabilitation, Driver
563 Optician
565 Optometrist
566 Optometrist, Corneal and Contact Management
567 Optometrist, Low Vision Rehabilitation
571 Optometrist, Occupational Vision
568 Optometrist, Pediatrics
569 Optometrist, Sports Vision
570 Optometrist, Vision Therapy
573 Pharmacist
574 Pharmacist, General Practice
575 Pharmacist, Nuclear Pharmacy
576 Pharmacist, Nutrition Support
577 Pharmacist, Pharmacotherapy
578 Pharmacist, Psychopharmacy
580 Physical Therapist
581 Physical Therapist, Cardiopulmonary
583 Physical Therapist, Electrophysiology, Clinical
582 Physical Therapist, Ergonomics
584 Physical Therapist, Geriatrics
585 Physical Therapist, Hand
586 Physical Therapist, Human Factors
587 Physical Therapist, Neurology
590 Physical Therapist, Orthopedic
588 Physical Therapist, Pediatrics
589 Physical Therapist, Sports
592 Physician Assistant
593 Physician Assistant, Medical
594 Physician Assistant, Surgical
596 Psychologist
597 Psychologist, Addiction (Substance Use Disorder)
598 Psychologist, Adult Development & Aging
599 Psychologist, Behavioral
602 Psychologist, Child, Youth & Family
600 Psychologist, Clinical
601 Psychologist, Counseling
603 Psychologist, Educational
604 Psychologist, Exercise & Sports
605 Psychologist, Family
606 Psychologist, Forensic
607 Psychologist, Health
608 Psychologist, Men & Masculinity
609 Psychologist, Mental Retardation & Developmental Disabilities
610 Psychologist, Psychoanalysis
611 Psychologist, Psychotherapy
612 Psychologist, Psychotherapy, Group
613 Psychologist, Rehabilitation
614 Psychologist, School
615 Psychologist, Women
672 Registered Nurse
673 Registered Nurse, Addiction (Substance Use Disorder)
674 Registered Nurse, Administrator
711 Registered Nurse, Ambulatory Care
681 Registered Nurse, Cardiac Rehabilitation
676 Registered Nurse, Case Management
677 Registered Nurse, College Health
678 Registered Nurse, Community Health
680 Registered Nurse, Continence Care
679 Registered Nurse, Continuing Education/Staff Development
675 Registered Nurse, Critical Care Medicine
682 Registered Nurse, Diabetes Educator
683 Registered Nurse, Dialysis, Peritoneal
684 Registered Nurse, Emergency
685 Registered Nurse, Enterostomal Therapy
686 Registered Nurse, Flight
688 Registered Nurse, Gastroenterology
687 Registered Nurse, General Practice
689 Registered Nurse, Gerontology
691 Registered Nurse, Hemodialysis
690 Registered Nurse, Home Health
692 Registered Nurse, Hospice
694 Registered Nurse, Infection Control
693 Registered Nurse, Infusion Therapy
695 Registered Nurse, Lactation Consultant
696 Registered Nurse, Maternal Newborn
697 Registered Nurse, Medical-Surgical
699 Registered Nurse, Neonatal Intensive Care
700 Registered Nurse, Neonatal, Low-Risk
701 Registered Nurse, Nephrology
702 Registered Nurse, Neuroscience
698 Registered Nurse, Nurse Massage Therapist (NMT)
703 Registered Nurse, Nutrition Support
719 Registered Nurse, Obstetric, High-Risk
720 Registered Nurse, Obstetric, Inpatient
721 Registered Nurse, Occupational Health
722 Registered Nurse, Oncology
725 Registered Nurse, Ophthalmic
724 Registered Nurse, Orthopedic
726 Registered Nurse, Ostomy Care
723 Registered Nurse, Otorhinolaryngology & Head-Neck
704 Registered Nurse, Pain Management
706 Registered Nurse, Pediatric Oncology
705 Registered Nurse, Pediatrics
710 Registered Nurse, Perinatal
714 Registered Nurse, Plastic Surgery
708 Registered Nurse, Psych/Mental Health
709 Registered Nurse, Psych/Mental Health, Adult
707 Registered Nurse, Psych/Mental Health, Child & Adolescent
712 Registered Nurse, Rehabilitation
713 Registered Nurse, Reproductive Endocrinology/Infertility
715 Registered Nurse, School
716 Registered Nurse, Urology
718 Registered Nurse, Women's Health Care, Ambulatory
717 Registered Nurse, Wound Care
617 Respiratory Therapist, Certified
618 Respiratory Therapist, Certified, Critical Care
620 Respiratory Therapist, Certified, Educational
619 Respiratory Therapist, Certified, Emergency Care
622 Respiratory Therapist, Certified, General Care
621 Respiratory Therapist, Certified, Geriatric Care
623 Respiratory Therapist, Certified, Home Health
628 Respiratory Therapist, Certified, Neonatal/Pediatrics
627 Respiratory Therapist, Certified, Palliative/Hospice
629 Respiratory Therapist, Certified, Patient Transport
624 Respiratory Therapist, Certified, Pulmonary Diagnostics
626 Respiratory Therapist, Certified, Pulmonary Function Technologist
625 Respiratory Therapist, Certified, Pulmonary Rehabilitation
630 Respiratory Therapist, Certified, SNF/Subacute Care
631 Respiratory Therapist, Registered
632 Respiratory Therapist, Registered, Critical Care
634 Respiratory Therapist, Registered, Educational
633 Respiratory Therapist, Registered, Emergency Care
636 Respiratory Therapist, Registered, General Care
635 Respiratory Therapist, Registered, Geriatric Care
637 Respiratory Therapist, Registered, Home Health
642 Respiratory Therapist, Registered, Neonatal/Pediatrics
641 Respiratory Therapist, Registered, Palliative/Hospice
643 Respiratory Therapist, Registered, Patient Transport
638 Respiratory Therapist, Registered, Pulmonary Diagnostics
640 Respiratory Therapist, Registered, Pulmonary Function Technologist
639 Respiratory Therapist, Registered, Pulmonary Rehabilitation
644 Respiratory Therapist, Registered, SNF/Subacute Care
646 Social Worker, Clinical
648 Specialist/Technologist, Other, Biomedical Engineering
506 Speech-Language Pathologist
649 Technician, Other, Biomedical Engineering
502 Other, Not Listed

Code Lists

Specialty Boards - Allied Providers

940 Academy of Certified Social Workers
1150 ACNM Certification Council
360 American Academy of Ambulatory Care Nursing
1550 American Academy of Anesthesiologist Assistants
230 American Academy of Audiology
370 American Academy of Experts in Traumatic Stress
270 American Academy of Health Providers in the Addictive Disorders
200 American Academy of Medical Acupuncture
405 American Academy of Nurse Practitioners
380 American Academy of Nursing
1330 American Academy of Optometry
1480 American Academy of Physician Assistants
1110 American Association for Marriage and Family Therapy
390 American Association of Critical Care Nurses
1590 American Association of Nurse Anesthetists
330 American Association of Pastoral Counselors
1010 American Association of Sex Educators, Counselors and Therapists
710 American Board Medical Psychotherapists
280 American Board of Addiction Medicine
950 American Board of Examiners in Clinical Social Work
720 American Board of Medical Psyhotherapists & Psychodiagnosticians
400 American Board of Nursing Specialties
1240 American Board of Nutrition
1300 American Board of Occupational Medicine
1360 American Board of Ophthalmology
1510 American Board of Physical Therapy Specialties
700 American Board of Professional Psychology
1130 American Naturopath Certification Board
350 American Nurses Credentialing Center
740 American Psychological Association
750 American Psychological Society
760 American Psychotherapy Association
290 American Society of Addiction Medicine
1650 American Speech-Language-Hearing Association
250 Biofeedback Certification Institute of America
1430 Board of Pharmaceutical Specialties
1250 Commission on Dietetic Registration
960 Employee Assistance Professionals Association
780 National Association for the Advancement of Psychoanalysis
1450 National Association of Boards of Pharmacy
1600 National Association of Nurse Anes hetists
770 National Association of School Psychologists
980 National Association of Social Workers
1310 National Board for Certification in Occupational Therapy
1490 National Board for Certification of Orthopaedic Physician Assistants
790 National Board for Certified Clinical Hypnotherapists
310 National Board for Certified Counselors
1630 National Board for Respiratory Care
300 National Board of Addiction Examiners
800 National Board of Cognitive Behavioral Therapists
1350 National Board of Examiners in Optometry
1090 National Certification Board for Therapeutic Massage and Bodywork
210 National Certification Commission for Acupuncture and Oriental Medicine
1440 National Institute for Standards in Pharmacist Credentialing
220 Other - Not Listed

Specialty Boards - MD / DDS / DMD / DO / DPM

MD Boards
044 American Board of Allergy & Immunology
045 American Board of Anesthesiology
046 American Board of Colon & Rectal Surgery
047 American Board of Dermatology
048 American Board of Emergency Medicine
049 American Board of Family Medicine
050 American Board of Internal Medicine
051 American Board of Medical Genetics
052 American Board of Neurological Surgery
053 American Board of Nuclear Medicine
054 American Board of Obstetrics & Gynecology
055 American Board of Ophthalmology
109 American Board of Oral & Maxillofacial Surgeons
056 American Board of Orthopedic Surgery
057 American Board of Otolaryngology
058 American Board of Pathology
059 American Board of Pediatrics
060 American Board of Physical Medicine & Rehabilitation
061 American Board of Plastic Surgery
062 American Board of Preventive Medicine
063 American Board of Psychiatry & Neurology
064 American Board of Radiology
065 American Board of Surgery
066 American Board of Thoracic Surgery
067 American Board of Urology
142 Boards other than ABMS/AOA

Dental Boards
113 American Board of Endodontics
114 American Board of Oral & Maxillofacial Pathology
117 American Board of Oral & Maxillofacial Radiology
109 American Board of Oral & Maxillofacial Surgeons
108 American Board of Orthodontics
112 American Board of Pediatric Dentistry
111 American Board of Periodontology
115 American Board of Prosthodontics
106 American Board of Public Health Dentistry
120 Boards other than ABMS/AOA

DO Boards
118 American Osteopathic Board of Anesthesiology
119 American Osteopathic Board of Dermatology
120 American Osteopathic Board of Emergency Medicine
121 American Osteopathic Board of Family Practice
123 American Osteopathic Board of Internal Medicine
124 American Osteopathic Board of Neurology and Psychiatry
125 American Osteopathic Board of Neuromuskuloskeletal Medicine
126 American Osteopathic Board of Nuclear Medicine
127 American Osteopathic Board of Obstetrics and Gynecology
128 American Osteopathic Board of Ophthalmology and Otolaryngology
129 American Osteopathic Board of Orthopedic Surgery
130 American Osteopathic Board of Pathology
131 American Osteopathic Board of Pediatrics
132 American Osteopathic Board of Preventive Medicine
133 American Osteopathic Board of Proctology
134 American Osteopathic Board of Radiology
135 American Osteopathic Board of Rehabilitation Medicine
136 American Osteopathic Board of Surgery

DPM Boards
140 American Board of Medical Specialists in Podiatry
137 American Board of Podiatric Orthopedics and Primary Podiatric Medicine
138 American Board of Podiatric Surgery
139 American Council of Certified Podiatric Surgeons and Physicians

HIV/AIDS SPECIALIST DESIGNATION

This legislation requires standing referrals to HIV/AIDS specialists for patients who need continued care for their HIV/AIDS. The Department of Managed Health Care (DMHC) recently defined an HIV/AIDS specialist under Regulation LS - 34 -01.

In order to comply with this regulation, we need to identify appropriately qualified specialists within our network who meet the definition of an HIV/AIDS specialist.

We will use your information for internal referral procedures and for publication listing in the Provider Directory.

As always, if information about your practice changes, please notify us promptly.

☐ No, I do not wish to be designated as an HIV/AIDS specialist.

☐ Yes, I do wish to be designated as an HIV/AIDS specialist based on the below criteria:

☐ I am credentialed as an "HIV Specialist" by the American Academy of HIV Medicine. **OR**

☐ I am board certified in HIV Medicine or have earned a Certificate of Added Qualification in the field of HIV Medicine granted by a member board of the American Board of Medical Specialties. **OR**

☐ I am board certified in Infectious Disease by a member board of the American Board of Medical Specialties and meet the following qualifications:

1. In the immediately preceding 12 months, I have clinically managed medical care to a minimum of 5 patients who are infected with HIV; **AND**
2. In the immediately preceding 12 months, I have successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment or both of HIV-infected patients, including a minimum of 5 hours related to antiretroviral therapy per year; **OR**

☐ In the immediately preceding 24 months, I have clinically managed medical care to a minimum of 20 patients who are infected with HIV; **AND**

1. In the immediately preceding 12 months, I have obtained board certification or re-certification in the field of Infectious Disease from a member board of the American Board of Medical Specialties; **OR**
2. In the immediately preceding 12 months, I have successfully completed a minimum of 30 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment or both, of HIV-infected patients; **OR**
3. In the immediately preceding 12 months, I have successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment or both, of HIV-infected patients Medicine and successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV Medicine.

Continue to the Next Page for Attestation Questions

ATTESTATION QUESTIONS

INSTRUCTIONS: Please answer the following questions "Yes" or "No". If your answer to any of the following questions is "**Yes**", please provide full details on a separate sheet of paper.

1. Has your license to practice medicine, Drug Enforcement Administration (DEA) registration or an applicable narcotic registration in any jurisdiction ever been denied, limited, restricted, suspended, revoked, not renewed, or subject to probationary conditions, or have you voluntarily or involuntarily relinquished any such license or registration or voluntarily or involuntarily accepted any such actions or conditions or have you been fined or received a letter of reprimand or is such action pending? ◯ Yes ◯ No

2. Have you ever been charged, suspended, fined, disciplined, or otherwise sanctioned, subjected to probationary conditions, restricted or excluded, or have you voluntarily or involuntarily relinquished eligibility to provide services or accepted conditions on your eligibility to provide services, for reasons relating to possible incompetence or improper professional conduct, or breach of contract or program conditions by Medicare, Medicaid, or any federal program or is any such action pending? ◯ Yes ◯ No

3. Have your clinical privileges, membership, contractual participation or employment by any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with (public) federal programs), or other health delivery entity or system), ever been denied, suspended, restricted, reduced, subject to probationary conditions, revoked or not renewed for possible incompetence, improper professional conduct or breach of contract, or is any such action pending? ◯ Yes ◯ No

4. Have you ever surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership or clinical privileges, terminated contractual participation or employment, or resigned from any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), or other health delivery entity or system) while under investigation for possible incompetence or improper professional conduct, or breach of contract, or in return for such an investigation not being conducted, or is any such action pending? ◯ Yes ◯ No

5. Have you ever surrendered, voluntarily withdrawn, or been requested or compelled to relinquish your status as a student in good standing in any internship, residency, fellowship, preceptorship, or other clinical education program? ◯ Yes ◯ No

6. Have you ever been denied certification/recertification by a specialty board? ◯ Yes ◯ No

7. Have you ever chosen not to recertify or voluntarily surrender your board certification while under investigation? ◯ Yes ◯ No

8. a. Have you ever been convicted of, or pled guilty to a criminal offense (e.g., felony or misdemeanor) and/or placed on deferred adjudication or probation for a criminal offense other than a misdemeanor traffic offense? ◯ Yes ◯ No
   b. Are any such actions pending? ◯ Yes ◯ No

9. Have any judgments been entered against you, or settlements been agreed to by you within the last seven (7) years, in professional liability cases? If **YES**, please complete Addendum B. ◯ Yes ◯ No

10. Are there any professional liability lawsuits/arbitrations against you that have been dismissed or currently pending? If **YES**, please complete Addendum B. ◯ Yes ◯ No

11. Has your professional liability insurance ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged, or have you ever been denied professional liability insurance, or has any professional liability carrier provided you with written notice of any intent to deny, cancel, not renew, or limit your professional liability insurance or its coverage of any procedures? ◯ Yes ◯ No

12. Do you have any physical or mental condition which would prevent or limit your ability to perform the essential functions of the position and/or privileges for which your qualifications are being evaluated in accordance with accepted standards of professional performance, with or without reasonable accommodations? If **YES**, please describe on a separate sheet any accommodations that could reasonably be made to facilitate your performance of such functions without risk of compromise. ◯ Yes ◯ No

Continue to the Next Page for Additional Attestation Questions

ATTESTATION QUESTIONS (Continued)

INSTRUCTIONS: Please answer the following questions "Yes" or "No". If your answer to any of the following questions is "**Yes**", please provide full details on a separate sheet of paper.

13. Have you ever rendered professional medical services as an employee of a staff model HMO, an entity insured by the federal government (such as the military or a Federally Qualified Health Center) or an academic institution. ◯ Yes ◯ No

    If **YES**, have you, in the past seven (7) years, been named as a defendant in a lawsuit (whether or not you were later dismissed from the matter)? ◯ Yes ◯ No

14. Is your current ability to practice impaired by chemical dependency or substance abuse, including present use of illegal drugs? ◯ Yes ◯ No

15. Within the last three (3) years, has your membership, privileges, participation or affiliation with any healthcare organization (e.g., a hospital or HMO), been terminated, suspended or restricted; or have you taken a leave of absence from a health care organization for reasons related to the abuse of, or dependency on, alcohol or drugs? ◯ Yes ◯ No

I hereby affirm that the information submitted in this Section, Attestation Questions, Application, and any addenda thereto is current, correct, and complete to the best of my knowledge and belief and in good faith. I understand that material omissions or misrepresentations may result in denial of my application or termination of my privileges, employment or physician participation agreement.

APPLICANT SIGNATURE (Stamp is Not Acceptable) | **PRINTED NAME** | **DATE**

Continue to the Next Page for Information Release/Acknowledgements

California Participating Practitioner Application

Addendum A

Practitioner Rights

Right to Review

The practitioner has the right to review information obtained by the Healthcare Organization for the purpose of evaluating that practitioner's credentialing or recredentialing application. This includes non-privileged information obtained from any outside source (e.g., malpractice insurance carriers, state licensing boards), but does not extend to review of information, references or recommendations protected by law from disclosure.

The practitioner may request to review such information at any time by sending a written request, via certified letter, to the Credentialing Department at the Healthcare Organization's offices. The Credentialing Department of the Healthcare Organization's offices will notify the practitioner within 72 hours of the date and time when such information will be available for review at the Credentialing Department office.

Right to be Informed of the Status of Credentialing/Recredentialing Application

Practitioners may request to be informed of the status of their credentialing/recredentialing application. The practitioner may request this information by sending a written request by letter, email or fax to the Credentialing Department of the Healthcare Organization's offices.

The provider will be notified in writing by fax, email or letter no more than seven working days of the current status of your application with respect to outstanding information required to complete the application process.

Notification of Discrepancy

Practitioners will be notified in writing via fax, email or certified letter, when information obtained by primary sources varies substantially from information provided on the practitioner's application. Examples of information that substantial variance include reports of practitioner's malpractice claims history, actions taken against a practitioner's license/certificate, suspension or termination of hospital privileges or board certification expiration when one or more of these examples have not been self-reported by the practitioner on his/her application form. Practitioners will be notified of the discrepancy at the time of primary source verification. Sources will not be revealed if information obtained is not intended for verification of credentialing elements or is protected from disclosure by law.

Correction of Erroneous Information

If a practitioner believes that erroneous information has been supplied to Healthcare Organization by primary sources, the practitioner may correct such information by submitting written notification to the Credentialing Department. Practitioners must submit a written notice, via certified letter, along with a detailed explanation to the Credentialing Department at the Healthcare Organization, within 48 hours of the Healthcare Organization's notification to the practitioner of a discrepancy or within 24 hours of a practitioner's review of his/her credentials file.

Upon receipt of notification from the practitioner, the Healthcare Organization will re-verify the primary source information in dispute. If the primary source information has changed, correct will be made immediately to the practitioner's credentials file. The practitioner will be notified in writing, via certified letter, that the correction has been made to his/her credentials file. If, upon review, primary source information remains inconsistent with practitioner's notification, the Credentialing Department will so notify the practitioner via certified letter. The practitioner may then provide proof of correction by the primary source body to Healthcare Organization's Credentialing Department via certified letter at the address below within 10 working days. The Credentialing Department will re-verify primary source information if such documentation is provided.

Healthcare Organization's Credentialing Department Address:

Address:	5[illegible]5 City [illegible] arkway West				
City:	Orange	ST:	CA	Zip:	92868

APPLICANT SIGNATURE (Stamp is Not Acceptable) ✖

PRINTED NAME ✖

DATE ✖

Policy:	GG.1651Δ
Title:	**Assessment and Re-Assessment of Organizational Providers**
Department:	Medical Management
Section:	Quality Improvement
CEO Approval:	*/s/*
Effective Date:	06/01/2017
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE ☐ Administrative

I. PURPOSE

This policy ~~establishes~~describes the ~~framework to assess~~process by which CalOptima evaluates and determines an Organizational ~~Providers'~~Provider's (OPs) ~~participation~~ eligibility to participate in ~~the CalOptima provider network, prior to contracting and every three (3) years thereafter~~CalOptima programs.

II. POLICY

A. CalOptima shall establish guidelines ~~by which CalOptima shall evaluate and select~~ for evaluation of OPs ~~to participate~~participation eligibility in CalOptima~~,~~ programs, in accordance with ~~Title 42, Code of Federal Regulations, Section 422.204 and other~~ applicable laws, regulations, and regulatory guidance.

B. CalOptima may delegate the assessment and reassessment of OPs to a Health Network in accordance with CalOptima Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities.

1. A Health Network shall establish policies and procedures to assess and reassess OPs to participate in its CalOptima ~~network~~ programs that, at minimum, meet the requirements as outlined in this policy.

C. The Chief Medical Officer (CMO~~),~~) or his or her physician Designee~~,~~ shall have direct responsibility over and shall actively participate in the assessment and reassessment of an OP.

D. The CalOptima Credentialing and Peer Review Committee (CPRC) shall be responsible for reviewing an OP's application information and CalOptima's findings for determining an OP's participation in CalOptima's provider network.

E. CalOptima shall require that the OP be successfully assessed, including confirmation that the OP is in good standing with state and federal regulatory agencies, prior to contracting and every three (3) years thereafter.

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F. CalOptima shall require OPs to be reviewed and approved by an accrediting body or have received an on-site quality assessment consistent with the provisions of this Policy if the provider is not accredited, as applicable.

G. CalOptima shall ensure that the OP is actively enrolled in Medi-Cal and has not opted-out of Medicare, as applicable.

~~H. On a monthly basis, CalOptima shall monitor the Medicare and Medi-Cal Sanction Lists, which include Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE), System for Award Management (SAM), CMS Preclusion List and Medi-Cal Suspended & Ineligible (S&I). CalOptima shall immediately suspend any OP identified on the sanction lists in accordance with CalOptima Policy GG.1607Δ: Monitoring Adverse Actions.~~

H. Upon initial assessment, reassessment, and on a monthly basis, CalOptima shall confirm the Medi-Cal and Medicare participation status of the OP.

I. If CalOptima declines to include an OP in the CalOptima provider network, CalOptima shall notify, in writing, such OP within sixty (60) calendar days of the reason for its decision. An OP shall have the right to file a complaint about the decision in accordance with CalOptima Policies HH.1101: CalOptima Provider Compliant and MA.9006: Provider Complaint Process, as applicable.

J. CalOptima shall maintain the confidentiality of credentialing files, in accordance with CalOptima Policy GG.1604Δ: Confidentiality of Credentialing Files.

~~K. The CalOptima Board of Directors shall review and approve this Policy periodically.~~

III. PROCEDURE

A. OP Initial Assessment

1. Upon notification of an intent to contract, CalOptima shall confirm the OP is in good standing with state and/or federal regulatory agencies based on an examination of the sources listed in Section ~~II.H~~III.C. of this Policy.

2. The OP shall submit an application, signed and dated by an authorized official of the OP, along with the following supplemental documentation:

a. Confirmation that the OP is in compliance with any other applicable state or federal requirements, and possess a business license (or business tax certificate), as applicable;

b. Accreditation and/or Government Issued Certification, as applicable. ~~Issuing bodies include, but are not limited to:~~

i. The Joint Commission (TJC): A copy of the certificate of accreditation by the Joint Commission, or another Centers for Medicare & Medicaid Services (CMS)-deemed accreditation organization for hospitals, ambulatory surgery centers, skilled nursing facilities, and home health agencies;

ii. Accreditation Association for Ambulatory Health Care (AAAHC) for outpatient settings including ambulatory surgery centers, office-based surgery facilities, endoscopy centers, medical and dental group practices, community health centers, and retail clinics;

iii. Commission on Accreditation of Rehabilitation Facilities (CARF) for aging services, behavioral health, child and youth services, vision rehabilitation services, medical rehabilitation, Durable Medical Equipment, prosthetics and orthotics supplies, and opioid treatment programs;

iv. Community Health Accreditation Program (CHAP) for home health agencies, hospice providers, pharmacies, home medical equipment suppliers, private duty nursing, palliative care, and infusion therapy nursing;

v. American Board for Certification (ABC) for prosthetists, orthotists, and pedorthists;

vi. American Speech-Language-Hearing Association (ASHA) for speech, language, hearing and audiology certification;

vii. Durable Medical Equipment (DME) or Durable Medical Equipment Prosthetics Orthotics Supplier (DMEPOS);

viii. Commission on ~~accreditation~~Accreditation of ~~ambulance services~~Ambulance Services (CAAS) for ambulance organizations;

ix. College of American Pathologist (CAP) for laboratories, biorepositories, and reproductive laboratories;

x. Healthcare Quality Association on Accreditation (HQAA) for home medical equipment suppliers, Durable Medical Equipment prosthetics orthotic suppliers, pharmacies; and

xi. Inter-Societal Accreditation Commission (IAC) for radiology or diagnostic imaging providers, and procedure-based modalities.

xii. Det Norske Veritas Germanischer Lloyd (DNV GL)-Health Care for hospitals.

xiii. National Dialysis Accreditation Commission (NDAC) for the accreditation of End State Renal Disease Facilities.

c. If an OP is not accredited, the OP may submit evidence of an on-site quality review by the state, CMS, or similar agency, or CalOptima must provide evidence of on-site quality review. The on-site quality review must include the criteria used for the assessment, and the process for ensuring that the providers credential their Practitioners. The State, CMS, or a similar agency, quality review must be no more than three (3) years old. If the review is older than three (3) years, then CalOptima shall conduct its own onsite quality review.

d. Certificate of current liability insurance of at least the minimum amounts required by provider type per the Contract for Health Care Services, as applicable:

i. General/Commercial Liability Insurance;

ii. Professional liability;

iii. Worker's Compensation Insurance.

e. A copy of any history of sanctions, preclusions, exclusions, suspensions or terminations from Medicare and/or Medi-Cal, as applicable.

f. Active enrollment in Medi-Cal and has not opted-out of Medicare , if applicable;

g. A copy of the organization's Quality Plan, if applicable;

h. Staff roster and copy of all staff certifications, or licensure, if applicable;

i. A valid Type 2 National Provider Identifier (NPI) number;

j. IRS Form SS-4, if applicable; and

k. A current W-9.

3. CalOptima shall conduct and communicate the results of a Facility Site Review (FSR) for Community Clinics and Free-Standing Urgent Care centers providing services to CalOptima Members pursuant to CalOptima Policy GG.1608Δ: Full Scope Site Reviews to incorporate the documents to support review prior to approval decisions.

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

B. OP Re-assessment

1. CalOptima shall reassess an OP at least every three (3) years after initial assessment. At the time of re-assessment, CalOptima shall:

a. Collect and verify, at a minimum, all of the information required for initial assessment, as set forth in Section III.A. of this Policy; and

b. Incorporate the following data in the decision-making process:

i. Quality review activities, including but not limited to, information from:

a) DHCS, CMS, or another agency, as applicable;

b) CalOptima quality review results, including, but not limited to, Grievances, Appeals, Potential Quality Issue (PQI) cases, and Compliance cases, as applicable;

c) Review of Facility Site Review (FSR) or Physical Accessibility Review Survey (PARS) results, as applicable; and

d) Review of Medical Records, as applicable.

ii. Member experience, if applicable;

iii. Liability claims history, if applicable; and

iv. Compliance with the terms of the Provider's contract.

2. CalOptima shall ensure that an OP has current appropriate licensure, accreditation (if applicable), and insurance at all times during such OP's participation in CalOptima.

C. Upon initial assessment, reassessment, and on a monthly basis, CalOptima shall monitor the Medicare and Medi-Cal Sanction Lists, which include Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE), System for Award Management (SAM), CMS Preclusion List, Medi-Cal Suspended & Ineligible (S&I), and DHCS Restricted Provider Database. CalOptima shall immediately suspend any OP identified on the sanction lists in accordance with CalOptima Policy GG.1607Δ: Monitoring Adverse Actions.

D. Credentialing Peer Review Committee (CPRC)

1. ~~CalOptima shall designate a~~ CalOptima's CPRC ~~that uses a peer review process to~~shall make recommendations and decisions regarding ~~CalOptima's provider network~~an OP's eligibility to participate in CalOptima programs through the peer review process, as necessary.

2. Completed OP files will either be presented to the CMO, or his or her physician Designee, on a clean file list for signature, or will be presented at CPRC for review and approval.

   a. A clean file consists of a complete signed application, required supporting documents that are current and valid, and verification there have been no liability claim(s) that resulted in settlements or judgments paid by, or on behalf of, the OP within the last seven (7) years from the date of the assessment has occurred, and confirmation that the OP is in good standing with state and federal regulatory agencies.

      i. A clean file shall be considered approved and effective on the date that the CMO, or his or her physician Designee, review and approve an OP's assessment and re-assessment file, and deem the file clean.

      ii. ~~Approved, clean~~Clean file lists approved by a medical director shall be presented at the CPRC for final approval and reflected in the meeting minutes.

   b. Files that do not meet the clean file review process and require further review by CPRC include but are not limited to those files that include a history of liability claim(s) that resulted in settlements, or judgments, paid by or on behalf of the OP.

      i. Non-clean list files will be reviewed by CPRC for determination to accept, or deny, the application. Files that are incomplete will not be processed until the provider submits all the required information.

      ii. CPRC minutes shall reflect thoughtful consideration of information presented in the file.

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

3. The CPRC shall make recommendations ~~based~~ on the OP's ability to ~~deliver services~~participate in CalOptima programs based on the information ~~collected from the file review process~~reviewed as specified in this Policy.

   a. The CalOptima Quality Improvement Department shall send the OP, or applicant, a decision letter, within sixty (60) calendar days of the ~~Initial~~ decision~~:~~ indicating:

i. Acceptance;

ii. Denial of the application, along with information regarding the right to file a complaint, with a letter of explanation forwarded to the applicant.

4. Upon acceptance of the participation application, the CalOptima Quality Improvement Department shall generate a provider profile and forward the provider profile to the Contracting and Provider Data Management Service (PDMS) Departments. The PDMS Department will enter the contract and provider data into CalOptima's core business system, which updates pertinent information into the online Provider Directory.

IV. ATTACHMENT(S)

A. Organizational Provider Application
B. Onsite Quality Review Tool

V. REFERENCE(S)

A. CalOptima Contract for Health Care Services
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
E. CalOptima PACE Program Agreement
F. CalOptima Policy GG.1604Δ: Confidentiality of Credentialing Files
G. CalOptima Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities
H. CalOptima Policy GG.1607Δ: Monitoring Adverse Actions
I. CalOptima Policy GG.1608Δ: Full Scope Site Reviews
J. CalOptima Policy HH.1101: CalOptima Provider ~~Compliant~~Complaint
K. CalOptima Policy MA.9006: Provider Complaint Process
N. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-004: Provider Credentialing / Recredentialing and Screening / Enrollment
O. California Evidence Code, §1157
P. Title 42, Code of Federal Regulations, §§422.204(a), 422.205, 455.450 and Parts 424~~,~~ and 431 ~~and 455.450~~
Q. Title 45, Code of Federal Regulations, ~~§~~Part 455
R. Title 42, United States Code, §1320a-7(a)
S. Title XVIII and XIV of the Social Security Act
T. Medicare Managed Care Manual Chapter 6-70 Institutional Provider and Supplier Certification

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
07/15/2020	Department of Health Care Services (DHCS)

~~None to Date~~

VII. BOARD ACTION(S)

Date	Meeting
06/01/2017	Regular Meeting of the CalOptima Board of Directors
06/04/2020	Regular Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/01/2017	GG.1651Δ	Credentialing and Recredentialing of Healthcare Delivery Organizations	Medi-Cal OneCare OneCare Connect PACE
Revised	01/01/2018 ~~06/04/2020~~	GG.1651Δ	Credentialing and Recredentialing of Healthcare Delivery Organizations	Medi-Cal OneCare OneCare Connect PACE
Revised	06/04/2020	GG.1651Δ	Assessment and Re-Assessment of Organizational Providers	Medi-Cal OneCare OneCare Connect PACE
Revised	TBD	GG.1651Δ	Assessment and Re-Assessment of Organizational Providers	Medi-Cal OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Appeal	Medi-Cal: A ~~request by the Member or the Member's Authorized Representative for~~ review by CalOptima of ~~any decision to deny, modify,~~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 ~~discontinue~~level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service~~.~~; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the timeframes provided in 42 CFR 438.408(b). OneCare: Any of the procedures that deal with the review of an adverse initial determination made by CalOptima on health care services or benefits under Part C or D the Member believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the Member), or on any amounts the Member must pay for a service or drug as defined in 42 CFR §422.566(b) and §423.566(b). These procedures include reconsideration or redetermination , a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (MAC), and judicial review. OneCare Connect: In general, a Member's actions, both internal and external to CalOptima requesting review of CalOptima's denial, reduction or termination of benefits or services, from CalOptima. Appeals relating to Medi-Cal covered benefits and services shall proceed pursuant to the laws and regulations governing Medi-Cal Appeals. Appeals relating to Medicare covered benefits and services shall proceed pursuant to the laws and regulations governing Medicare Appeals. A Medi-Cal based Appeal is defined as review by CalOptima of an Adverse Benefit Determination. PACE: A Member's action taken with respect to the PACE organization's noncoverage of, modification of, or nonpayment for, a service including denials, reductions or termination of services, as defined by federal PACE regulation 42 CFR Section 460.122.
Credentialing	The process of obtaining, verifying, assessing, and monitoring the qualifications of a provider to provide quality and safe patient care services.
Credentialing Peer Review Committee	Peer review body who reviews provider information and files and makes recommendations and decisions regarding Credentialing and Recredentialing
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.

Term	Definition
Durable Medical Equipment (DME)and Durable Medical Equipment Prosthetics Orthotics Supplier (DMEPOS):	~~Durable~~Medi-Cal & OneCare Connect: Medically Necessary medical equipment ~~means equipment~~that is prescribed ~~by a licensed practitioner to meet medical equipment needs of~~for the Member ~~that~~by Provider and is used in the Member's home, in the community or in an institution that is used as a home. DME: 1. Can withstand repeated use. 2. Is used to serve a medical purpose. 3. Is not useful to an individual in the absence of an illness, injury, functional impairment, or congenital anomaly. 4. Is appropriate for use in or out of the patient's home. OneCare: Durable medical equipment means equipment prescribed by a licensed practitioner to meet medical equipment needs of the Member that: 1. Can withstand repeated use. 2. Is used to serve a medical purpose. 3. Is not useful to an individual in the absence of an illness, injury, functional impairment, or congenital anomaly. ~~1.~~4. Is appropriate for use in or out of the patient's home.
Facility Site Review	An on-site inspection of primary care sites to evaluate the capacity or continuing capacity of a site to support the delivery of quality health care services using the DHCS Facility Site Review (FSR), Medical Record Review (MRR) or Physical Accessibility Review Survey (PARS) tools.

Term	Definition
Grievance	~~An oral or written expression of dissatisfaction, including any Complaint, dispute, request for reconsideration, or Appeal made by a Member.~~Medi-Cal: An oral or written expression of dissatisfaction about any matter other than an action that is an adverse benefit determination, as identified within the definition of an Appeal, and may include, but is not limited to: the quality of care or services provided, interpersonal relationships with a Provider or CalOptima's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima to make an authorization decision. OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. 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." PACE: A complaint, either written or oral, expressing dissatisfaction with service delivery or the quality of care furnished, as defined by the federal PACE regulation 42 CFR Section 460.120.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that health network.
Medical Record Review (MRR)	A DHCS tool utilized to audit PCP medical records for format, legal protocols, and documented evidence of the provision of preventive care and coordination and continuity of care services.
Member	~~An enrollee~~ A beneficiary ~~of~~enrolled in a CalOptima program.
Organizational Provider	For purposes of this Policy, Organizations or institutions that are contracted to provide medical services such ~~as~~, but not limited to: ~~hospitals~~, home health agencies, nursing facilities (includes skilled nursing, long term care, and sub-acute), free standing ambulatory surgical centers, hospice services, community clinics including Federally Qualified Health Centers, urgent care centers, End-Stage renal disease services (dialysis centers), Residential Care Facility for the Elderly (RCFE), Community Based Adult Services (CBAS), Managed Long Term Services and Supports (MLTSS), durable medical equipment suppliers, radiology centers, clinical laboratories, outpatient rehabilitation facilities, outpatient physical therapy and speech pathology providers, diabetes centers, ~~and~~ portable x-ray suppliers and methadone clinics, non-emergency medical transportation (NEMT), mobile blood bank, community home support services for housing, non-medical service practitioners.

Term	Definition
Physical Accessibility Review Survey (PARS)	A DHCS tool used to assess the level of physical accessibility of provider sites, including PCPs, high volume specialists and ancillary service providers, and CBAS centers
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
Provider	Any person or institution that furnishes Covered Services.
Re-Assessment	The process by which provider status is verified in order to make determinations relating to their continued eligibility for participation in the CalOptima program.

1

Policy:	GG.1651Δ
Title:	**Assessment and Re-Assessment of Organizational Providers**
Department:	Medical Management
Section:	Quality Improvement
CEO Approval:	*/s/*
Effective Date:	06/01/2017
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE ☐ Administrative

I. PURPOSE

This policy describes the process by which CalOptima evaluates and determines an Organizational Provider's (OPs) eligibility to participate in CalOptima programs.

II. POLICY

A. CalOptima shall establish guidelines for evaluation of OPs participation eligibility in CalOptima programs, in accordance with applicable laws, regulations, and regulatory guidance.

B. CalOptima may delegate the assessment and reassessment of OPs to a Health Network in accordance with CalOptima Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities.

1. A Health Network shall establish policies and procedures to assess and reassess OPs to participate in its CalOptima programs that, at minimum, meet the requirements as outlined in this policy.

C. The Chief Medical Officer (CMO) or his or her physician Designee shall have direct responsibility over and shall actively participate in the assessment and reassessment of an OP.

D. The CalOptima Credentialing and Peer Review Committee (CPRC) shall be responsible for reviewing an OP's application information and CalOptima's findings for determining an OP's participation in CalOptima's provider network.

E. CalOptima shall require that the OP be successfully assessed, including confirmation that the OP is in good standing with state and federal regulatory agencies, prior to contracting and every three (3) years thereafter.

F. CalOptima shall require OPs to be reviewed and approved by an accrediting body or have received an on-site quality assessment consistent with the provisions of this Policy if the provider is not accredited, as applicable.

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G. CalOptima shall ensure that the OP is actively enrolled in Medi-Cal and has not opted-out of Medicare, as applicable.

H. Upon initial assessment, reassessment, and on a monthly basis, CalOptima shall confirm the Medi-Cal and Medicare participation status of the OP.

I. If CalOptima declines to include an OP in the CalOptima provider network, CalOptima shall notify, in writing, such OP within sixty (60) calendar days of the reason for its decision. An OP shall have the right to file a complaint about the decision in accordance with CalOptima Policies HH.1101: CalOptima Provider Compliant and MA.9006: Provider Complaint Process, as applicable.

J. CalOptima shall maintain the confidentiality of credentialing files, in accordance with CalOptima Policy GG.1604Δ: Confidentiality of Credentialing Files.

III. PROCEDURE

A. OP Initial Assessment

1. Upon notification of an intent to contract, CalOptima shall confirm the OP is in good standing with state and/or federal regulatory agencies based on an examination of the sources listed in Section III.C. of this Policy.

2. The OP shall submit an application, signed and dated by an authorized official of the OP, along with the following supplemental documentation:

a. Confirmation that the OP is in compliance with any other applicable state or federal requirements, and possess a business license (or business tax certificate), as applicable;

b. Accreditation and/or Government Issued Certification, as applicable.

i. The Joint Commission (TJC): A copy of the certificate of accreditation by the Joint Commission, or another Centers for Medicare & Medicaid Services (CMS)-deemed accreditation organization for hospitals, ambulatory surgery centers, skilled nursing facilities, and home health agencies;

ii. Accreditation Association for Ambulatory Health Care (AAAHC) for outpatient settings including ambulatory surgery centers, office-based surgery facilities, endoscopy centers, medical and dental group practices, community health centers, and retail clinics;

iii. Commission on Accreditation of Rehabilitation Facilities (CARF) for aging services, behavioral health, child and youth services, vision rehabilitation services, medical rehabilitation, Durable Medical Equipment, prosthetics and orthotics supplies, and opioid treatment programs;

iv. Community Health Accreditation Program (CHAP) for home health agencies, hospice providers, pharmacies, home medical equipment suppliers, private duty nursing, palliative care, and infusion therapy nursing;

v. American Board for Certification (ABC) for prosthetists, orthotists, and pedorthists;

vi. American Speech-Language-Hearing Association (ASHA) for speech, language, hearing and audiology certification;

vii. Durable Medical Equipment (DME) or Durable Medical Equipment Prosthetics Orthotics Supplier (DMEPOS);

viii. Commission on Accreditation of Ambulance Services (CAAS) for ambulance organizations;

ix. College of American Pathologist (CAP) for laboratories, biorepositories, and reproductive laboratories;

x. Healthcare Quality Association on Accreditation (HQAA) for home medical equipment suppliers, Durable Medical Equipment prosthetics orthotic suppliers, pharmacies; and

xi. Inter-Societal Accreditation Commission (IAC) for radiology or diagnostic imaging providers, and procedure-based modalities.

xii. Det Norske Veritas Germanischer Lloyd (DNV GL)-Health Care for hospitals.

xiii. National Dialysis Accreditation Commission (NDAC) for the accreditation of End State Renal Disease Facilities.

c. If an OP is not accredited, the OP may submit evidence of an on-site quality review by the state, CMS, or similar agency, or CalOptima must provide evidence of on-site quality review. The on-site quality review must include the criteria used for the assessment, and the process for ensuring that the providers credential their Practitioners. The State, CMS, or a similar agency, quality review must be no more than three (3) years old. If the review is older than three (3) years, then CalOptima shall conduct its own onsite quality review.

d. Certificate of current liability insurance of at least the minimum amounts required by provider type per the Contract for Health Care Services, as applicable:

i. General/Commercial Liability Insurance;

ii. Professional liability;

iii. Worker's Compensation Insurance.

e. A copy of any history of sanctions, preclusions, exclusions, suspensions or terminations from Medicare and/or Medi-Cal, as applicable.

f. Active enrollment in Medi-Cal and has not opted-out of Medicare , if applicable;

g. A copy of the organization's Quality Plan, if applicable;

h. Staff roster and copy of all staff certifications, or licensure, if applicable;

i. A valid Type 2 National Provider Identifier (NPI) number;

j. IRS Form SS-4, if applicable; and

k. A current W-9.

3. CalOptima shall conduct and communicate the results of a Facility Site Review (FSR) for Community Clinics and Free-Standing Urgent Care centers providing services to CalOptima Members pursuant to CalOptima Policy GG.1608Δ: Full Scope Site Reviews to incorporate the documents to support review prior to approval decisions.

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

B. OP Re-assessment

1. CalOptima shall reassess an OP at least every three (3) years after initial assessment. At the time of re-assessment, CalOptima shall:

a. Collect and verify, at a minimum, all of the information required for initial assessment, as set forth in Section III.A. of this Policy; and

b. Incorporate the following data in the decision-making process:

i. Quality review activities, including but not limited to, information from:

a) DHCS, CMS, or another agency, as applicable;

b) CalOptima quality review results, including, but not limited to, Grievances, Appeals, Potential Quality Issue (PQI) cases, and Compliance cases, as applicable;

c) Review of Facility Site Review (FSR) or Physical Accessibility Review Survey (PARS) results, as applicable; and

d) Review of Medical Records, as applicable.

ii. Member experience, if applicable;

iii. Liability claims history, if applicable; and

iv. Compliance with the terms of the Provider's contract.

2. CalOptima shall ensure that an OP has current appropriate licensure, accreditation (if applicable), and insurance at all times during such OP's participation in CalOptima.

C. Upon initial assessment, reassessment, and on a monthly basis, CalOptima shall monitor the Medicare and Medi-Cal Sanction Lists, which include Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE), System for Award Management (SAM), CMS Preclusion List, Medi-Cal Suspended & Ineligible (S&I), and DHCS Restricted Provider Database. CalOptima shall immediately suspend any OP identified on the sanction lists in accordance with CalOptima Policy GG.1607Δ: Monitoring Adverse Actions.

D. Credentialing Peer Review Committee (CPRC)

1. CalOptima's CPRC shall make recommendations and decisions regarding an OP's eligibility to participate in CalOptima programs through the peer review process, as necessary.

2. Completed OP files will either be presented to the CMO, or his or her physician Designee, on a clean file list for signature, or will be presented at CPRC for review and approval.

    a. A clean file consists of a complete signed application, required supporting documents that are current and valid, and verification there have been no liability claim(s) that resulted in settlements or judgments paid by, or on behalf of, the OP within the last seven (7) years from the date of the assessment has occurred, and confirmation that the OP is in good standing with state and federal regulatory agencies.

        i. A clean file shall be considered approved and effective on the date that the CMO, or his or her physician Designee, review and approve an OP's assessment and re-assessment file, and deem the file clean.

        ii. Clean file lists approved by a medical director shall be presented at the CPRC for final approval and reflected in the meeting minutes.

    b. Files that do not meet the clean file review process and require further review by CPRC include but are not limited to those files that include a history of liability claim(s) that resulted in settlements, or judgments, paid by or on behalf of the OP.

        i. Non-clean list files will be reviewed by CPRC for determination to accept, or deny, the application. Files that are incomplete will not be processed until the provider submits all the required information.

        ii. CPRC minutes shall reflect thoughtful consideration of information presented in the file.

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

3. The CPRC shall make recommendations on the OP's ability to participate in CalOptima programs based on the information reviewed as specified in this Policy.

    a. The CalOptima Quality Improvement Department shall send the OP, or applicant, a decision letter, within sixty (60) calendar days of the decision indicating:

        i. Acceptance;

        ii. Denial of the application, along with information regarding the right to file a complaint, with a letter of explanation forwarded to the applicant.

4. Upon acceptance of the participation application, the CalOptima Quality Improvement Department shall generate a provider profile and forward the provider profile to the Contracting and Provider Data Management Service (PDMS) Departments. The PDMS Department will enter the contract and provider data into CalOptima's core business system, which updates pertinent information into the online Provider Directory.

IV. ATTACHMENT(S)

A. Organizational Provider Application
B. Onsite Quality Review Tool

V. REFERENCE(S)

A. CalOptima Contract for Health Care Services
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
E. CalOptima PACE Program Agreement
F. CalOptima Policy GG.1604Δ: Confidentiality of Credentialing Files
G. CalOptima Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities
H. CalOptima Policy GG.1607Δ: Monitoring Adverse Actions
I. CalOptima Policy GG.1608Δ: Full Scope Site Reviews
J. CalOptima Policy HH.1101: CalOptima Provider Complaint
K. CalOptima Policy MA.9006: Provider Complaint Process
N. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-004: Provider Credentialing / Recredentialing and Screening / Enrollment
O. California Evidence Code, §1157
P. Title 42, Code of Federal Regulations, §§422.204(a), 422.205, 455.450 and Parts 424 and 431
Q. Title 45, Code of Federal Regulations, Part 455
R. Title 42, United States Code, §1320a-7(a)
S. Title XVIII and XIV of the Social Security Act
T. Medicare Managed Care Manual Chapter 6-70 Institutional Provider and Supplier Certification

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
07/15/2020	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

Date	Meeting
06/01/2017	Regular Meeting of the CalOptima Board of Directors
06/04/2020	Regular Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/01/2017	GG.1651Δ	Credentialing and Recredentialing of Healthcare Delivery Organizations	Medi-Cal OneCare OneCare Connect PACE

Action	Date	Policy	Policy Title	Program(s)
Revised	01/01/2018	GG.1651Δ	Credentialing and Recredentialing of Healthcare Delivery Organizations	Medi-Cal OneCare OneCare Connect PACE
Revised	06/04/2020	GG.1651Δ	Assessment and Re-Assessment of Organizational Providers	Medi-Cal OneCare OneCare Connect PACE
Revised	TBD	GG.1651Δ	Assessment and Re-Assessment of Organizational Providers	Medi-Cal OneCare OneCare Connect PACE

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IX. GLOSSARY

Term	Definition
Appeal	Medi-Cal: A review by CalOptima of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the timeframes provided in 42 CFR 438.408(b). OneCare: Any of the procedures that deal with the review of an adverse initial determination made by CalOptima on health care services or benefits under Part C or D the Member believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the Member), or on any amounts the Member must pay for a service or drug as defined in 42 CFR §422.566(b) and §423.566(b). These procedures include reconsideration or redetermination , a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (MAC), and judicial review. OneCare Connect: In general, a Member's actions, both internal and external to CalOptima requesting review of CalOptima's denial, reduction or termination of benefits or services, from CalOptima. Appeals relating to Medi-Cal covered benefits and services shall proceed pursuant to the laws and regulations governing Medi-Cal Appeals. Appeals relating to Medicare covered benefits and services shall proceed pursuant to the laws and regulations governing Medicare Appeals. A Medi-Cal based Appeal is defined as review by CalOptima of an Adverse Benefit Determination. PACE: A Member's action taken with respect to the PACE organization's noncoverage of, modification of, or nonpayment for, a service including denials, reductions or termination of services, as defined by federal PACE regulation 42 CFR Section 460.122.
Credentialing	The process of obtaining, verifying, assessing, and monitoring the qualifications of a provider to provide quality and safe patient care services.
Credentialing Peer Review Committee	Peer review body who reviews provider information and files and makes recommendations and decisions regarding Credentialing and Recredentialing
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.

Term	Definition
Durable Medical Equipment (DME)and Durable Medical Equipment Prosthetics Orthotics Supplier (DMEPOS);	Medi-Cal & OneCare Connect: Medically Necessary medical equipment that is prescribed for the Member by Provider and is used in the Member's home, in the community or in an institution that is used as a home. DME: 1. Can withstand repeated use. 2. Is used to serve a medical purpose. 3. Is not useful to an individual in the absence of an illness, injury, functional impairment, or congenital anomaly. 4. Is appropriate for use in or out of the patient's home. OneCare: Durable medical equipment means equipment prescribed by a licensed practitioner to meet medical equipment needs of the Member that: 1. Can withstand repeated use. 2. Is used to serve a medical purpose. 3. Is not useful to an individual in the absence of an illness, injury, functional impairment, or congenital anomaly. 4. Is appropriate for use in or out of the patient's home.
Facility Site Review	An on-site inspection of primary care sites to evaluate the capacity or continuing capacity of a site to support the delivery of quality health care services using the DHCS Facility Site Review (FSR), Medical Record Review (MRR) or Physical Accessibility Review Survey (PARS) tools.
Grievance	Medi-Cal: An oral or written expression of dissatisfaction about any matter other than an action that is an adverse benefit determination, as identified within the definition of an Appeal, and may include, but is not limited to: the quality of care or services provided, interpersonal relationships with a Provider or CalOptima's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima to make an authorization decision. OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. 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." 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.

Term	Definition
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that health network.
Medical Record Review (MRR)	A DHCS tool utilized to audit PCP medical records for format, legal protocols, and documented evidence of the provision of preventive care and coordination and continuity of care services.
Member	A beneficiary enrolled in a CalOptima program.
Organizational Provider	For purposes of this Policy, Organizations or institutions that are contracted to provide medical services such as, but not limited to: hospitals, home health agencies, nursing facilities (includes skilled nursing, long term care, and sub-acute), free standing ambulatory surgical centers, hospice services, community clinics including Federally Qualified Health Centers, urgent care centers, End-Stage renal disease services (dialysis centers), Residential Care Facility for the Elderly (RCFE), Community Based Adult Services (CBAS), Managed Long Term Services and Supports (MLTSS), durable medical equipment suppliers, radiology centers, clinical laboratories, outpatient rehabilitation facilities, outpatient physical therapy and speech pathology providers, diabetes centers, portable x-ray suppliers and methadone clinics, non-emergency medical transportation (NEMT), mobile blood bank, community home support services for housing, non-medical service practitioners.
Physical Accessibility Review Survey (PARS)	A DHCS tool used to assess the level of physical accessibility of provider sites, including PCPs, high volume specialists and ancillary service providers, and CBAS centers
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
Provider	Any person or institution that furnishes Covered Services.
Re-Assessment	The process by which provider status is verified in order to make determinations relating to their continued eligibility for participation in the CalOptima program.

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A Public Agency
Better. Together.

Applicant Tax ID:_____

Organizational Provider (OP)
Quality Assessment Application
and Survey of Specialties and Services

The following application is for organizations which intend to contract with CalOptima. Upon approval, organization then becomes eligible contract should CalOptima be in need of the provider type or services organization provides. Please complete application as accurately and completely as possible. Inclomplete applications will not be accepted. In the event organization is assigned with either a moderate or high risk level, CalOptima may perform an on-site visit.

Name of Organization:			
DBA (If Applicable):			
Billing NPI:		**Tax ID:**	
Business Type:	[ ] LLC	[ ] Corporation	[ ] LP

Line of Business Intended to Contract as:

[ ] CalMediConnect	[ ] Medi-Cal	[ ] OneCare
CalOptima Program(s)	[ ] Behavioral Health	[ ] PACE	[ ] MSSP / IHSS

Registrations and Enrollment

Type	ID	Effective Date	Type/Specialty
Medi-Cal Registration/Enrollment			
Medicare Registration/Enrollment			
Medicare (CMS) Certification			
DHCS/California Licensure			
California Children's Services			

Primary Speci lty: _____ *select from one listed in 'Organization Specialty" section below*

Organization Type:

[ ] Agency	[ ] Laboratory	[ ] Respite Care
[ ] Ambulatory Care Facility	[ ] Practitioner/Physician Group	[ ] Supplier
[ ] Hospital	[ ] Nursing & Custodial Care Facility	[ ] Transportation Services
[ ] Hospital Unit	[ ] Residential Treatment Facility	[ ] Other

Count of Accreditations Held _____ **Count of Service Addresses** _____

Business/Administrative Information

Business Address

Street **Suite/Unit #** **City** **State** **Zip**

Phone **Fax**

Business License / Tax Certificate Issued By:

Billing Address

[ ] *Billing is performed by a third party. If so, indicate company name*_____

Street **Suite/Unit #** **City** **State** **Zip**

Phone **Fax**

Mailing Address

[ ] *Mailing address is the same as the business address*

Street **Suite/Unit #** **City** **State** **Zip**

Phone **Fax**

Organization's Authorized Official(s)

Authorized Official Name			
Title			
Email Address		**Contact Phone**	

If applicable to applicant organization, supply the below contact information. **Please note CalOptima uses email as the primary method for communication.** If a similar role is held by your organization, please enter the individuals information.

	Name	**Email Address**
Practitioner Credentialing Contact		
CEO *(Chief Executive Officer)*		
CAO *(Chief Administration Officer)*		
CMO *(Chief Medical Officer)*		
CFO *(Chief Financial Officer)*		
Director of Nursing		

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Applicant Tax ID:_____

Organization Accreditation or Government Issued Certification *(If more than one is held, complete page 3 for each held)*

Accrediting/Certifying Body	
Identification Number	

[ ] Check if on-site visit was performed

Last Survey Date	
Next Survey Date	

Check all which apply below, as it applies to the organization's accreditation or Certification. Data will be used to assist with Member Referrals and Authorizations

Administration

- [ ] Case Management (CM)
- [ ] Credentialing/Staffing (CR)
- [ ] Patient Safety/Plan (PS)
- [ ] Quality Improvement/Plan (QI)
- [ ] Utilization Management (UM)

Programs/Services

- [ ] Ambulatory Care
- [ ] Ambulatory Surgery
- [ ] Anesthesia
- [ ] Aquatic Therapy
- [ ] Behavioral Health
- [ ] Behavioral Health (Home)
- [ ] Canes and Crutches
- [ ] Chronic Kidney Disease
- [ ] Chronic Obstructive Pulmonary Disease
- [ ] Community Integration
- [ ] Comprehensive Cardiac Center
- [ ] Convenient Care
- [ ] CT Scanner
- [ ] Custom Othoses Fabricated
- [ ] Dementia Care
- [ ] Dentistry
- [ ] Diabetes Self Management
- [ ] Diagnostic Imaging
- [ ] Dialysis
- [ ] Donor Center / Testing
- [ ] Durable Medical Equipment
- [ ] EEG/EKG/FMG Lab
- [ ] Emergency Medicine/Department
- [ ] Enteral Nutrients
- [ ] Gastroenterology
- [ ] Gynecology
- [ ] Heart Failure
- [ ] Heart Failure
- [ ] Hip and Knee Replacement

Programs/Services, cont.

- [ ] Home Care
- [ ] Home Health (Aides)
- [ ] Home Health (Non-Hospice)
- [ ] Hospital
- [ ] Hospital (Critical Access)
- [ ] Hospital (Pediatric)
- [ ] Hospital (Psychiatric)
- [ ] Hospital Beds - Electric
- [ ] Hospital Beds - Manual
- [ ] Immunohematology
- [ ] Inpatient Diabetes
- [ ] Inpatient Unit
- [ ] Laboratory (General)
- [ ] Lung Volume Reduction Surgery
- [ ] Magnetic Resonance Imaging (MRI)
- [ ] Medical/Surgical Unit
- [ ] Molecular Testing
- [ ] Nebulizers Equipment
- [ ] Nursing Care
- [ ] Obstetrics
- [ ] Occupational Therapy
- [ ] Office Based Surgery
- [ ] Orthopedic Surgery
- [ ] Out of Hospital Transfusion Administra
- [ ] Out Patient Clinic
- [ ] Trigger Point Injections
- [ ] Palliative Care
- [ ] Palliative Care (Community Based)
- [ ] Patient Lists and Accessories
- [ ] Pediatric Medicine
- [ ] Perform Invasive Procedure
- [ ] Perinatal Care
- [ ] Perioperative Service
- [ ] Personal Care/Support (Non-Hospice)
- [ ] Pharmacy/Dispensary (General)

Programs/Services, cont.

- [ ] Physical Therapy
- [ ] Plastic Surgery
- [ ] Post-Acute Care
- [ ] Primary Care Medical
- [ ] Primary Stroke Center
- [ ] Rehabilitation Services
- [ ] Respiratory Equipment
- [ ] Skilled Nursing (Care)
- [ ] Skilled Nursing (Services)
- [ ] Social Services
- [ ] Social Services (Medical)
- [ ] Speech Language Pathology
- [ ] Stroke (Advance)
- [ ] Stroke (Comprehensive)
- [ ] Supplies
- [ ] Support Surfaces for Beds
- [ ] Thrombectomy-Capable Stroke Center
- [ ] Transfusion Service
- [ ] Ultrasound
- [ ] Ventricular Assist Device
- [ ] Walkers, Canes and Crushes
- [ ] Wheelchairs - Manual (Non-Custom)
- [ ] X-ray
- [ ] _____
- [ ] _____
- [ ] _____
- [ ] _____
- [ ] _____
- [ ] _____
- [ ] _____
- [ ] _____

Organizational Specialties

( ) Single-specialty ( ) Multi-specialty

Please identify all specialties below which apply to applicant organization in which intentions are to either contract or submit claims for. Additionally, for each identified specialty, also identify if either an accreditation, certification and/or license is held by the applicant for the specialty.

Check All Which Apply	Specialty	Taxonomy Code	Current Organizational Accreditation Held	Current State and/or Federal Licensure/ Certification Held
	Agencies			
[ ]	Case Management	251B00000X	[ ]	[ ]
[ ]	Day Training, Developmentally Disabled Services	251C00000X	[ ]	[ ]
[ ]	Home Health	251E00000X	[ ]	[ ]
[ ]	Home Health (subunit)	251E00000X	[ ]	[ ]
[ ]	Home Infusion	251F00000X	[ ]	[ ]
[ ]	Hospice Care, Community Based	251G00000X	[ ]	[ ]
[ ]	Nursing Care	251J00000X	[ ]	[ ]
[ ]	Public Health or Welfare	251K00000X	[ ]	[ ]
[ ]	Community/Behavioral Health	251S00000X	[ ]	[ ]
[ ]	Program of All-Inclusive Care for the Elderly (PACE) Provider Organization	251T00000X	[ ]	[ ]
[ ]	Voluntary or Charitable	251V00000X	[ ]	[ ]
[ ]	Early Intervention Provider Agency	252Y00000X	[ ]	[ ]
[ ]	In Home Supportive Care	253Z00000X	[ ]	[ ]
	Ambulatory Health Care Facilities [Clinic/Center]			
[ ]	Ambulatory Family Planning Facility	261QA0005X	[ ]	[ ]
[ ]	Adult Day Care	261QA0600X	[ ]	[ ]
[ ]	Ambulatory Surgical	261QA1903X	[ ]	[ ]
[ ]	Birthing	261QB0400X	[ ]	[ ]
[ ]	Critical Access Hospital	261QC0050X	[ ]	[ ]
[ ]	Community Health	261QC1500X	[ ]	[ ]
[ ]	Corporate Health	261QC1800X	[ ]	[ ]
[ ]	Dental	261QD0000X	[ ]	[ ]
[ ]	Developmental Disabilities	261QD1600X	[ ]	[ ]
[ ]	Emergency Care	261QE0002X	[ ]	[ ]
[ ]	End-Stage Renal Disease (ESRD) Treatment	261QE0700X	[ ]	[ ]
[ ]	Endoscopy	261QE0800X	[ ]	[ ]
[ ]	Family Planning, Non-Surgical	261QF0050X	[ ]	[ ]
[ ]	Federally Qualified Health Center (FQHC)	261QF0400X	[ ]	[ ]
[ ]	Genetics	261QG0250X	[ ]	[ ]
[ ]	Health Service	261QH0100X	[ ]	[ ]
[ ]	Hearing and Speech	261QH0700X	[ ]	[ ]
[ ]	Infusion Therapy	261QI0500X	[ ]	[ ]
[ ]	Mental Health (Including Community Mental Health Center)	261QM0801X	[ ]	[ ]
[ ]	Adult Mental Health	261QM0850X	[ ]	[ ]
[ ]	Adolescent and Children Mental Health	261QM0855X	[ ]	[ ]
[ ]	Migrant Health	261QM1000X	[ ]	[ ]
[ ]	Magnetic Resonance Imaging (MRI)	261QM1200X	[ ]	[ ]

Check All Which Apply	Specialty	Taxonomy Code	Current Organizational Accreditation Held	Current State and/or Federal Licensure/ Certification Held
Ambulatory Health Care Facilities [Clinic/Center] (cont.)				
[ ]	Medical Specialty	261QM2500X	[ ]	[ ]
[ ]	Methadone	261QM2800X	[ ]	[ ]
[ ]	Podiatric	261QP1100X	[ ]	[ ]
[ ]	Physical Therapy	261QP2000X	[ ]	[ ]
[ ]	Primary Care	261QP2300X	[ ]	[ ]
[ ]	Pain	261QP3300X	[ ]	[ ]
[ ]	Radiology	261QR0200X	[ ]	[ ]
[ ]	Radiology, Mammography	261QR0206X	[ ]	[ ]
[ ]	Radiology, Mobile Mammography	261QR0207X	[ ]	[ ]
[ ]	Radiology, Mobile	261QR0208X	[ ]	[ ]
[ ]	Outpatient Rehabilitation (mixed specialty - OT,PT,SLP)	261QR0400X	[ ]	[ ]
[ ]	Rehabilitation, Comprehensive Outpatient Rehabilitation Facility (CORF)	261QR0401X	[ ]	[ ]
[ ]	Rehabilitation, Cardiac Facilities	261QR0404X	[ ]	[ ]
[ ]	Rehabilitation, Substance Use Disorder	261QR0405X	[ ]	[ ]
[ ]	Research	261QR1100X	[ ]	[ ]
[ ]	Rural Health	261QR1300X	[ ]	[ ]
[ ]	Oral and Maxillofacial Surgery	261QS0112X	[ ]	[ ]
[ ]	Ophthalmologic Surgery	261QS0132X	[ ]	[ ]
[ ]	Sleep Disorder Diagnostic	261QS1200X	[ ]	[ ]
[ ]	Urgent Care	261QU0200X	[ ]	[ ]
[ ]	Occupational Medicine	261QX0100X	[ ]	[ ]
[ ]	Oncology	261QX0200X	[ ]	[ ]
[ ]	Oncology, Radiation	261QX0203X	[ ]	[ ]
[ ]	Optometry	152W00000X	[ ]	[ ]
Hospitals				
[ ]	Chronic Disease Hospital	281P00000X	[ ]	[ ]
[ ]	Chronic Disease Hospital [Pediatric]	281PC2000X	[ ]	[ ]
[ ]	Long Term Care Hospital	282E00000X	[ ]	[ ]
[ ]	General Acute Care Hospital	282N00000X	[ ]	[ ]
[ ]	General Acute Care Hospital [Critical Care]	282NC0060X	[ ]	[ ]
[ ]	General Acute Care Hospital [Pediatric]	282NC2000X	[ ]	[ ]
[ ]	General Acute Care Hospital [Rual]	282NR1301X	[ ]	[ ]
[ ]	General Acute Care Hospital [Women's]	282NW0100X	[ ]	[ ]
[ ]	Psychiatric Hospital	283Q00000X	[ ]	[ ]
[ ]	Rehabilitation Hospital	283X00000X	[ ]	[ ]
[ ]	Rehabilitation Hospital [Pediatric]	283XC2000X	[ ]	[ ]
[ ]	Religious Non-Medical Health Care Institution	282J00000X	[ ]	[ ]
[ ]	Special Hospital	284300000X	[ ]	[ ]
[ ]	Military Hospital	286500000X	[ ]	[ ]
[ ]	Military Hospital [General Acute Care Hospital]	2865M2000X	[ ]	[ ]

Check All Which Apply	Specialty	Taxonomy Code	Current Organizational Accreditation Held	Current State and/or Federal Licensure/ Certification Held
	Hospital Units			
[ ]	Epilepsy Unit	273100000X	[ ]	[ ]
[ ]	Psychiatric Unit	273R00000X	[ ]	[ ]
[ ]	Rehabilitation Unit	273Y00000X	[ ]	[ ]
[ ]	Medicare Defined Swing Bed Unit	275N00000X	[ ]	[ ]
[ ]	Rehabilitation, Substance Use Disorder Unit	276400000X	[ ]	[ ]
	Laboratories			
[ ]	Military Clinical Medical Laboratory	291900000X	[ ]	[ ]
[ ]	Clinical Medical Laboratory	291U00000X	[ ]	[ ]
[ ]	Dental Laboratory	292200000X	[ ]	[ ]
[ ]	Physiological Laboratory	293D00000X	[ ]	[ ]
	Organizations			
[ ]	Exclusive Provider Organization	302F00000X	[ ]	[ ]
[ ]	Health Maintenance Organization	302R00000X	[ ]	[ ]
[ ]	Preferred Provider Organization	305R00000X	[ ]	[ ]
[ ]	Point of Service	305S00000X	[ ]	[ ]
	Nursing & Custodial Care Facilities			
[ ]	Assisted Living Facility	310400000X	[ ]	[ ]
[ ]	Intermediate Care Facility, Mental Illness	310500000X	[ ]	[ ]
[ ]	Alzheimer Center (Dementia Center)	311500000X	[ ]	[ ]
[ ]	Custodial Care Facility	311Z00000X	[ ]	[ ]
[ ]	Custodial Care Facility [Adult Care Home]	311ZA0620X	[ ]	[ ]
[ ]	Nursing Facility/Intermediate Care Facility	313M00000X	[ ]	[ ]
[ ]	Skilled Nursing Facility	314000000X	[ ]	[ ]
[ ]	Skilled Nursing Facility [Pediatric]	3140N1450X	[ ]	[ ]
[ ]	Hospice, Inpatient	315D00000X	[ ]	[ ]
[ ]	Intermediate Care Facility, Mentally Retarded	315P00000X	[ ]	[ ]
	Residential Treatment Facilities			
[ ]	Residential Treatment Facility, Mental Retardation and/or Developmental Disabilities	320600000X	[ ]	[ ]
[ ]	Residential Treatment Facility, Physical Disabilities	320700000X	[ ]	[ ]
[ ]	Community Based Residential Treatment Facility, Mental Illness	320800000X	[ ]	[ ]
[ ]	Community Based Residential Treatment Facility, Mental Retardation and/or Developmental Disabilities	320900000X	[ ]	[ ]
[ ]	Residential Treatment Facility, Emotionally Disturbed Children	322D00000X	[ ]	[ ]
[ ]	Psychiatric Residential Treatment Facility	323P00000X	[ ]	[ ]
[ ]	Substance Abuse Rehabilitation Facility	324500000X	[ ]	[ ]
[ ]	Substance Abuse Rehabilitation Facility [Pediatric]	3245S0500X	[ ]	[ ]
	Respite Care Facility			
[ ]	Respite Care	385H00000X	[ ]	[ ]

Check All Which Apply	Specialty	Taxonomy Code	Current Organizational Accreditation Held	Current State and/or Federal Licensure/ Certification Held
Suppliers				
[ ]	Blood Bank	331L00000X	[ ]	[ ]
[ ]	Military/U.S. Coast Guard Pharmacy	332000000X	[ ]	[ ]
[ ]	Department of Veterans Affairs (VA) Pharmacy	332100000X	[ ]	[ ]
[ ]	Non-Pharmacy Dispensing Site	332900000X	[ ]	[ ]
[ ]	Durable Medical Equipment & Medical Supplies	332B00000X	[ ]	[ ]
[ ]	Durable Medical Equipment & Medical Supplies[Customized Equipment]	332BC3200X	[ ]	[ ]
[ ]	Durable Medical Equipment & Medical Supplies[Dialysis Equipment]	332BD1200X	[ ]	[ ]
[ ]	Durable Medical Equipment & Medical Supplies[Nursing Facility Supplies]	332BN1400X	[ ]	[ ]
[ ]	Durable Medical Equipment & Medical Supplies[Perenteral & Enteral Nutrition]	332BP3500X	[ ]	[ ]
[ ]	Durable Medical Equipment & Medical Supplies [Oxygen Equipment & Supplies]	332BX2000X	[ ]	[ ]
[ ]	Eyewear Supplier	332H00000X	[ ]	[ ]
[ ]	Hearing Aid Equipment	332S00000X	[ ]	[ ]
[ ]	Home Delivered Meals	332U00000X	[ ]	[ ]
[ ]	Emergency Response System Companies	333300000X	[ ]	[ ]
[ ]	Pharmacy	333600000X	[ ]	[ ]
[ ]	Pharmacy[Clinic Pharmacy]	3336C0002X	[ ]	[ ]
[ ]	Pharmacy[Community Retail]	3336C0003X	[ ]	[ ]
[ ]	Pharmacy[Compounding Pharmacy]	3336C0004X	[ ]	[ ]
[ ]	Pharmacy[Home Infusion Therapy Pharmacy]	3336H0001X	[ ]	[ ]
[ ]	Pharmacy[Institutional Pharmacy]	3336I0012X	[ ]	[ ]
[ ]	Pharmacy[Long Term Care Pharmacy]	3336L0003X	[ ]	[ ]
[ ]	Pharmacy[Mail Order Pharmacy]	3336M0002X	[ ]	[ ]
[ ]	Pharmacy[Managed Care Organization Pharmacy]	3336M0003X	[ ]	[ ]
[ ]	Pharmacy[Nuclear Pharmacy]	3336N0007X	[ ]	[ ]
[ ]	Pharmacy[Specialty Pharmacy]	3336S0011X	[ ]	[ ]
[ ]	Prosthetic/Orthotic Supplier	335E00000X	[ ]	[ ]
[ ]	Medical Foods Supplier	335G00000X	[ ]	[ ]
[ ]	Organ Procurement Organization	335U00000X	[ ]	[ ]
[ ]	Portable X-ray and r Other Portable Diagnostic Imaging Supplier	335V00000X	[ ]	[ ]
Transportation Services				
[ ]	Ambulance [Air Transport]	3416A0800X	[ ]	[ ]
[ ]	Ambulance [Land Transport]	3416L0300X	[ ]	[ ]
[ ]	Ambulance Water Transport]	3416S0300X	[ ]	[ ]
[ ]	Military/U.S. Coast Guard Transport	341800000X	[ ]	[ ]
[ ]	Secured Medical Transport (VAN)	343800000X	[ ]	[ ]
[ ]	Non-emergency Medical Transport (VAN)	343900000X	[ ]	[ ]
[ ]	Transportation Broker	347E00000X	[ ]	[ ]

If specialty is not found in this section please provide the following:

	Specialty	Taxonomy Code *(if known)*
Primary Specialty		
Specialty 2		
Specialty 3		
Specialty 4		
Specialty 5		
Specialty 6		

Sec ion intentionally left blank

CalOptima
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Applicant Tax ID:_____

Service Address(es) | **Location 1 of _____**

[ ] Check if location is included in organization's accreditation

Address Type(s) **[ ] After hours** **[ ] Service Address** **[ ] Unit**

If applicable, alternate location name

Location NPI

Street **Suite/Unit#** **City** **State** **Zip**

Member Access Phone

Member Fax

Admit Address for After Hours? ☐ YES ☐ NO

After Hours Phone Number

Website URL:

Administrative Contact for Location

Name Phone Email

Hours of Operation: **[ ] Check if open 24/7**

☐ Including holidays ☐ Excluding holidays

		SUN	MON	TUE	WED	THU	FRI	SAT
AM	Open	:	:	:	:	:	:	:
	Close	:	:	:	:	:	:	:
PM	Open	:	:	:	:	:	:	:
	Close	:	:	:	:	:	:	:

Ages Served

[ ] Per-Natal **[ ] Child** **[ ] Adult**

[ ] Infant **[ ] Adolescent** **[ ] Geriatric**

Languages Spoken

Enter all languages spoken by Member facing staff

Special Services at Location

☐ Location is Enrolled in Medi-Cal

☐ Telehealth Distant Site

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Applicant Tax ID:_____

Service Address(es) | **Location 2 of _____**

[ ] Check if location is included in organization's accreditation

Address Type(s) **[ ] After hours** **[ ] Service Address** **[ ] Unit**

If applicable, alternate location name

Location/Unit NPI

Street **Suite/Unit#** **City** **State** **Zip**

Member Access Phone

Member Fax

Admit Address for After Hours? ☐ YES ☐ NO

After Hours Phone Number

Website URL:

Administrative Contact for Location

Name Phone Email

Hours of Operation: **[ ] Check if open 24/7**

☐ Including holidays ☐ Excluding holidays

		SUN	MON	TUE	WED	THU	FRI	SAT
AM	Open	:	:	:	:	:	:	:
	Close	:	:	:	:	:	:	:
PM	Open	:	:	:	:	:	:	:
	Close	:	:	:	:	:	:	:

Ages Served

[ ] Per-Natal **[ ] Child** **[ ] Adult**

[ ] Infant **[ ] Adolescent** **[ ] Geriatric**

Languages Spoken

Enter all languages spoken by member facing staff

Special Services at Location

☐ Location is Enrolled in Medi-Cal

☐ Telehealth Distant Site

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Applicant Tax ID:_____

Service Address(es)	Location 3 of _____

[ ] Check if location is included in organization's accreditation

Address Type(s) [ ] After hours [ ] Service Address [ ] Unit

If applicable, alternate location name	
Location NPI	

Street **Suite/Unit#** **City** **State** **Zip**

Member Access Phone

Member Fax

Admit Address for After Hours? ☐ YES ☐ NO

After Hours Phone Number

Website URL:

Administrative Contact for Location

Name **Phone** **Email**

Hours of Operation [ ] Check if open 24/7

☐ Including holidays ☐ Excluding holidays

		SUN	MON	TUE	WED	THU	FRI	SAT
AM	Open	:	:	:	:	:	:	:
	Close	:	:	:	:	:	:	:
PM	Open	:	:	:	:	:	:	:
	Close	:	:	:	:	:	:	:

Ages Served

[ ] Peri-Natal [ ] Child [ ] Adult
[ ] Infant [ ] Adolescent [ ] Geriatric

Languages Spoken

Enter all languages spoken by member facing staff

Special Services at Location

☐ Location is Enrolled in Medi-Cal ☐ Telehealth Distant Site

Attestation

I attest that all of the information submitted by me in this document is true, correct, and complete to the best of my knowledge and belief. I understand that any significant misstatements in, or omissions from, this application may constitute cause for denial of participation or cause for summary dismissal from CalOptima or be subject to applicable State or Federal penalties for perjury. I warrant that I have the authority to sign this applic i on behalf of the entity for which I am signing in a representative capacity.

You and your agents must meet CalOptima's Eligibility Status requirements. This means that you and your agents must be eligible to participate in Federal and/or State healthcare programs, including the Medi-Cal Program (not currently suspended, excluded or otherwise ineligible and not excluded at any time based on a mandatory exclusion in 42 U.S.C. 1396a-7(a), hold appropriate government issued licensures, not held liable in any criminal or civil proceedings for fraud waste or abuse and not convicted of a criminal offense related to healthcare in the prior seven (7) years).

Persons or entities that do not meet the Eligibility Status requirements are not eligible to receive reimbursement from CalOptima. As referred to in this application which also erves as CalOptima's registration form, "your agents" means all of your employees, subcontractors, and/or agents furnishing items or services to CalOptima and its members.

You and your agents must comply with any exec e contra s with CalOptima, CalOptima's Compliance Program, all CalOptima Policies and Procedures applicable to items a /or services you furnish to CalOptima and its members.

Name of Authorized Official

Title of Authorized Official

Signature of Authorized Official

Date

Email Address

Submit completed application and supplemental documents to

OrgProviderQuality@CalOptima.org

Organizational Provider/ Site Review Tool & Corrective Action Plan					Survey Date:	
Type of Organizational Provider					**Reviewer Information**	
	Total Number of on-site staff =				**Reviewer Name:**	
Name of Organization:	Physician(s)		NP(s)			
	RN(s)		PA(s)		**Reviewer's Organization Name:**	
Address, City, ST, ZIP:	LVN(s)		RD(s)			
	Clerical (s)		LCSW/SW(s)		**Reviewer Phone:**	
Phone:	Other:					
	Site Visit Purpose				**Reviewer Email:**	
Fax Number:		**Initial Assessment/ Re-Assessment (Mark X if applicable)**				
		Complaint Review (Mark X if applicable)				
Administrator Name:		**CAP Follow-up 1 (Date of this Follow-up)**			**Corrective Action Plan**	
		CAP Follow-up 2 (Date of this Follow-up)			**Scores below [enter % per your organizations policy] require a CAP.**	
Nursing Director Name:						
		Other:			**[Optional may define other CAP requirements here] Critical element deficiency requires CAP regardless of score.**	
Medical Director Name:						

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Assessment Summary				
		Points Earned	Actual Available Points*	Possible Available Points*
A.	Administrative Services	0	0	4
B.	Policies & Procedures	0	0	10
C.	Personnel	0	0	4
D.	Environment	0	0	9
E.	Environment - Emergency Plan	0	0	7
F.	Infection Control	0	0	11
G.	QAPI	0	0	5
H.	QAPI - Documents	0	0	5
I.	Medical Records	0	0	6

CAP INFORMATION	
Next Follow-up Date:	
Next Follow-up Date:	
CAP Closure Date:	
In-person visit	
Documentation Req'd	
Telephone follow-up	

Facility Score	
Total Points Earned:	0
Total Points Available:*	0
Total Score :	#DIV/0!

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Name of Organization:	Date of Survey:			Facility Audit Tool
A. Administrative Services	**YES**	**NO**	**N/A**	**COMMENTS**
1. Organization has local, state License/Certification as needed. Information is appropriately posted.				
2. There is an established organizational structure with defined functions and responsibilities. (This may be an organizational chart or other document)				
3. The OP clearly identified contracted services and temporary staff.				
4. There is access to interpreter services for patients with limited English proficiency and those with hearing impairments.				
B. Policies & Procedures	**YES**	**NO**	**N/A**	**COMMENTS**
1. Medical Record keeping				
2. Infection Control				
· Qualified Infection Control Professional				
· Vaccinations encouraged and monitored				
· Personal Protective Equipment				
· Hazardous waste				
3. Equipment Maintenance				
4. Emergency Procedures				
5. Patient Rights: The patients' rights are protected according to the regulations appropriate for the facility. This may include the right to give informed consent (in the appropriate language) ; the right to privacy and the privacy of personally identifiable healthcare information; and the right to report grievances , abuse or neglect.				
6. There is a policy & procedure regarding licensure & credentialing and privileging of staff.				
7. There is evidence that the policies & procedures have been reviewed, revised, and approved. periodically				

C. Personnel	YES	NO	N/A	COMMENTS
1. Physician(s) and other LIP(s) are credentialed and privileged according to policy and procedures.				
2. Rendering and Supervising Personnel have License, Training, and Education on file.				
3. There is evidence that agency/contracted staff are appropriately reviewed.				
4. There is documentation of staff education and training.				

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Name of Organization:	Date of Survey:			Facility Audit Tool
D. Environment	**YES**	**NO**	**N/A**	**COMMENTS**
1. There are accessible exits which are clearly marked and emergency evacuation routes are posted.				
2. There is evidence of sufficient fire protection equipment (smoke detectors, fire extinguishers, fire blankets, etc.) and a record of fire drills.				
3. Medical equipment is clean, in good working condition and inspected according to policy and procedures to assure safety.				
4. There is sufficient handicap parking, access and accommodations within the building.				
5. Bio hazard waste is handled appropriately and there is a contract for its regular disposal.				
6. The facility is clean and the waiting area is of sufficient size to accommodate patients comfortably and to assure privacy during registration.				
7. Life Safety Code waivers (if any) no not adversely affect the operation of the facility.				
8. OP with special requirements (such as Dialysis Centers and Ambulatory surgical centers) follow established guidelines.				
9. Medication refrigerator temperature trending logs are correct and complete per policy and procedure.				

E. Environment - Emergency Plan	**YES**	**NO**	**N/A**	**COMMENTS**
1. The OP has a health care emergency plan in which staff have received training.				
2. If part of the plan, a readily accessible Crash Cart is on site that contains at least the follo ing:				
a. Defibrillator, or AED.				
b. Suction				
c. Airway Management Devices (airways, oxygen masks/cannulas, ambu b g)				
d. Medications (per Medical Emergencies Policy)				
3. Emergency phone numbers posted at nurse's station ar c rent.				
4. Staff with Advance Life Support (ALS) and/or Basic Life Support (BLS) are identified and their certification is current				

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Name of Organization:	Date of Survey:			Facility Audit Tool
F. Infection Control Practices	**YES**	**NO**	**N/A**	**COMMENTS**
1. Does the OP have an infection control program based on established Policies and Procedures.				
2. Does the Infection Control program follow recognized guidelines.				
3. Does the OP have a licensed professional qualified to direct the program.				
4. Does the OP have a system to encourage vaccinations and prevent the spread of infections.				
5. Do staff members receive IC training.				
6. Do staff perform good hand hygiene.				
7. Do staff use good injection practices(injectable medication, saline, and other infusates)				
8. Environmental cleaning is appropriate and staff receive training				
9. Point of care devices used and cleaned appropriately.				
10. Proper use of Personal Protective Equipment observed (gloves, gowns, masks, etc.)				
11. Infection Control information is reviewed as part of Quality Assurance Performance Improvement.				

G. Quality Assurance Performance Improvement (QAPI)	**YES**	**NO**	**N/A**	**COMMENTS**
1. Is there a QAPI committee which meets regularly and keeps minutes				
2. The QAPI committee reviewed performance standards for medical records, infection control, environment, personnel and other areas of concern.				
3. The QAPI identified concerns, initiated corrective actions plans, monitored the results of the plans, and made appropriate changes based on an analysis of the data.				
4. The QAPI committee is aware of serious events (sentinel events, abuse allegations, privacy breaches, complaints and grievances) and takes appropriate actions.				
5. The QAPI committee has reviewed surveys, inspections, and reports submitted by outside agencies. Corrective action plans are available.				

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Name of Orgaization:	Date of Survey:			Facility Audit Tool
H. QAPI Documentation Which Demonstrates Compliance	**YES**	**NO**	**N/A**	**COMMENTS**
1. Designated QA&PI coordinator.				
2. The QAPI committee reviewed performance standards for medical records, infection control, environment, personnel and other areas of concern.				
3. The QAPI identified concerns, initiated corrective action plans, monitored the results of the plans and made changes on based on an analysis of the data.				
4. The QAPI committee is aware of serious events (sentinel events, abuse allegations, privacy breaches, complaints and grievances) and takes appropriate actions.				
5. The QAPI committee has reviewed surveys, inspections, and reports from outside agencies. They have copies of the corrective action plans.				

I. Medical Records/BH Review	**YES**	**NO**	**N/A**	**COMMENTS**
1. The Policies and Procedures must reflect current practices, assure privacy, and include Electronic Medical Records if used. All entries in the medical record follow established policy and procedure.				
2. Admission data is complete, informed consents, H&P and notes are signed and dated.				
3. All known Allergies are noted in the record.				
4. The medical records are uniquely identified to safeguard patient privacy.				
5. Advanced directives and surrogate healthcare decision makers are noted in the record.				
6 . Policy and procedures allow prompt retrieval and long term storage of medical records fo the time required by regulation.				

Additional Information	**YES**	**NO**	**N/A**	**COMMENTS**

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Organizational Provider/ Site Review Tool

Corrective Action Plan (CAP) Follow-Up

Name of Organization:	Date of Survey	Reviewer Name:	
	DD/MM/YYY	(Reviewer Name here)	
Deficiency # and Description	**Date of Comment**	**Comments**	**CAP Closed**

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Policy:	GG.1655
Title:	**Reporting Provider Preventable Conditions (PPC)**
Department:	Medical Management
Section:	Quality Improvement
CEO Approval:	
Effective Date:	05/01/2017
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy describes the method by which CalOptima reports Provider Preventable Conditions (PPC) to the Department of Health Care Services (DHCS).

II. POLICY

A. ~~In~~CalOptima shall report PPC events to DHCS in accordance with Title 42, Code of Federal Regulations (C.F.R), Section 438.3(g~~).~~) and DHCS guidance, including All Plan Letter (APL) 17-009: Reporting Requirements Related to Provider Preventable Conditions~~, CalOptima shall report PPC events to the Department of Health Care Services (DHCS).~~ and Duals Plan Letter (DPL) 17-002: Reporting Requirement Related to Provider Preventable Conditions.

B. CalOptima shall screen claims and Encounter data received from its Health Networks and Network Providers for the presence of PPCs.

C. PPC reports submitted by CalOptima shall include PPCs identified through a review of Encounter and claims data submitted by Health Networks or Network Providers, as well as PPCs reported directly to CalOptima ~~through the DHCS 7107 Form or its equivalent.~~when the Health Network or Network Provider reports via the DHCS portal.

~~1. Network Providers shall submit PPCs to CalOptima in accordance with Section III.B of this Policy.~~

~~2.~~1. Health Networks and Network Providers shall submit PPCs to DHCS in accordance with California Welfare & Institutions Code, Section 14131.11(f) and in a manner specified by DHCS.

~~D. CalOptima shall not issue payment to Medi-Cal providers for the treatment of PPCs.~~

2. Health Networks and Network Providers shall submit PPCs to CalOptima in accordance with Section III.B of this Policy.

~~E.~~D. Health Networks and Network Providers shall report all PPC events, regardless of ineligibility for reimbursement.

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~~F.~~E. CalOptima shall issue a special notice informing Health Networks and Network Providers of the requirement to submit PPCs utilizing DHCS' secure on-line reporting portal.

~~G.~~F. Health Networks and Network Providers shall have policies and procedures, in compliance with State and Federal guidance for PPCs, which are consistent with DHCS All Plan Letter (APL ~~16-011~~) 17-009: Reporting Requirements Related to Provider Preventable Conditions~~,~~ and DPL 17-002: Reporting Requirements Related to Provider Preventable Conditions and their obligations under CalOptima's Health Network Service Agreement.

G. CalOptima shall not issue payment to a Network Provider for the treatment of PPCs, except when the PPC existed prior to the initiation of treatment for the Member by the Network Provider. Overpayment recovery shall be in accordance with CalOptima Policies FF.2001: Claims Processing for Covered Services for which CalOptima is Financially Responsible.

III. PROCEDURE

A. ~~CalOptima's~~The CalOptima Quality Improvement (QI) Department shall review claims and Encounter data submitted by Health Networks and Network Providers for potential PPC events~~.~~, on a monthly basis.

1. CalOptima shall ~~complete~~submit the PPC via the DHCS ~~7107 form~~PPC online portal for any PPC event identified through the screening process ~~and shall submit it in the manner specified by DHCS~~ on a monthly basis.

2. CalOptima shall notify Health Networks and Network Providers of any PPC events identified through the screening process.

B. Network Providers shall report PPC events directly to DHCS in a manner specified by DHCS~~,~~ and shall send secure copies of ~~all DHCS 7107 Forms~~PPC submission to CalOptima's Quality Improvement (QI) Department via e-mail to qualityofcare@caloptima.org or fax to 657-900-1615.

C. CalOptima shall retain copies of all ~~DHCS 7107 Forms submitted.~~PPCs submitted to DHCS, in accordance with CalOptima Policy HH.2022Δ: Record Retention and Access.

IV. ATTACHMENTS

Not Applicable
~~A. DHCS Form 7107: Medi-Cal Provider Preventable Conditions (PPC) Reporting Form~~

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Network Service Agreement
C. CalOptima Policy FF.2001: Claims Processing for Covered Services for which CalOptima is Financially Responsible
D. CalOptima Policy HH.2022Δ: Record Retention and Access
~~B. CalOptima Policy MA.1005: Hospital Acquired Conditions Reimbursement~~
E. Department of Health Care Services (DHCS) All Plan Letter 17-009: Reporting Requirements Related to Provider Preventable Conditions
~~C.~~F. Department of Health Care Services (DHCS) Duals Plan Letter (DPL) 17-002: Reporting Requirement Related to Provider Preventable Conditions
~~D.~~G. Title 42, Code of Federal Regulations (C.F.R), §§434.6(a)(12), 438.8(g), and 447.26
~~E.~~H. Welfare & Institutions Code, §14131.11

VI. REGULATORY AGENCY APPROVALS

Date	Regulatory Agency
06/09/2017	Department of Health Care Services (DHCS)
10/26/2021	Department of Health Care Services (DHCS)

VII. BOARD ACTIONS

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/2017	GG.1655	Reporting Provider Preventable Conditions (PPC)	Medi-Cal
Revised	TBD	GG.1655	Reporting Provider Preventable Conditions (PPC)	Medi-Cal ~~OneCare~~ OneCare Connect

IX. GLOSSARY

Term	Definition
Encounter	Any single medically related service rendered by (a) medical provider(s) to a Member enrolled in CalOptima during the date of service. It includes, but is not limited to, all services for which CalOptima incurred any financial liability.
Health Care Acquired Conditions (HCACs)	As defined in ~~Tile~~Title 42 of the Code of Federal Regulations (C.F.R), Section 447.26(b), any one of the following conditions, occurring in any inpatient hospital setting, identified as a Hospital Acquired Condition (HAC) by the Secretary under section 1886(d)(4)(D)(iv) of the Social Security Act for purposes of the Medicare program identified in the State plan as described in section 1886(d)(4)(D)(ii) and (iv) of the Social Security Act. • Any unintended foreign object retained after surgery • A clinically significant air embolism • An incidence of blood incompatibility • A stage III or stage IV pressure ulcer that developed during the patient's stay in the hospital • A significant fall or trauma that resulted in fracture, dislocation, intracranial injury, crushing injury, burn, or electric shock • A catheter-associated urinary tract infection • Any of the following manifestations of poor glycemic control: diabetic ketoacidosis; nonketotic hyperosmolar coma; hypoglycemic coma; secondary diabetes with ketoacidosis; or secondary diabetes with hyperosmolarity • A surgical site infection following: ▪ Coronary artery bypass graft (CABG) - mediastinitis ▪ Bariatric surgery; including laparoscopic gastric bypass, gastroenterostomy, laparoscopic gastric restrictive surgery ▪ Orthopedic procedures; including spine, neck, shoulder, elbow ▪ Cardiac implantable electronic device procedures • Deep vein thrombosis/pulmonary embolism following total knee replacement or hip replacement with pediatric and obstetric exceptions • Latrogenic pneumothorax with venous catheterization • • A vascular catheter-associated infection
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO), that contracts with CalOptima to provide Covered Services to Members assigned to that ~~Health Network.~~health network.
Member	A beneficiary enrolled in a CalOptima Program.
Network Provider	~~A~~For purposes of this Policy, a Provider that subcontracts with CalOptima Direct or a Health Network for the delivery of the Medi-Cal or OneCare Connect Covered Services to Members.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, or other person or institution that furnishes Covered Services.

Term	Definition
Other Provider Preventable Conditions (OPPCs)	As defined in 42 CFR 447.26, a condition occurring in any health care setting that meets the following criteria: 1. Is identified by the State Plan; 2. Is reasonably preventable through the application of procedures supported by evidence-based guidelines; 3. Has negative consequences for the Member; 4. Is auditable; and 5. Includes, at a minimum, the following procedures: • Wrong surgical or other invasive procedure performed on a patient. • Surgical or other invasive procedure performed on the wrong body part. • • Surgical or other invasive procedure performed on the wrong patient.
Provider Preventable Condition (PPC)	A condition that meets the definition of a "health care-acquired condition" or an "other provider-preventable condition," as defined in 42 CFR 447.26(b)

1

Policy:	GG.1655
Title:	**Reporting Provider Preventable Conditions (PPC)**
Department:	Medical Management
Section:	Quality Improvement
CEO Approval:	
Effective Date:	05/01/2017
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy describes the method by which CalOptima reports Provider Preventable Conditions (PPC) to the Department of Health Care Services (DHCS).

II. POLICY

A. CalOptima shall report PPC events to DHCS in accordance with Title 42, Code of Federal Regulations (C.F.R), Section 438.3(g) and DHCS guidance, including All Plan Letter (APL) 17-009: Reporting Requirements Related to Provider Preventable Conditions and Duals Plan Letter (DPL) 17-002: Reporting Requirement Related to Provider Preventable Conditions.

B. CalOptima shall screen claims and Encounter data received from its Health Networks and Network Providers for the presence of PPCs.

C. PPC reports submitted by CalOptima shall include PPCs identified through a review of Encounter and claims data submitted by Health Networks or Network Providers, as well as PPCs reported directly to CalOptima when the Health Network or Network Provider reports via the DHCS portal.

1. Health Networks and Network Providers shall submit PPCs to DHCS in accordance with California Welfare & Institutions Code, Section 14131.11(f) and in a manner specified by DHCS.

2. Health Networks and Network Providers shall submit PPCs to CalOptima in accordance with Section III.B of this Policy.

D. Health Networks and Network Providers shall report all PPC events, regardless of ineligibility for reimbursement.

E. CalOptima shall issue a special notice informing Health Networks and Network Providers of the requirement to submit PPCs utilizing DHCS' secure on-line reporting portal.

F. Health Networks and Network Providers shall have policies and procedures, in compliance with State and Federal guidance for PPCs, which are consistent with DHCS All Plan Letter (APL) 17-009: Reporting Requirements Related to Provider Preventable Conditions and DPL 17-002:

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Reporting Requirements Related to Provider Preventable Conditions and their obligations under CalOptima's Health Network Service Agreement.

G. CalOptima shall not issue payment to a Network Provider for the treatment of PPCs, except when the PPC existed prior to the initiation of treatment for the Member by the Network Provider. Overpayment recovery shall be in accordance with CalOptima Policies FF.2001: Claims Processing for Covered Services for which CalOptima is Financially Responsible.

III. PROCEDURE

A. The CalOptima Quality Improvement (QI) Department shall review claims and Encounter data submitted by Health Networks and Network Providers for potential PPC events, on a monthly basis.

1. CalOptima shall submit the PPC via the DHCS PPC online portal for any PPC event identified through the screening process on a monthly basis.

2. CalOptima shall notify Health Networks and Network Providers of any PPC events identified through the screening process.

B. Network Providers shall report PPC events directly to DHCS in a manner specified by DHCS and shall send secure copies of PPC submission to CalOptima's Quality Improvement (QI) Department via e-mail to qualityofcare@caloptima.org or fax to 657-900-1615.

C. CalOptima shall retain copies of all PPCs submitted to DHCS, in accordance with CalOptima Policy HH.2022Δ: Record Retention and Access.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Network Service Agreement
C. CalOptima Policy FF.2001: Claims Processing for Covered Services for which CalOptima is Financially Responsible
D. CalOptima Policy HH.2022Δ: Record Retention and Access
E. Department of Health Care Services (DHCS) All Plan Letter 17-009: Reporting Requirements Related to Provider Preventable Conditions
F. Department of Health Care Services (DHCS) Duals Plan Letter (DPL) 17-002: Reporting Requirement Related to Provider Preventable Conditions
G. Title 42, Code of Federal Regulations (C.F.R), §§434.6(a)(12), 438.8(g), and 447.26
H. Welfare & Institutions Code, §14131.11

VI. REGULATORY AGENCY APPROVALS

Date	Regulatory Agency
06/09/2017	Department of Health Care Services (DHCS)
10/26/2021	Department of Health Care Services (DHCS)

VII. BOARD ACTIONS

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/2017	GG.1655	Reporting Provider Preventable Conditions (PPC)	Medi-Cal
Revised	TBD	GG.1655	Reporting Provider Preventable Conditions (PPC)	Medi-Cal OneCare Connect

IX. GLOSSARY

Term	Definition
Encounter	Any single medically related service rendered by (a) medical provider(s) to a Member enrolled in CalOptima during the date of service. It includes, but is not limited to, all services for which CalOptima incurred any financial liability.
Health Care Acquired Conditions (HCACs)	As defined in Title 42 of the Code of Federal Regulations (C.F.R), Section 447.26(b), any one of the following conditions, occurring in any inpatient hospital setting, identified as a Hospital Acquired Condition (HAC) by the Secretary under section 1886(d)(4)(D)(iv) of the Social Security Act for purposes of the Medicare program identified in the State plan as described in section 1886(d)(4)(D)(ii) and (iv) of the Social Security Act. • Any unintended foreign object retained after surgery • A clinically significant air embolism • An incidence of blood incompatibility • A stage III or stage IV pressure ulcer that developed during the patient's stay in the hospital • A significant fall or trauma that resulted in fracture, dislocation, intracranial injury, crushing injury, burn, or electric shock • A catheter-associated urinary tract infection • Any of the following manifestations of poor glycemic control: diabetic ketoacidosis; nonketotic hyperosmolar coma; hypoglycemic coma; secondary diabetes with ketoacidosis; or secondary diabetes with hyperosmolarity • A surgical site infection following: ▪ Coronary artery bypass graft (CABG) - mediastinitis ▪ Bariatric surgery; including laparoscopic gastric bypass, gastroenterostomy, laparoscopic gastric restrictive surgery ▪ Orthopedic procedures; including spine, neck, shoulder, elbow ▪ Cardiac implantable electronic device procedures • Deep vein thrombosis/pulmonary embolism following total knee replacement or hip replacement with pediatric and obstetric exceptions • Latrogenic pneumothorax with venous catheterization • A vascular catheter-associated infection
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO), that contracts with CalOptima to provide Covered Services to Members assigned to that health network.
Member	A beneficiary enrolled in a CalOptima Program.
Network Provider	For purposes of this Policy, a Provider that subcontracts with CalOptima Direct or a Health Network for the delivery of the Medi-Cal or OneCare Connect Covered Services to Members.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, or other person or institution that furnishes Covered Services.

Term	Definition
Other Provider Preventable Conditions (OPPCs)	As defined in 42 CFR 447.26, a condition occurring in any health care setting that meets the following criteria: 1. Is identified by the State Plan; 2. Is reasonably preventable through the application of procedures supported by evidence-based guidelines; 3. Has negative consequences for the Member; 4. Is auditable; and 5. Includes, at a minimum, the following procedures: • Wrong surgical or other invasive procedure performed on a patient. • Surgical or other invasive procedure performed on the wrong body part. • Surgical or other invasive procedure performed on the wrong patient.
Provider Preventable Condition (PPC)	A condition that meets the definition of a "health care-acquired condition" or an "other provider-preventable condition," as defined in 42 CFR 447.26(b)

1

Medi-Cal Provider-Preventable Conditions (PPC) Reporting Form

By law, providers must identify provider-preventable conditions that are associated with claims for Medi-Cal payment or with courses of treatment furnished to Medi-Cal patients for which Medi-Cal payments would otherwise be available. See instructions for a more detailed description of PPCs.

1. Name of facility where PPC occurred:			
2. National Provider Identifier (NPI):			
3. Billing NPI if different from No. 2:			
4. Facility Address where PPC occurred:			
City:	State:	Zip code:	
5. PPC – Other Provider-Preventable Condition (OPPC) in any health care setting:			
Date OPPC occurred:	Admission date:		
☐ Wrong surgery/invasive procedure			
☐ Surgery/invasive procedure on the wrong body part			
☐ Surgery/invasive procedure on the wrong patient			
6. PPC – Health Care-Acquired Condition (HCAC) in an acute inpatient setting:			
Date HCAC occurred:	Admission date:		
☐ Air embolism	☐ Blood incompatibility		
☐ Catheter-associated urinary tract infection	☐ Deep vein thrombosis/pulmonary embolism		
☐ Falls/trauma	☐ Foreign object retained after surgery		
☐ Iatrogenic pneumothorax with venous catheterization			
☐ Manifestations of poor glycemic control	☐ Stage III or IV pressure ulcers		
☐ Surgical site infection	☐ Vascular catheter-associated infection		
7. Patient's name:			
8. Client Index Number (CIN):			
9. Patient's birthdate:			
10. Patient's address:			
City:	State:	Zip Code:	Apt. No.:
11a. Is the patient enrolled in a Medi-Cal Managed Care Plan? ☐ Yes ☐ No (Fee-for Service)			
11b. If "yes" to question No. 11a, what is the plan's three-digit Health Care Plan Code?			
11c. Name of Health Care Plan:	HCP County:		
12a. Do you intend to submit a claim? ☐ Yes ☐ No ☐ Unknown			
12b. If "yes," what is the claim control number?			
13. Name of person completing report:			
14. Title of person completing report:			
15. Submitted by: ☐ Medi-Cal Managed Care Plan ☐ Provider			
16. Phone (including ext.):	Email:		
17. Signature of person completing form:			

Please note: *When applicable, both Medi-Cal Managed Care Plans (MCP) and Medicare-Medicaid Plans (MMP) are required to report PPCs using this form.*

INSTRUCTIONS

Providers must complete and send one form (front page only) for each provider-preventable condition (PPC). ***Please note that reporting PPCs to the Department of Health Care Services for a Medi-Cal beneficiary does not preclude the reporting of adverse events and healthcare associated infections (HAIs), pursuant to the Health and Safety Code sections 1279.1 and 1288.55, to the California Department of Public Health*** *for the same beneficiary. Providers must report any PPC to DHCS that* ***did not exist prior to the provider initiating treatment*** *for a Medi-Cal beneficiary, even if the provider does not intend to bill Medi-Cal.*

Mark "PROTECTED HEALTH INFORMATION: CONFIDENTIAL" and send completed first page only of the report related to a Medi-Cal beneficiary to:

Via Secure Fax
Department of Health Care Services
Audits and Investigations Division
Occurrence of Provider-Preventable Conditions
(916) 327-2835

Via U.S. Post Office
Department of Health Care Services
Occurrence of Provider-Preventable Condition
Audits and Investigations Division, MS 2100
P.O. Box 997413
Sacramento, CA 95899-7413

Via UPS, FedEx, or Golden State Overnight
Department of Health Care Services
Occurrence of Provider-Preventable Condition
Audits and Investigations Division, MS 2100
1500 Capitol Ave., Suite 72.624
Sacramento, CA 95814-5006

Providers must send this form to the Department of Health Care Services (DHCS), Audits and Investigations Division, via fax, U.S. Post Office, UPS, or FedEx. Providers must submit the form after discovery of the event and confirmation that the patient is a Medi-Cal beneficiary. The preferred methods of sending the reports for confidentiality are No. 1, overnight courier with appropriate marking; No. 2, secure fax machine with appropriate marking; and No. 3, U.S. mail with appropriate marking. Providers must comply with HIPAA and any other relevant privacy laws to ensure the confidentiality of patient information. Providers may email questions about PPCs to PPCHCAC@dhcs.ca.gov.

Facility information (boxes 1-4)

1. Enter name of the facility where the PPC occurred.
2. Enter the National Provider Identifier (NPI) of the facility where the PPC occurred.
3. Enter the billing NPI if it is different from the NPI for the facility where the PPC occurred.
4. Enter the street address, city, state, and zip code of the facility where the beneficiary was being treated when the PPC occurred.

Other Provider-Preventable Condition in any health care setting (box 5)

5. If you are reporting an OPPC, enter the date (mm/dd/yyyy) that the PPC occurred and the admission date if the beneficiary was admitted to an inpatient hospital.

   Select one of the following if:
   - Provider performed the wrong surgical or other invasive procedure on a patient.
   - Provider performed a surgical or other invasive procedure on the wrong body part.
   - Provider performed a surgical or other invasive procedure on the wrong patient.

Health Care-Acquired Condition (HCAC) in an acute inpatient setting (box 6)
(HCACs are the same conditions as hospital-acquired conditions (HACs) that are reportable for Medicare, with the exception of reporting deep vein thrombosis/pulmonary embolism for pregnant women and children under 21 years of age, as noted below.)

6. Enter the date (mm/dd/yyyy) that the HCAC occurred and the admission date the beneficiary was admitted to an inpatient hospital.

Select one of the following if the beneficiary experienced:

- A clinically significant air embolism
- An incidence of blood incompatibility
- A catheter-associated urinary tract infection
- Deep vein thrombosis (DVT)/pulmonary embolism (PE) following total knee replacement or hip replacement in an inpatient setting. Do **not** check the box if the beneficiary was under 21 or pregnant at time of PPC.
- A significant fall or trauma that resulted in fracture, dislocation, intracranial injury, crushing injury, burn, or electric shock
- Any unintended foreign object retained after surgery
- Iatrogenic pneumothorax with venous catheterization
- Any of the following manifestations of poor glycemic control: diabetic ketoacidosis, nonketotic hyperosmolar coma, hypoglycemic coma, secondary diabetes with ketoacidosis, or secondary diabetes with hyperosmolarity
- A stage III or stage IV pressure ulcer
- One of the following surgical site infections:
  - Mediastinitis following coronary artery bypass graft (CABG)
  - Following bariatric surgery for obesity: laparoscopic gastric bypass, gastroenterostomy, or laparoscopic gastric restrictive surgery
  - Certain orthopedic procedures: Spine, neck, shoulder, and elbow
  - Following cardiac implantable electronic device (CIED) procedures
- A vascular catheter-associated infection

Beneficiary information (boxes 7-11c)

7. Enter beneficiary's name (first, middle, last) as listed on the Beneficiary Identification Card.
8. Enter beneficiary's Client Index Number (CIN) from the Beneficiary Identification Card.
9. Enter the beneficiary's birthdate (mm/dd/yyyy).
10. Enter the beneficiary's home street address, including city, state, zip code, and apartment number, if applicable.

11a. Check "yes" if the beneficiary is enrolled in a Medi-Cal Managed Care Plan or "no" if the beneficiary has Fee-For-Service (FFS) Medi-Cal.

11b. If the beneficiary has Medi-Cal Managed Care, the beneficiary's Managed Care Plan should enter the Health Care Plan's (HCP) three-digit plan code.

11c. If the beneficiary has Medi-Cal Managed Care, enter the name of the Managed Care HCP and the county of the HCP where the PPC occurred.

Claim information (boxes 12a-12b)

12a. Click "yes" if you intend to submit a claim to Medi-Cal for the course of treatment associated with the PPC, "no" if you do not, or "unknown" if you do not know at this time.

12b. Enter the Claim Control Number (CCN) if you have already submitted a claim for the course of treatment.

Provider Contact information (boxes 13-17)

13. Enter the name of the person completing this report.
14. Enter the title of the person completing this report.
15. Check the appropriate box to indicate whether the person completing this report is a representative for a Medi-Cal Managed Care Plan or a provider.
16. Enter a work phone number, including extension if necessary, and email address where DHCS can contact the person who completed this report.
17. Sign and date the form. Adobe "digital signatures" are accepted.

THE INFORMATION CONTAINED IN THE COMPLETED FORMS IS PROTECTED HEALTH INFORMATION AND PERSONALLY IDENTIFIABLE INFORMATION, UNDER FEDERAL (HIPAA) LAWS AND CA STATE PRIVACY LAWS. THE PROVIDER IS RESPONSIBLE FOR ENSURING THE CONFIDENTIALITY OF THIS INFORMATION.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 7, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

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

Contacts

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

Recommended Actions

- Receive and File 2021 CalOptima Quality Improvement Program Evaluation, and
- Approval of the 2022 Quality Improvement Program

Background

CalOptima's Quality Improvement (QI) Program encompasses all clinical care, health and wellness services, and customer service provided to our members, which aligns with our vision to provide an integrated and well-coordinated system of care to ensure optimal health outcomes for all our members. The QI Program is designed to identify and analyze significant opportunities for improvement in care and service, to develop improvement strategies and to assess whether adopted strategies achieve defined benchmarks.

CalOptima's QI Program is reviewed, evaluated, and approved annually by the Board of Directors. The QI Program defines the structure within which QI activities are conducted and establishes objective methods for systematically evaluating and improving the quality of care for all CalOptima members.

The 2021 Quality Improvement Program Evaluation (QI Evaluation) analyzes the core clinical and service indicators to determine if the 2021 QI Program has achieved its key performance goals during the year.

CalOptima had the following achievements in 2021:

- July 2021 – Achieved National Committee of Quality Assurance (NCQA) Accreditation through 2024
- September 2021 – Received a 4 out of 5 NCQA's Medicaid Health Plan rating
- September 2021 – Received mPulse award for Achieving Health Equity related to health care innovation
- September 2021 – Received Orange County Chapter of the Public Relations Society of America's Award of Excellence for COVID-19 response
- October 2021 – CalOptima PACE program recognized by Assemblywoman Cottie Petrie-Norris for use of telehealth technology

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- November 2021 – Received Department of Health Care Services (DHCS) 2021 Consumer Satisfaction Award – Adult (for large scale health plan)

In 2021, CalOptima remained committed to innovative approaches to member engagement. CalOptima expanded member engagement and outreach strategies to include vaccination incentives, on-site member events, collaboration with community partners in addition to direct mailings, email, and mobile texting.

Discussion

CalOptima staff has updated the 2022 QI Program and QI Workplan to ensure that it is aligned with health network and strategic organizational changes. This will ensure that all regulatory requirements and NCQA accreditation standards are met in a consistent manner across all lines of business.

The 2022 QI Program is based on the Board-approved 2021 QI Program and describes: (i) the scope of services provided; (ii) the population served; (iii) key business processes; and (iv) important aspects of care and service for all lines of business to ensure they are consistent with regulatory requirements, NCQA standards and CalOptima's strategic initiatives.

The revisions are summarized as follows:

1. Updated existing program initiatives to align with health equity and current operational practices
2. Added new programs and initiatives:
    - DHCS Comprehensive Quality Strategy
    - Health Equity Framework
    - CalAIM effective 1/1/2022
3. Added Medi-Cal Rx pharmacy administration change
4. Updated data, roles, and network hierarchies
5. Removed PACE from the QI Program as PACE has its own Quality Improvement Committee and no longer reports to QIC

The 2022, the CalOptima QI Program and Work Plan will be flexible and able to align with new strategic goals and objectives as defined by the Board of Directors. Staff will remain agile in the shifting health care landscape while continuing to stay focused on providing members with timely access to quality health care services in a compassionate and equitable manner.

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2022 QI Program Recommendations:

1. Incorporate social determinants of health (SDOH) and health equity in targeted quality initiatives
2. Collaborate with external stakeholders and partners in the comprehensive assessment of our members
3. Develop robust community-based interventions using analytical tools, such as geomapping
4. Strategize and streamline member outreach by using multiple modes of communication
5. Expand collaboration on quality initiatives with health networks
6. Implement Enhanced Care Management (ECM) and Community Supports as part of California Advancing and Innovating Medi-Cal (CalAIM) Program
7. Increase emphasis on preventive measures and screenings that may have been neglected during the pandemic
8. Align QI Program with DHCS 2022 Comprehensive Quality Strategy

The recommended changes to CalOptima's QI Program are reflective of current clinical operations and are necessary to meet the requirements specified by the Centers of Medicare and Medicaid Services, California Department of Health Care Services and NCQA accreditation standards.

Fiscal Impact

The recommended action to approve the 2022 QI Program has no additional fiscal impact beyond what was incorporated in the Fiscal Year (FY) 2021-22 Operating Budget. Staff will include updated expenditures for the period of July 1, 2022, through December 31, 2022, in the FY 2022-23 Operating Budget.

Concurrence

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

Attachments

1. 2021 Quality Improvement Program Evaluation
2. 2022 Quality Improvement Program and Work Plan DRAFT FINAL (Redline version)
3. Proposed 2022 Quality Improvement Program and Work Plan DRAFT FINAL (Clean version)
4. PowerPoint Presentation: 2021 QI Evaluation, 2022 QI Program and Work Plan

/s/ Michael Hunn *03/31/2022*
Authorized Signature **Date**

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QUALITY IMPROVEMENT PROGRAM ANNUAL EVALUATION

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2021 QUALITY IMPROVEMENT PROGRAM ANNUAL EVALUATION

SIGNATURE PAGE

Quality Improvement Committee Chair:

Richard Pitts, D.O., Ph.D. **Date**

Chief Medical Officer

Board of Directors' Quality Assurance Committee Chair:

Trieu Tran, M.D. **Date**

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2021 Quality Improvement Evaluation of Overall Program Effectiveness

EXECUTIVE SUMMARY

The 2021 Quality Improvement (QI) Evaluation analyzes the core clinical and service indicators to determine if the QI Program has achieved key performance goals during the year. This evaluation focuses on quality activities initiated during measurement year 2020, which impacted results in 2021, as well as activities undertaken during the first three quarters of the 2021 calendar year to improve health care and services available to CalOptima members.

The final 2021 QI Work Plan, with the full calendar year results, will be presented as a separate document in Q1 2022 to the Quality Improvement Committee (QIC). The 2021 QI Program Evaluation also identifies key areas that offer opportunities for improvement to be implemented or continued as part of the 2022 QI Program and its Work Plan.

The year 2021 continued to be unprecedented as a result of the COVID-19 pandemic and the ongoing public health emergency that began in 2020. The Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) issued several guidance documents with flexibility in regulations addressing member access to care during the pandemic. DHCS issued All Plan Letter (APL) 20-022, COVID-19 Vaccine Administration, to provide support in the delivery of vaccines to Medi-Cal members.

In December 2020, when the COVID-19 vaccine became available, CalOptima pivoted quickly to develop an equitable strategy to assist our members in obtaining vaccines. In January 2021, CalOptima's Board of Directors approved a CalOptima Vaccine Incentive Program, which provided a $25 non-monetary incentive to members, per vaccine dose, to encourage vaccination. CalOptima also collaborated with Orange County Health Care Agency on the Vaccine Equity Pilot Program, to directly allocate COVID-19 vaccine doses to health network providers and community health centers. CalOptima developed a strategic plan for member engagement and outreach and supported vaccination clinics for diverse communities to address vaccine hesitancy. In September 2021, CalOptima enrolled in the DHCS COVID-19 Vaccination Incentive Program to improve Medi-Cal members' vaccination rates across the state of California. Although CalOptima made great strides in vaccination during 2021, CalOptima is committed to continuing member outreach, targeting disproportionately affected communities and increasing vaccination rates until community immunity is reached.

In 2021, the QI strategy aligned with CalOptima's strategic priorities with a focus on member engagement, access to care and quality outcomes. CalOptima remained focused on advancing QI initiatives to achieve 2021 QI goals and objectives to provide members with access to quality health care services. CalOptima also adopted a strong Plan-Do-Study-Act (PDSA) approach to developing initiatives in 2020 that continued into 2021. These initiatives are focused on long-term improvement efforts for selected high-priority measures. In 2022, based on the 2021 QI Program Evaluation, QI will continue to support a strategy, as identified in the 2022 QI Program, that aligns with

CalOptima's strategic priorities and regulatory requirements and focuses on activities and incentives that will improve member engagement, access to care and quality outcomes.

2021 ACHIEVEMENTS

Awards and Recognitions

- **July 2021:** NCQA renewed CalOptima's Accreditation through 2024. CalOptima was awarded 100% of the allowable points.
- **September 2021:** CalOptima received a rating of 4 out of 5 in NCQA's Medicaid Health Plan Ratings 2021. No other Medi-Cal Plan in California earned a rating higher than 4 out of 5. Nationwide, only 16 of the 185 Medicaid plans reviewed scored higher.
- **September 2021**: CalOptima was honored for Achieving Health Equity, by mPulse Mobile, a digital engagement solution company for the health care industry. Winners of this award are recognized as achieving impressive results related to health care innovation, outcomes and health care equity among patient populations. CalOptima was recognized for promoting COVID-19 vaccination through the use of mPulse Mobile to reach Medi-Cal members via texting in seven languages. The campaign promoted pandemic safety and vaccination, including programs tailored to specific geolocations and helped homebound members access in-home vaccinations.
- **September 2021:** Assemblywoman Cottie Petrie-Norris recognized CalOptima's Program of All-Inclusive Care for the Elderly (PACE), particularly the use of telehealth technology for more than 400 participants, with an Assembly Resolution for the program's contributions to Orange County seniors over the past eight years.
- **October 2021:** CalOptima's Communications team was honored with the Orange County Chapter of the Public Relations Society of America's (OCPRSA) Award of Excellence in the category of COVID-19 Response Crisis Communications/Issues Management Programs. The award recognizes CalOptima's COVID-19 prevention and vaccination campaigns, which launched in mid-2020 and early 2021, respectively. The campaigns used newspaper, radio, video, social media, and other formats to provide reliable COVID-19 resource information to members and providers as well as inform the community about COVID-19 vaccine availability.
- **November 2021:** CalOptima received the 2021 Consumer Satisfaction Award – Adult for large-scale health plans from DHCS. The award is based on adult responses to the CAHPS survey, a standardized method health plans use to collect information about members' experience with their health plan and provider services.

Quality Achievements: Review of 2021 Recommendations

CalOptima achieved many of organizational objectives in 2021:

1. Received NCQA Accreditation for the fourth consecutive survey renewal.
2. Continued and expanded health rewards to members for receiving a COVID-19 vaccine.
3. Intensified targeted member outreach by using multiple modes of communications per members' preference, through website, direct mailings, email, member outreach calls,

mobile texting, on-site member outreach and member engagement activities, especially in support of COVID-19 vaccination.

4. Implemented new measures to the Pay for Value (P4V) program for Measurement Year (MY) 2021 for Behavioral Health (BH) Applied Behavior Analysis (ABA) services to help drive improvement in these measures.
5. Prioritized data bridge efforts to improve data exchanges, both at the health network level and plan level in anticipation of many hybrid measures converting to administrative measures. Continued data mining efforts to continuously identify and close data gaps. Areas of focus for MY2021 included improving access to electronic medical record systems and remedying the lab data not currently available through limited contract data exchanges.
6. Expanded Virtual Care Strategy to increase access to care for members, such as BH Virtual Care visits, and telehealth for CalOptima PACE.
7. Continued to partner with UCI on the Orange County Nursing Home COVID-19 Prevention Program to create online toolkits, videos, posters and resources as well as offer webinars and consultative sessions to help stop the spread of COVID-19 in nursing homes.
8. Continued to offer the Post-Acute Infection Prevention Quality Incentive (PIPQI) to nursing facilities who administer the Chlorhexidine (CHG) antiseptic soap in order to reduce the number of nosocomial infections and hospitalizations related to infections for Long-Term Care (LTC) members.

For 2021, CalOptima had adequate staffing and resources and a well-defined quality committee structure in place to meet the required needs of the QI Program. The QI Program structure includes a Quality Improvement Committee (QIC), with several subcommittees reporting to the QIC, which included the Whole-Child Model Clinical Quality Committee (WCM CAC), Utilization Management Committee (UMC), Credentialing and Peer Review Committee (CPRC), Member Experience Committee (MEMX), and Grievance Appeal and Resolution (GARS) Committee. The QIC had exceptional participation from external and internal practitioners as well as staff.

In 2021, CalOptima implemented a robust Population Health Management (PHM) strategy to focus on health disparities and equity. PHM implemented a targeted approach to member outreach that included a focus on interventions for diverse populations and communities, ranging from cancer screenings to managing members with multiple complex conditions. The program had strong member and provider engagement, which was monitored on a quarterly basis. In response to the COVID-19 pandemic and amplification of health disparities for people of color, CalOptima conducted a population segment analysis based on race and ethnicity. The population segment analysis results and opportunities to improve health equity were incorporated in the 2021 QI Program.

In 2022, based on the 2021 QI Program Evaluation, CalOptima will continue its PHM strategy in alignment with CalOptima's strategic priorities to focus on activities and incentives that will improve member engagement, access to care and quality outcomes.

RECOMMENDATIONS FOR 2022

This past year continued to bring uncertainty in health care delivery due to the unprecedented COVID-19 pandemic that has impacted lives locally, nationally and globally. The CalOptima QI Program and Work Plan for 2022 will be flexible to align with the new strategic goals and objectives

as defined by the Board of Directors. Staff will remain agile in the shifting health care landscape while continuing to stay focused on providing members with timely access to quality health care services in a compassionate and equitable manner.

Based on the 2021 QI Program Evaluation, in addition to continuing to advance CalOptima's mission and improve quality outcomes of members, we recommend the following initiatives and projects to drive improvements that impact members.

1. Incorporate SDOH factors and analysis of health disparities in the strategic plan for targeted quality initiatives.
2. Collaborate with external stakeholders and partners in comprehensive assessments of our members.
3. Develop robust community-based interventions using analytical tools, such as geomapping in collaboration with community partners and entities that have a good understanding of the target population barriers and behaviors.
4. Strategize and streamline member outreach by using multiple modes of communication via contracted external vendors, including through website, direct mailings, email, Interactive Voice Response (IVR) calls, mobile texting, targeted social media campaigns and robocall technology.
5. Expand collaboration on quality initiatives in partnership with health networks to broaden and expand the reach of coordinated data sharing to close gaps in care.
6. Implement the Enhanced Care Management (ECM) and Community Supports as part of California Advancing and Innovating Medi-Cal (CalAIM).
7. Increase emphasis on preventive measures and screenings that may have been neglected during the pandemic, such as pediatric vaccinations and cancer screenings.
8. Align with proposed DHCS 2022 Comprehensive Quality Strategy, which is a multiple year program.

Evaluation of 2021 Priority Initiatives

COVID-19 VACCINATIONS

CalOptima engaged in a multilayered strategy to encourage COVID-19 vaccinations among members. As of December 31, 2021, 474,715 members have been vaccinated. This equates to 68% of CalOptima members age 16 and older, 67% of members age 12 years and older having received a vaccine, and 59% of members 5 years and older. The rate of vaccination for Whole Child Model members was 47%. Those age 65 years and older had a rate of 80%. Those members in LTC had a rate of 87%. In all age brackets, CalOptima's vaccination was greater than that of the statewide vaccination rate for Medi-Cal members. The highest rate of vaccination by location, 70%–72%, occurred in members living in the cities of Irvine, Garden Grove and Westminster. The highest rate of vaccination by ethnicity was the Asian population at 81%; the lowest rate was among the Black population at 45%.

Member Engagement

CalOptima made several COVID-19 vaccination outreach efforts and provided incentives to members. From May to December 2021, CalOptima organized 10 immunization clinics at various community locations, vaccinating a total of 7,268 people. CalOptima also held special immunization clinics for the frail elderly population located at our PACE clinic, vaccinating 277 participants and 55 staff. Additionally, CalOptima worked with the Coalition of Orange County Community Health Centers and Orange County Health Care Agency to distribute 1,669 gift cards to members experiencing homelessness who had gotten the vaccine.

Texting Strategy

Because Medicaid populations nationwide are vaccinated against COVID-19 at lower rates than the wider population, CalOptima sought to promote vaccination among members who may be vaccine hesitant or face barriers to care. CalOptima engaged mPulse Mobile to roll out a large-scale, COVID-19 texting campaign in seven languages, which was written at the sixth-grade reading level. The campaign promoted pandemic safety and vaccination, including programs tailored to specific geolocations and to help homebound members access in-home vaccinations. Members who responded to the text with vaccine hesitancy were provided with the CDC website for more information. The texting promoted the vaccine events and rewards program, which resulted in 5,318 individuals vaccinated and 2,486 gift cards distributed.

Carenet

CalOptima engaged the services of Carenet to conduct member outreach and encourage members to obtain the COVID-19 vaccination. Carenet was provided a list of 65,100 unvaccinated CalOptima Community Network (CCN) members to perform member outreach, check vaccination status, schedule for vaccination and identify member hesitancy concerns. These calls ran from July–September 2021.

Carenet successfully scheduled COVID-19 vaccination appointments for 8,774 members, which is almost 17% of the population. The member outreach rate ranged from 13%–24%, depending on month. Many members expressed vaccine hesitancy for a variety of reasons. The reasons members provided to Carenet for refusing the vaccine included fear and lack of trust, right to refusal, and political affiliation.

CalOptima has collaborated with the community to combat vaccine misinformation and hesitancy by providing education and engaging with trusted messengers.

CalOptima Homeless Health Initiative

CalOptima's Homeless Health Initiative continued in 2021 with modifications due to the COVID-19 pandemic to maintain telephonic outreach. In 2021, the Clinical Field Team made 244 calls and treated 204 of those outreached, with 133 being CalOptima members. There has been a total of 54 referrals to recuperative care with 34 being CalOptima members. In 2021, CalOptima began establishing regular video office hours at Orange County shelters, with the first location being the Yale Navigation Center. September 2021 brought the first step to re-establish face-to-face engagement with an outreach event at Mary's Kitchen. Collaborative efforts remain in place for coordinating care between housing partners and health networks. The referral process for the Health Homes Program (HHP) was streamlined in 2021, and HHP will sunset on December 31, 2021. All members will transition into CalAIM on January 1, 2022. CalAIM will eventually expand eligibility to a broader set of members and populations.

Since implementation, the Homeless Clinical Access Program (HCAP) has onboarded eight community health centers of which all are still actively participating. Since August 2019, HCAP has been in the field for more than 7,700 hours, paid out $1.5 million in provider incentives and treated 6,346 homeless participants (CalOptima and non-CalOptima members).

Next steps include assessing COVID-19 impacts, determining ongoing needs, and evaluating data and outcomes.

Pay for Value (P4V) Program

The P4V program recognizes outstanding performance and supports ongoing improvement aimed at strengthening CalOptima's mission of providing quality health care. P4V programs are implemented for both Medi-Cal and OneCare Connect, each with separate measures and scoring criteria. All health network and CCN PCPs "in good standing" are eligible to participate in the programs. A new methodology was adopted for MY2020 for the Medi-Cal P4V program, which aims for greater transparency, consistency and administrative simplification. The new Health Network Quality Rating (HNQR) methodology aligns with changes to the measures that are important to CalOptima's NCQA Accreditation status, CMS Star Rating Status, newly required DHCS Managed Care Accountability Set (MCAS) and/or overall NCQA Health Plan Rating. This new methodology was approved by the CalOptima Board of Directors in February 2020. The new methodology more than doubles the per member per month (PMPM) incentive to network providers and health networks for the P4V program, from $2.00 PMPM to $5.00 PMPM.

The HNQR methodology was implemented with MY2020 as the first evaluation year. The program incentivizes all DHCS MCAS measures required to achieve a minimum performance level (MPL) and also includes measures of member satisfaction.

Health network performance scoring and incentive payments on the HEDIS and member satisfaction measures for MY2020 for Medi-Cal and OneCare Connect are currently in progress.

The public health emergency during 2020 had a notable impact on overall health plan performance on both HEDIS and CAHPS scores but the increase in the PMPM payment rate for MY2020 did provide additional incentive to health networks to maintain the performance of most measures at the same level as MY2019 performance. Despite the public health emergency, CalOptima had only two measures that did not achieve the MPL this year.

HEDIS Overview

CalOptima reports HEDIS annually for all lines of business (LOB). HEDIS enables "apples-to-apples" comparison of health plan care across six domains of care:

1. Prevention
2. Access and Availability of Care
3. Utilization
4. Member Experience (CAHPS)
5. Health Plan Descriptive Information (such as membership, language and ethnicity of membership)
6. New measures using Electronic Clinical Data Sources (Adult Immunization Status, Prenatal Immunization Status and Depression Screening)

These results are audited by certified HEDIS Compliance Auditors. All measures fully passed audit, giving CalOptima confidence in the reliability of the results that are used to inform our QI Program and initiatives.

These clinical quality measures are used to evaluate multiple aspects of patient care, including preventive care, coordination of care, patient safety and management of chronic conditions.

Overall Performance Highlights

Medi-Cal

1. Despite the public health emergency in MY2020, CalOptima achieved the MPL for all measures except two: Cervical Cancer Screening (CCS) and Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD).
2. CalOptima received a 4.0 rating in NCQA's Medicaid Health Plan Ratings 2021. This achievement extended CalOptima's recognition to seven years as one of the top Medi-Cal plans in California.
3. Due to the public health emergency, most of the HEDIS measures for MY2020 are lower compared with the previous year, especially those related to preventive care and requiring office visits and lab tests. However, some measures still showed statistically significant improvement from the prior year. Examples include Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB), Antidepressant Medications Management (AMM).

Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA) and Use of Opioids from Multiple Providers (UOP).

4. P4V program measures showed improvement, but several are still below the 50th percentile.
5. There is opportunity for improvement in several measures, including CCS, SSD and Follow-Up Care for Children Prescribed ADHD Medication (ADD). These measures will be monitored in the 2022 QI Work Plan.

Key Measures With Opportunity for Improvement: Medi-Cal

Measure	MY2020 Rate	QC Percentile
Cervical Cancer Screening (CCS)	57.60%	33rd
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	71.23%	10th
Follow-Up Care for Children Prescribed ADHD Medication (Continuation Phase) (ADD)	46.38%	25th

Key Measures With Opportunity for Improvement: OneCare Measures Below 3 Stars

Measure	MY2020 Rate	Star Rating
Care for Older Adults (Functional Status Assessment)	46.98%	1 Star
Statin Therapy for Patients With Cardiovascular Disease — Treatment	71.43%	1 Star
Transitions of Care — Medication Reconciliation	58.96%	2 Stars

Key Measures With Opportunity for Improvement: OneCare Connect Measures Below 3 Stars

Measure	MY2020 Rate	Star Rating
Care for Older Adults (Functional Status Assessment)	50.85%	1 Star
Breast Cancer Screening	61.24%	2 Star
Transitions of Care — Medication Reconciliation	60.10%	2 Star

California Advancing and Innovating Medi-Cal (CalAIM)

CalAIM is a multiyear initiative, spanning from 2022 to 2027, by DHCS to improve the quality of life and health outcomes of the population by implementing broad delivery system, program and payment reforms across Medi-Cal. Two CalAIM components, ECM and Community Supports, will be implemented on January 1, 2022.

CalAIM has three primary goals:

1. Identify and manage member risk and need through whole person care approaches and addressing SDOH.
2. Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility.
3. Improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems and payment reform.

ECM provides a whole-person approach to care that addresses the clinical and non-clinical circumstances of high-need Medi-Cal members. Community Supports are flexible, wraparound services that provide a substitute to, or to avoid, other covered services, such as a hospital or skilled nursing facility admission.

CalOptima's implementation of ECM and Community Supports will build upon the existing HHP and Whole-Person Care (WPC) Pilot infrastructures by preserving existing member relationships with HHP and WPC service providers. CalOptima's HHP Community-Based Care Management Entities will transition to become ECM providers. This means that CalOptima and health networks will provide ECM services. ECM providers will be responsible for coordinating care with members' existing providers and other agencies to deliver the following seven core service components:

1. Outreach and Engagement
2. Comprehensive Assessment and Care Management Plan
3. Enhanced Coordination of Care
4. Health Promotion
5. Comprehensive Transitional Care
6. Member and Family Supports
7. Coordination of and Referral to Community and Social Support Services

Beginning, January 1, 2022, ECM goes live for the following populations of focus:

1. Homeless (adults and children)
2. High utilizer adults
3. Adults with Serious Mental Illness (SMI)/Substance Use Disorder (SUD)
4. Individuals transitioning from incarceration

Additionally, members participating in WPC and/or HHP will automatically transition into ECM

HHP and WPC service providers will continue to provide services under Community Supports as CalOptima works to expand its network of Community Supports providers that have the expertise and capacity to provide the specific services. Members eligible for Community Services must consent to participate and receive services. Beginning January 1, 2022, CalOptima will offer the following four, distinct Community Supports:

1. Housing Transition Navigation Services
2. Housing Deposits
3. Housing Tenancy and Sustaining Services
4. Recuperative Care (Medical Respite)

HEALTH EQUITY AND THE SDOH FRAMEWORK

Health equity is achieved when an individual has the opportunity to "attain his or her full health potential" and no one is "disadvantaged from achieving this potential because of social position or other socially determined circumstances." (Centers for Disease Control and Prevention)

SDOH are the conditions that exist in the places where people are born, live, learn, work, play, worship, and age that affect health outcomes. (Henry J. Kaiser Family Foundation)

In response to CalOptima' strategic plan, staff began the process to identify and address health equity and SDOH for vulnerable populations throughout Orange County. The framework includes several milestones from uncovering inequities, looking at root causes, designing a comprehensive intervention plan, to planning and tracking progress. It begins with a comprehensive Readiness Assessment to determine organizational capacity to undertake a health equity redesign. As the framework is developed, there will be opportunities to obtain feedback from internal and external stakeholders and include their input in the intervention and design process.
PHM will lead CalOptima's Health Equity Framework to ensure that all members have a fair and just opportunity to be as healthy as possible. This will include a long-term effort that includes:

1. Making an organizational commitment to advancing health equity
2. Assessing and building organizational capacity
3. Using data and narrative to describe inequities and their root causes (including SDOH)
4. Designing and implementing strategies to transform practices, policies and systems
5. Tracking progress, sharing lessons and strengthening ongoing capacity to eliminate health inequities

CANCER SCREENING ACTIVITIES CONTINUED FOR 2022

1. Continue Health Rewards for eligible CalOptima members for BCS, CCS and COL measures.
2. Continue IVR and mailers to increase awareness and the importance of cancer screenings.
3. Publish Medi-Cal and OCC newsletter articles about the importance of resuming cancer screenings during the COVID-19 pandemic.
4. Share social media messaging (Facebook, Instagram and Twitter) to occur during BCS, CCS, and COL awareness months in 2021 and 2022.
5. Geomap ZIP codes for members due for CCS to conduct a targeted social media campaign.
6. Look at disparities based on ethnicity and SDOH to have targeted interventions based on communities with highest needs.

7. Collaborate with various health networks to promote Health Reward Programs via their own outreach campaign efforts.
8. Initiate text messaging campaigns for the BCS and CCS measures.

Section 1: Quality Improvement Program Structure

Activities in the 2021 QI Program and associated Work Plan focused on refining the structure and process of care delivery, with the emphasis on member centric activity and consistency with regulatory and accreditation standards. All activities were undertaken in direct support of the Mission, Vision, Values and Strategic Initiatives of CalOptima's Board of Directors.

Components of the QI Program and Structure

The components of the QI Program are closely aligned to meet the goal of continuously improving the quality of care for our members.

QI Program Documents

1. **Annual Evaluation** — Completed a comprehensive evaluation of the QI Program and QI Work Plan at the end of the fiscal year that assesses the performance on measures/indicators.
2. **Program Description** — Developed and implemented a robust written QI program description that focuses on improving standards of care and addressing gaps in care identified in prior year's evaluation. The organization will enhance the QI Program by including "new initiatives" in the QI Program description that will outline measurable goals and objectives that CalOptima will focus on in subsequent years.
3. **Work Plan** — Created to monitor and evaluate performance of QI measures and interventions on an ongoing basis. This is a dynamic document that may change throughout the year based on priorities and opportunities.
4. **Policies and Procedures** — Ensure that the organization has developed and implemented appropriate policies and procedures that are needed to provide care to members.
5. **Delegation Grid —** Describes activities delegated to the health networks.
6. **Organizational Chart** — Provides a visual presentation of the reporting structure of the QI Committee, its subcommittees and its relationship to the Board of Directors.

Reviews of QI Documents

1. CalOptima successfully completed reviews of all of the above documents with the QI committees during 2021. The documents were reviewed and approved by the CalOptima Board of Directors.
2. Feedback from the practitioners who participated in the QI committee meetings were included in program documents (i.e., Program Description, Work Plan and Annual Evaluation).

Quality Improvement Committee (QIC)

1. The QIC is the primary committee that is responsible for the QI Program and reports to the Quality Assurance Committee (QAC) of the Board. The committee also recommends policy decisions.
2. The committee provides critical feedback and guidance to the QI department on key initiatives. The QIC also reviewed and approved all the key documents in a timely manner.
3. The committee provided oversight and direction to the QI Program, Work Plan and Evaluation in the first quarter of 2021. This gave the QI department a framework on how to start implementing the QI program in 2021. For the remainder of the year, the QI staff

updated the committee on the progress of the program through regular reports. In addition to reviewing and approving the reports, the QIC (which included participating practitioners) provided valuable insight on barriers and potential interventions. These recommendations focused on enhancing performance improvement activities directed toward clinical quality, quality of service, patient safety, as well as quality cultural and ethnic accessible services. Upon evaluation of the QI activities, the QIC recommended needed actions or improvements to the activities and ensured follow-up.

4. In 2021, the QIC reviewed and provided feedback on key clinical and other coordination of care initiatives, including member outreach, provider education and outreach, incentives, educational materials and more.
5. The committee also reviewed and approved the policies and procedures.
6. The committee reviewed and provided feedback on key reports: annual analysis of HEDIS and CAHPS; access to care; and complaints and appeals. Part of the feedback included specific actions that CalOptima could take to improve performance.
7. The committee also received quarterly reports from the CPRC, UMC, MEMX, GARS and WCM CAC. These reports were summarized and presented quarterly to the QAC.

Assessment of QI Staff and Resources

CalOptima continues to dedicate significant resources and staffing to meet the needs of the QI Program. In 2020, the QI department added staff to support changes to the DHCS requirements for Facility Site Review (FSR); however, implementation of the DHCS changes were pended due to the pandemic. In Q2 2021, staff re-implemented the FSR reviews. Staff in Potential Quality Issues (PQI) were shifted to support quality of care grievance reviews. Credentialing delegation oversight was transferred from the Audit & Oversight department to Q1 in July 2021. To support the development of the Health Equity Framework, the new position of Associate Director, Population Health Management, was created. The QI department also received support from other key departments within the organization including, but not limited to, the following:

1. Quality Analytics
2. Population Health Management
3. Behavioral Health Integration
4. Case Management
5. Member Services (including outreach and engagement)
6. Provider Relations and Contracting

Review of System Resources

CalOptima has dedicated significant resources to ensuring there are adequate systems in place to monitor and evaluate performance of QI programs on an ongoing basis. The resources include HEDIS Analysts for reporting, plus extensive analytic staff support. Additional support and collaboration were provided by Provider Relations, Network Management, Grievance and Appeals, and Customer Service departments.

CalOptima also utilizes three enterprise systems for utilization and care management (GuidingCare), claims payment (Facets) as well as credentialing data management (Cactus by Symplr). Although these systems are not integrated, data from the systems are stored in a data warehouse, and resources are allocated to create robust tools utilizing Tableau to analyze and generate quality reports, gaps in care reports and other relevant reports needed to support the QI Program. There is a robust data integration flow in place that allows the organization to utilize data from different sources and

identify improvement opportunities. The team also has an adequate number of business analysts as well as an ITS department that can support the reporting needs of the organization.

CalOptima issued Requests for Proposal (RFPs) for both the utilization and care management system and credentialing data management system. In 2022, CalOptima is seeking to contract with vendors who best meet system and business needs.

Overall Assessment of Program Structure

CalOptima had adequate staffing and resources required to meet the needs of the QI Program, in addition to organizational program requirements. CalOptima will continue to evaluate the needs of the program through the Work Plan, on a quarterly basis, and add staffing and additional resources, as needed, to supplement the QI department. The organization receives adequate feedback from its community practitioners about the development and implementation of the QI initiatives and programs. CalOptima continues to have significant participation from the medical directors in the development and implementation of clinical initiatives and programs throughout the year. The medical directors and QI directors report the information to senior leadership.

Section 2: Quality of Clinical Care

Adult Wellness

Evaluation of Initiatives for Specific HEDIS[1] and MCAS[2] Measures

HEDIS MY2020 results are reported in 2021, and this evaluation of quality initiatives focuses on activities performed in 2020 and 2021.

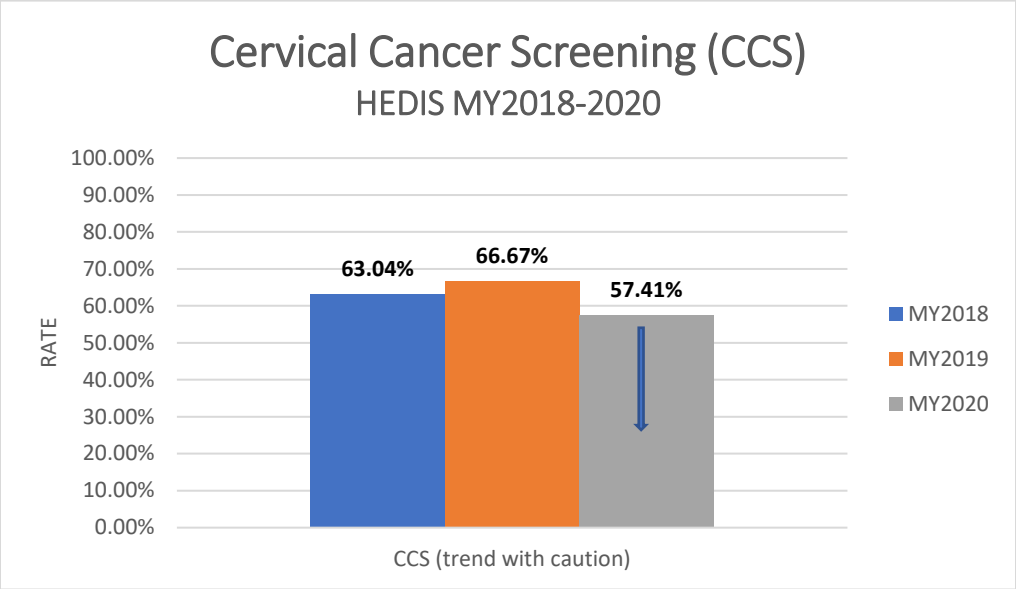
Cervical Cancer Screening (CCS): Medi-Cal

A hybrid HEDIS and MCAS measure, CCS measures the percentage of women aged 21–64 years who received one or more screening tests for cervical cancer during or within the three years prior to the measurement year or five years for women 30–64 with HPV co-testing. The figure below compares CalOptima Medi-Cal CCS rates for HEDIS MY2018, MY2019 and MY2020.

[1]HEDIS stands for Healthcare Effectiveness Data and Information Set

[2]MCAS stands for Managed Care Accountability Set, previously known as External Accountability Set (EAS)

CCS Figure 1: Trending HEDIS Rates MY2018–20 Results: Medi-Cal



NOTE: CCS Hybrid Rate Shown

CCS Table 1: CCS measure Medi-Cal Percentiles, Goal and Reporting Requirements

HEDIS Measure	QC 33rd Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements
Cervical Cancer Screening (CCS)	**57.42%**	**65.69%**	**72.68%**	**61.31%**	**HPR, MPL, P4V**

**Red is less than 33rd percentile, Green is met the goal, MPL met ++ measure triple weighted for Health Plan Ratings ↓↑ statistically higher or lower ↔ statistically no difference **HPR is health plan ratings, MPL is DHCS Minimum Performance Level, P4V is Pay for Value*

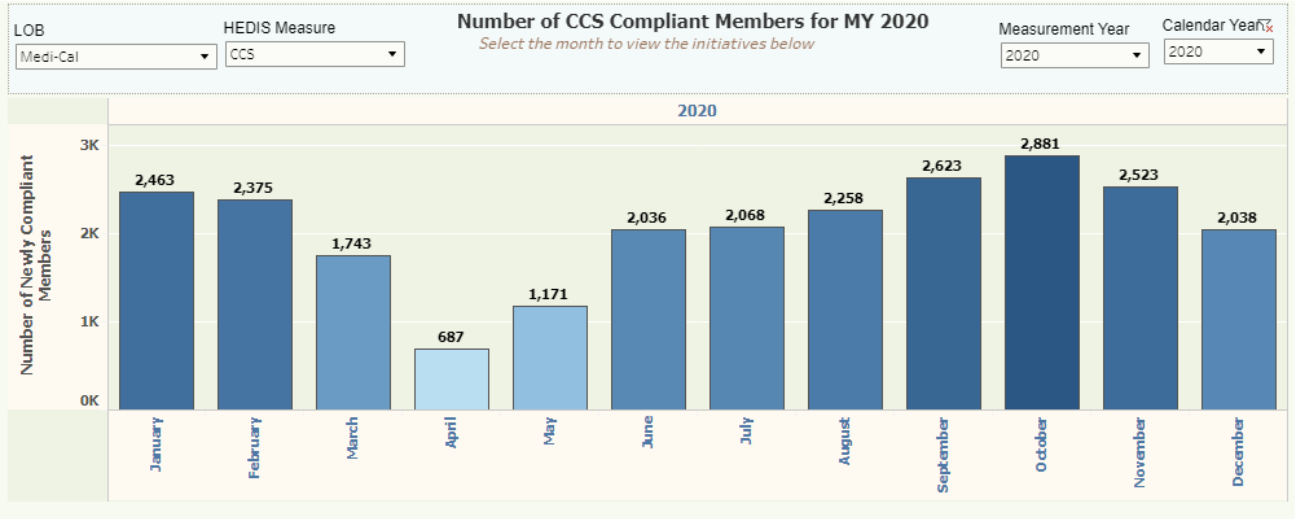
Medi-Cal

CalOptima's HEDIS MY2020 CCS rate for Medi-Cal was 57.41%. The rate decreased by 9.26 percentage points from the prior year. The CCS rates steadily increased for 2018–19, but as anticipated, there was a significant decrease in 2020 due to the COVID-19 pandemic. The measure did not meet goal of 61.31% and did not meet the MPL of 60.65%.

CCS Compliant Members for HEDIS 2020: Medi-Cal

The table below shows the number of unique members who received a cervical cancer screening month by month and the impact of interventions throughout the year.

CCS Figure 2: CCS Compliant Member for HEDIS 2020: Medi-Cal



CCS Table 2: List of MY2020 Medi-Cal CCS Initiatives

Initiative	Start Date	End Date	Outreach Population	Description
Interactive Voice Response (IVR)	2/5/2020	2/5/2020	Total Outreach: 55,529 Successful Contacts: 30,248	IVR campaign to promote Cervical Cancer Screening in Q1 2020
Member Incentive	1/1/2020	12/31/2020	Total Submission: 1165 Approved: 1043	1) $25 member incentive for completing a cervical cancer screening Other impacted measures: 1) AAP[1]
Member Mailing	9/15/2020	9/18/2020	Total: 66,362	Member incentive mailings promoting Cervical Cancer Screenings sent to eligible CalOptima members
Newsletter	7/13/2020	7/13/2020	Head of Household: 280,798	Medi-Cal Newsletter: 2020 CalOptima Health Rewards Programs
P4V	1/1/2020	12/31/2020	N/A	Pay 4 Value program
Provider Update Newsletter	12/20/2020	12/20/2020	All health networks, including CCN providers	Provider Update about Member Health Rewards Program
Website	3/1/2020	12/31/2020	All, public	Posted incentive forms on website

[1] *Adults' Access to Preventive/Ambulatory Health Services*

Medi-Cal

The data shows the declining number of members compliant for CCS began in March 2020. The lowest number of cervical cancer screenings occurred in April 2020, which coincides with COVID-19 pandemic statewide mandated shutdowns that began mid-March. This decrease in rate was followed by the increasing of cervical cancer screenings in May when preventive care screenings resumed and peaked in October 2020. Overall, the number of newly completed cervical cancer screenings month by month in 2020 was lower than the previous 2019 year except for November 2020.

CCS Table 3: Medi-Cal HEDIS MY2020 Rates by Race/Ethnicity

Admin	Race/Ethnicity									
HEDIS MY2020	Hispanic	White	Vietna-mese	No response	Other	Korean	Black	Filipino	Asian or Pacific Islander	Chinese
Numerator	28,964	14,712	15,437	10,755	2,346	1,429	1,387	1,201	903	805
Denominator	47,765	28,251	23,332	18,576	5,407	3,389	2,525	2,234	1,845	1,729
Rate	60.64%	52.08%	66.16%	57.90%	43.39%	42.17%	54.93%	53.76%	48.94%	46.56%

CCS Table 4: Medi-Cal HEDIS MY2020 Rates by Threshold Language

Admin	Language						
HEDIS MY2020	English	Spanish	Vietnamese	Korean	Farsi	Arabic	Chinese
Numerator	48,268	14,711	12,983	830	1,131	636	120
Denominator	89,283	23,238	18,851	1,909	1,757	1,173	231
Rate	54.06%	63.31%	68.87%	43.48%	64.37%	54.22%	51.95%

Note: Based on member written language preference

Medi-Cal

Table 3 examines the race/ethnicity rates for the top 10 race/ethnicity by denominator. Race/Ethnicity rates that fell below MPL of 60.65% for White, Korean, Black, Filipino, Asian or Pacific Islander, and Chinese. The lowest rate was for Korean members (42.17%) followed by members who identified as Other (43.39%). Vietnamese members have the highest rates at 66.16% followed by Hispanic members 60.64%.

Table 4 examines rates by member written language. The highest rate is for Vietnamese (68.87%) and the lowest rate is for Korean (43.48%).

2020 CCS Initiatives: Medi-Cal

1. **CCS Member Health Reward 1/1/2020–12/31/2020**
   - **A. Intervention**

     CalOptima offered a $25 gift card to eligible Medi-Cal members ages 21–64 who completed a cervical cancer screening between January to December 2020. The 2020 CCS member health reward was promoted through:
     1. IVR Outreach Call Campaign: 55,529
     2. CalOptima Website
     3. Member Newsletter Article
        1. Better Together. Medi-Cal Summer 2020: 280,798 households
     4. Member Mailing Campaign: 66,362
     5. Provider Update Newsletter

   - **B. Findings**

     The CCS health reward mailing originally scheduled for March 2020 was delayed and mailed in September 2020 to 66,362 eligible members who were due for CCS. To address health network concerns about urging preventive screening, a COVID-19 disclaimer was added to all mailings

encouraging members to discuss any risks with their doctors and to determine the best care plan weighing the risks against the benefits.

CCS Table 3: 2020 Cervical Cancer Screening Health Reward Member Mailing Campaign

CCS Health Reward Year	Forms Mailed*	Forms Received*	HEDIS Qualified	HEDIS Denominator	HEDIS Eligible Participation Rate
2020	66,362	1,165	1,032	137,772	0.75%

NOTE: The HEDIS denominator was used to calculate the participation rate.
**Kaiser members were excluded from member mailing campaign and member health reward*

C. Analysis

Medi-Cal

In September 2020, of the 66,362 members who were mailed the health reward form, 60,127 members remained in the denominator for the HEDIS MY2020 CCS measure. 3,678 members completed a CCS screening after the mail drop date with a rate of 2.67% (3,678/137,772). Of the 1,165 CCS health reward form submissions, 1,032 CCS health reward form submissions remained in the CCS measure denominator. The health reward participation rate for the HEDIS MY2020 CCS measure was 0.75% (1,032/137,772).

D. Barriers

1. Members may opt not to complete cervical cancer screening because of lack of general knowledge about the test itself or the physical or psychological discomfort associated with the screening.
2. Members may also have a fear about the test results and avoid getting screened.
3. Members may not be aware of the frequency of screening especially after having a previous screening with a negative result. Approximately 25% of members that were noncompliant in 2020 had a history of previously completing a cervical cancer screening.
4. Although cervical cancer screenings for Vietnamese members were the highest rate at 66.16%, other Asian subgroups have some of the lowest screening rates. There may be cultural nuances contributing to the lower screening rates for other Asian subgroups.
5. The CCS health reward mailing was originally scheduled for March 2020, yet it was delayed and mailed in September 2020 to all eligible members due to delays based on risks in members visiting providers during the height of the COVID-19 pandemic.
6. The direct mailing to members tends to be past the mid-year mark due to the HEDIS eligible population data not becoming available until the end of Q1 every year. Additionally, it is unknown which percentage of mail is returned due to wrong addresses.
7. The member health reward form requires a signed/stamped attestation by the primary care provider (PCP). This may prevent some members from participating in the CCS health reward.
8. The CCS health reward was not communicated to members or providers due to resource and budget limitations based on the pandemic and the constraints it created, which resulted in low participation.
9. Due to many factors related to the COVID-19 pandemic, such as quarantine, office closures, restrictions and general fear, preventive screenings like CCS were delayed or not completed, which may have affected member submissions of the health reward forms.

E. Opportunities for Improvement

1. Considering the current priority of the CCS measure, as HEDIS 2020 results showed the measure not meeting the minimum performance level, CCS has escalated to high priority for quality initiatives and member engagement.
2. Messaging can be more targeted for members previously compliant and provide health education on frequency of screening.
3. Develop health education material on cervical cancer screening that is culturally appropriate to race/ethnicity groups that were below MPL such as Korean, Black, Filipino, Asian or Pacific Islander, and Chinese.
4. Target higher risk members with health iniquities caused by age or race. For the Medi-Cal population, when looking at race/ethnicity, White members have the lowest rate of screening when compared to other race/ethnicity groups. In addition, we see that women ages 30–49 are less likely to be compliant than women ages 21–29 and women ages to 50–64.
5. Continue the CCS health reward through 2021 and 2022 to allow more time for members to be aware of it.
6. Conduct member reminders and enhance participation in the CCS member health reward by using multiple modes of communication, including via website, direct mailings, IVR campaigns, social medial targeted campaign and mobile text messaging.
7. Promote the CCS health reward among providers to increase participation in the program and motivate members to schedule and complete their cervical cancer screening. Have more direct collaboration with CCN providers and health network quality teams.
8. Due to new barriers experienced by COVID-19 in 2020, CalOptima will retain CCS on the 2021 and 2022 QI Work Plan and continue to focus on preventive care screenings to address expected dips in utilization through multimedia awareness messaging and communications.

2. CCS Interactive Voice Response (IVR) Outreach 2/5/2020

A. Intervention

CalOptima Medi-Cal members ages 21–64 who were noncompliant for CCS received a prerecorded message with two purposes: 1) encourage them to complete a CCS screening and 2) increase awareness about the available member health reward.

B. Findings

This table shows the results of noncompliant members who were targeted for the CCS IVR call campaign.

CCS Table 4: Cervical Cancer Screening IVR Outreach

2020 CCS IVR Outreach	Successful IVR Calls	Unsuccessful IVR Calls	Total IVR Calls	HEDIS MY2020 Denominator	Rate of Successful IVR Calls
CCS IVR Call Campaign	30,248	25,281	55,529	--	54.47%
HEDIS MY2020 CCS Measure	23,376	14,828	38,204	136,442	17.13%

C. Analysis

Medi-Cal

IVR prerecorded messages were in English, Spanish and Vietnamese. A successful IVR call was defined as prerecorded message was played to a live voice or prerecorded message left on voicemail. Of the 55,529 total IVR calls made, 30,248 of the calls were successfully completed, a rate of 54.47% (3,0248/55,529). Of the 55,529 members targeted, 38,204 were in the denominator for the HEDIS MY2020 CCS measure. The rate of successful IVR calls for the HEDIS MY2020 CCS measure was 17.13% (23,376/136,442).

D. Barriers

1. Unsuccessful IVR call outcomes were largely due to the members hanging up before listening to full prerecorded message, no answer/busy and bad number. Bad numbers accounted for 7.63% of the total IVR calls made.
2. IVR call campaigns were put on hold due to COVID-19 pandemic and Telephone Consumer Protection Act (TCPA) concerns.

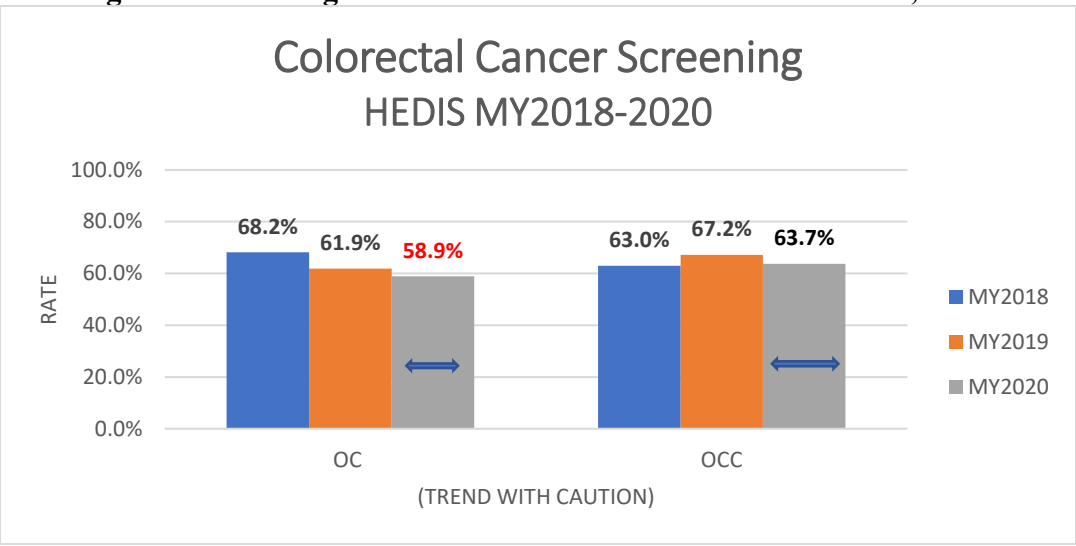
E. Opportunities for Improvement

1. Expand member outreach modality beyond CCS IVR call campaign as the only method to notify members when they are due for CCS.
2. Continue CCS IVR call campaign as part of a more robust member communication/touchpoint plan.
3. Redesign CCS IVR call campaign to be more targeted for members previously compliant or at higher risk due to health iniquities caused by age or race.
4. Make use of mobile text messaging and IVR campaigns in 2022.

Colorectal Cancer Screening (COL): OneCare, OneCare Connect

The hybrid HEDIS measure, COL, measures the percentage of members 50–75 years of age who had appropriate screening for colorectal cancer, which includes either Fecal Occult Blood Test (FOBT) during the measurement year, a flexible sigmoidoscopy during the past 5 years or a colonoscopy within the past 10 years. The table below compares CalOptima COL rates for HEDIS MY2018, MY2019 and MY2020 by line of business.

COL Figure 1: Trending HEDIS Rates MY2018–2020 Results: OC, OCC



COL Table 1: COL Measure OC and OCC Star Rating, Goal and Reporting Requirements

HEDIS Measure: COL	Projected 3-Star**	Projected 4-star**	Projected 5-star**	Goal	Reporting Requirements
OC	62%	73%	80%	73%	Star
OCC	62%	73%	80%	73%	Star, P4V

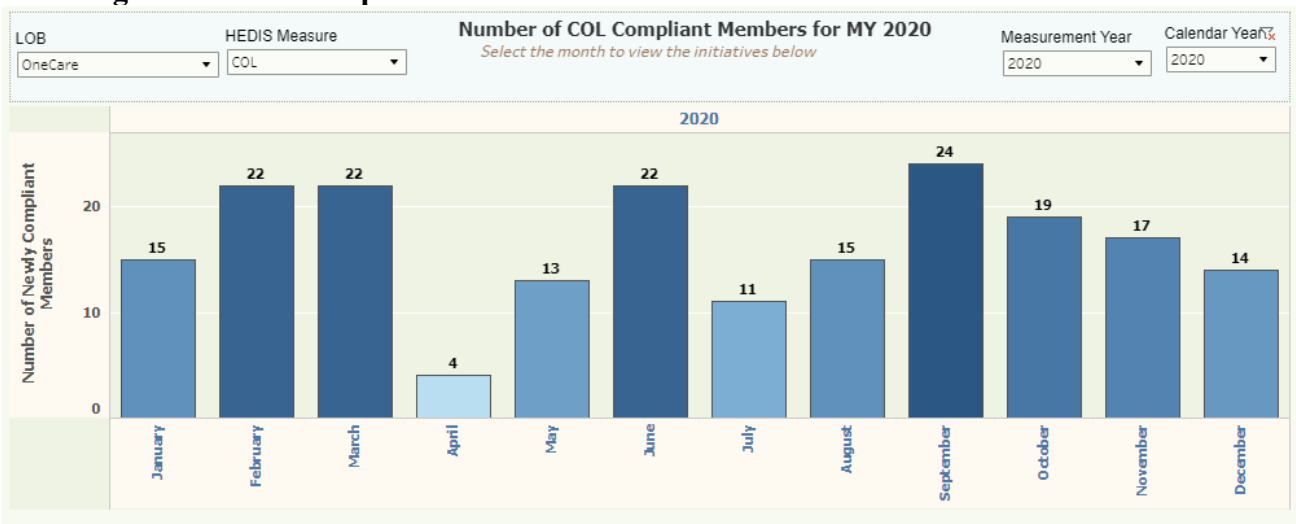
**Red is less than 3-Star or 50th percentile, Green is met the goal **Star cut points are previous year*
↓↑ statistically higher or lower ↔ statistically no difference

OneCare
CalOptima's HEDIS MY2020 COL rate for OneCare was 58.9%. The rate decreased by 3 percentage points from the prior year. The rates have decreased for COL from 2018–2020 with no significant difference between 2019 and 2020. As anticipated, there was further decline in the 2020 rate due to the COVID-19 pandemic, and CalOptima did not meet goal of 73%. As a result, CalOptima's Star rating is 2.

OneCare Connect
CalOptima's HEDIS MY2020 COL rate for OneCare Connect was 63.7%. The rate decreased by 3.5 percentage points from the prior year. The rates for COL have gradually increased from 2018–2019 with no significant difference between 2019 and 2020. However, as anticipated there was decline in the 2020 rate due to the COVID-19 pandemic. As a result, CalOptima's Star rating is 3.

COL Compliant Members for HEDIS 2020: OC, OCC
Figure 2 below shows the number of unique members who received a COL month by month and the impact of interventions throughout the year for OC and OCC.

COL Figure 2: COL Compliant Members for HEDIS 2020: OC

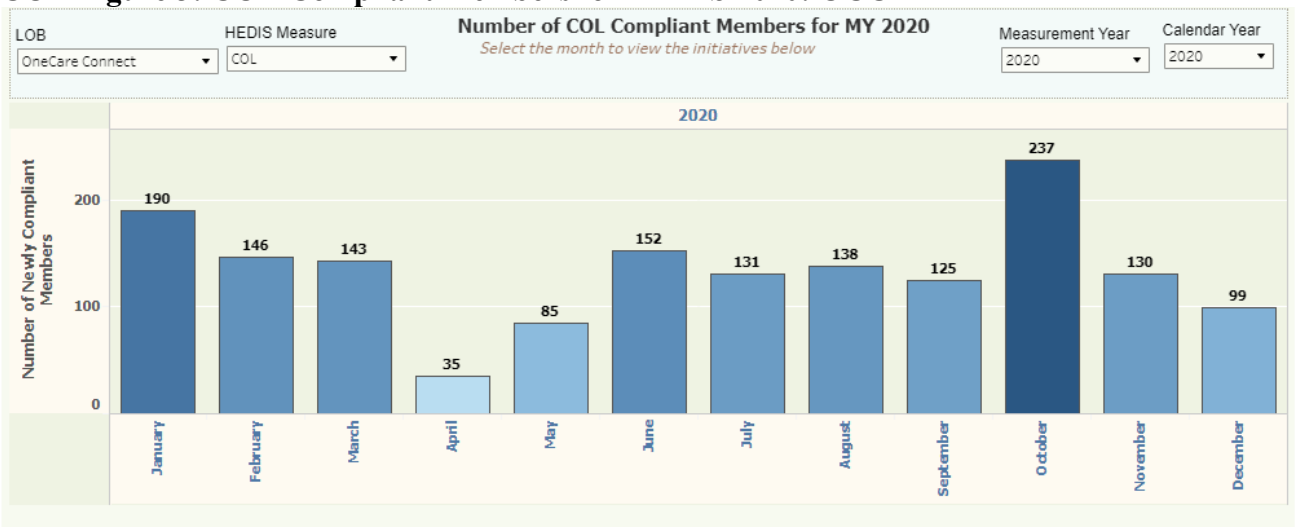


OneCare
The data shows the lowest number of colorectal cancer screenings occurred in April 2020, which coincides with COVID-19 pandemic statewide mandated shutdowns that began mid-March. Screenings increased in May, as preventive care resumed, and decreased again in July 2020 and peaked in September 2020.

COL Table 2: List of MY2020 OneCare COL Initiatives

Initiative	Start Date	End Date	Outreach Population	Description
Member Incentive	1/1/2020	12/31/2020	Total Submission: 0	1) $50 member incentive for completing a sigmoidoscopy or colonoscopy
Website	3/1/2020	12/31/2020	All, public	Posted incentive forms on website

COL Figure 3: COL Compliant Members for HEDIS 2020: OCC



OneCare Connect

The data shows the declining number of members compliant for COL began in March 2020. The lowest number of colorectal cancer screenings occurred in April 2020, which coincides with COVID-19 pandemic statewide mandated shutdowns that began mid-March. Screenings increased in May as preventive care resumed and peaked in October 2020.

COL Table 3: List of MY2020 OneCare Connect COL Initiatives

Initiative	Start Date	End Date	Outreach Population	Description
Member Incentive	1/1/2020	12/31/2020	Total Submission: 30 Approved: 21	1) $50 member incentive for completing a sigmoidoscopy or colonoscopy
Newsletter	4/17/2020	4/17/2020	HOH[1]: 14,217	OCC Newsletter: 2020 CalOptima Health Rewards Programs
Newsletter	8/6/2020	8/6/2020	HOH[1]: 14,501	OCC Newsletter: No-Cost Colorectal Cancer Screening for People 50 and Older/2020 CalOptima Heath Reward Program
P4V	1/1/2020	12/31/2020	N/A	Pay 4 Value program
Website	3/1/2020	12/31/2020	All, public	Posted incentive forms on website

[1]*HOH = Head of Household*

OneCare Connect
The data shows the declining number of members compliant for COL began in March 2020. The lowest number of colorectal cancer screenings occurred in April 2020, which coincides with COVID-19 pandemic statewide mandated shutdowns that began mid-March. Screenings increased in May as preventive care resumed and peaked in October 2020.

COL Table 4: OneCare HEDIS MY2020 Rates by Race/Ethnicity

Admin	Race/Ethnicity									
HEDIS MY2020	White	Hispanic	No response	Vietna-mese	Other	Filipino	Asian or Pacific Islander	Black	Chinese	Korean
Numerator	166	112	37	35	18	4	7	4	7	5
Denominator	343	220	97	62	41	16	13	11	11	7
Rate	48.40%	50.91%	38.14%	56.45%	43.90%	25.00%	53.85%	36.36%	63.64%	71.43%

COL Table 5: OneCare HEDIS MY2020 Rates by Threshold Language

Admin	Language					
HEDIS MY2020	English	Spanish	Vietnamese	Korean	Farsi	Arabic
Numerator	265	91	40	3	2	1
Denominator	607	165	57	4	2	1
Rate	43.66%	55.15%	70.18%	75.00%	100.00%	100.00%

Note: Based on member written language preference

OneCare
Table 4 examines the race/ethnicity rates for the top 10 race/ethnicity by denominator. The race/ethnicity groups that fell below a 3 Star rating of 62% are White, Hispanic, Vietnamese, Filipino, Asian or Pacific Islander, and Black members. The lowest rate is for Black members (36.36%) but the group has a low denominator count. The lowest rate with substantial members is for White members (48.40%). Korean members have the highest rate at 71.43% followed by Chinese members 63.64% but both groups have a low denominator count. The highest rate with substantial members is Hispanic members (50.91%). Table 5 examines rates by member written language the highest rate with substantial member count is Vietnamese (70.18%) and the lowest rate is for English members (43.66%).

COL Table 6: OneCareConnect HEDIS MY2020 Rates by Race/Ethnicity

Admin	Race/Ethnicity									
HEDIS MY2020	Hispanic	White	No response	Vietna-mese	Other	Asian or Pacific Islander	Black	Filipino	Unknown	Chinese
Numerator	996	712	536	308	196	153	62	73	51	28
Denominator	1,746	1,489	1,144	607	367	330	129	112	83	53
Rate	57.04%	47.82%	46.85%	50.74%	53.41%	46.36%	48.06%	65.18%	61.45%	52.83%

COL Table 7: OneCareConnect HEDIS MY2020 Rates by Threshold Language

Admin	Language						
HEDIS MY 2020	English	Spanish	Vietnamese	Farsi	Arabic	Korean	Chinese
Numerator	1551	1019	520	57	27	12	0
Denominator	3225	1762	1050	87	40	19	1
Rate	48.09%	57.83%	49.52%	65.52%	67.50%	63.16%	0.00%

Note: Based on member written language preference

OneCare Connect

Table 6 examines the race/ethnicity rates for the top 10 race/ethnicity by denominator. All race/ethnicity rates, except Filipino, fell below a 3-star rating of 62%. The lowest rate was for Asian or Pacific Islander (48.06%) followed by members that did not provide race/ethnicity information (46.85%). Filipino members have highest rate of 65.18%. Table 7 examines rates by member written language, with the highest rate for Arabic (67.50%) and the lowest rate for English (48.09%).

2020 COL Initiatives: OneCare, OneCare Connect

1. COL Member Health Reward 1/1/2020–12/31/2020

A. Intervention

CalOptima offered a $50 gift card to eligible CalOptima OneCare and OneCare Connect members ages 50–75 who completed a sigmoidoscopy or colonoscopy between January to December 2020. The 2020 COL member health reward was promoted through:

1. CalOptima website
2. Member newsletter article (OCC only)
    a. OneCare Connections Spring 2020. Head of Household (HOH) 14,217
    b. OneCare Connections Summer 2020. HOH 14,501

B. Findings

The table below shows the results of COL health reward form submissions for 2020.

COL Table 4: 2020 Colorectal Cancer Screening Health Reward

COL LOB	Forms Received	HEDIS Qualified	HEDIS Denominator	HEDIS Health Reward Participation Rate
OneCare	0	0	836	0%
OneCare Connect	30	12	6,184	0.19%

NOTE: The HEDIS denominator was used to calculate the participation rate.
**Kaiser members were excluded from member health reward.*

C. Analysis

OC

The health reward participation rate for the HEDIS 2020 COL was 0%.

OCC

In 2020, of the 30 COL health reward form submissions, 12 COL health reward form submissions remained in the COL measure denominator. The health reward participation rate for the HEDIS 2020 COL was 0.19%.

D. Barriers

1. Members may not complete their colorectal cancer screening because of the discomfort associated with the procedure and/or fear about learning of the test results.
2. Members are not aware of the multiple screening options that are available to them and the frequency of screening for each option.
3. There was no COL health reward mailing scheduled in 2020 due to resource and budget constraints.
4. The member health reward form requires a signed/stamped attestation by the PCP. This may prevent some members from participating in the program.
5. The member health reward was not communicated effectively to members or providers resulting in low member participation.
6. Due to the COVID-19 pandemic, there was a drop in colorectal cancer screenings starting in April 2020. CalOptima's rate report continues to show a decline when compared with the same time the prior year.

E. Opportunity for Improvement

1. The messaging can be more targeted for members who were previously compliant. In the messaging, CalOptima will include information about the screening options and frequency.
2. CalOptima will target higher risk members due to health iniquities caused by age or ethnicity. For OC and OCC population, when examining ethnicity, White members have the lowest rate of screening when compared with other ethnic groups. In addition, we see members ages 65–75 are less likely to be compliant than members 50–64 years of age.
3. CalOptima will continue the COL member health reward through 2021 and 2022 to allow more time for members to be aware of the health reward offered.
4. Participation in the COL member health reward can be enhanced by using multiple modes of communication via website, direct mailings, IVR campaigns, social media targeted campaigns and mobile text messaging. Improve direct collaboration with CCN

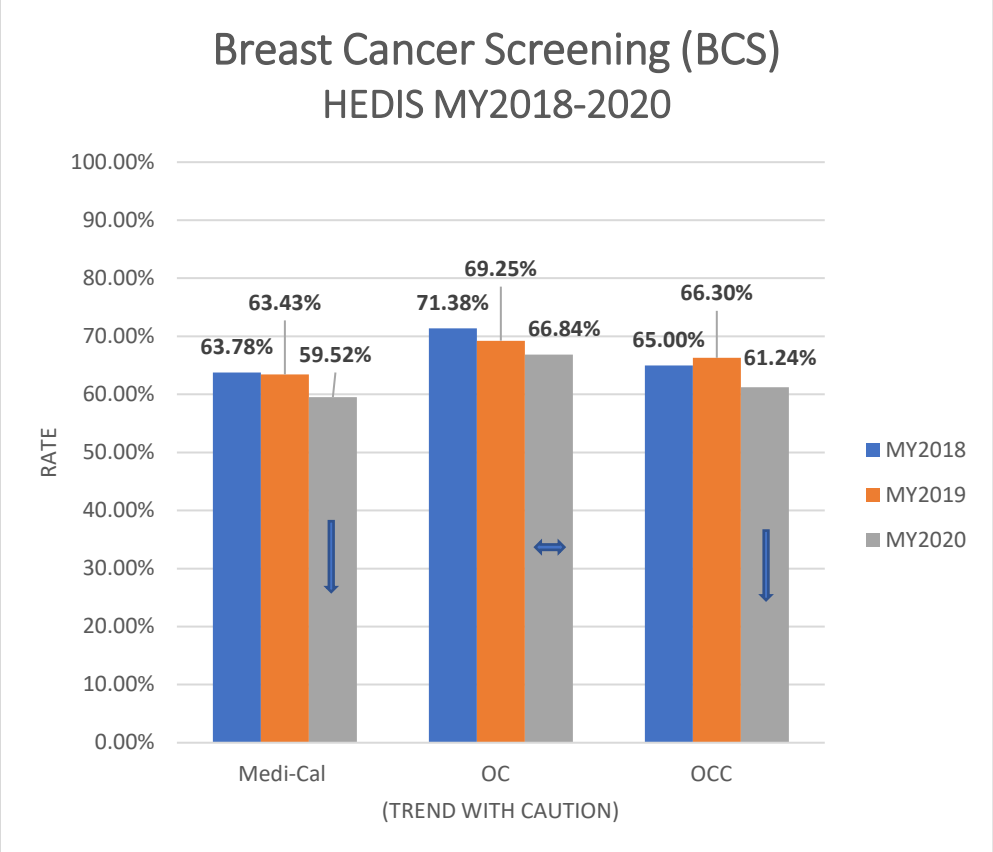
providers and health network quality teams. CalOptima plans to use more strategic member engagement strategies with external vendors.

5. Due to new barriers experienced from COVID-19 in 2020, CalOptima will retain COL on the 2021 and 2022 QI Work Plan and continue to focus on preventive care screenings to address expected dips in utilization through multimedia awareness messaging and communications.

Breast Cancer Screening (BCS): Medi-Cal, OneCare, OneCare Connect

The administrative HEDIS and MCAS measure, BCS, measures the percentage of members who are women in the age range of 50–74 years old, and have received one or more mammograms on or between October 1 two years prior to the measurement year and December 31 of the measurement year. The figure below compares CalOptima BCS rates for HEDIS MY2018, MY2019 and MY2020 by line of business.

BCS Figure 1: Trending HEDIS Rates MY2018–2020 Results: Medi-Cal, OC, OCC



BCS Table 1: BCS Measure Medi-Cal Percentiles, Goal and Reporting Requirements

HEDIS Measure: BCS Medi-Cal	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
Medi-Cal	**55.08%**	**61.84%**	**69.22%**	**58.82%**	HPR, **MPL**, P4V

**Red is less than 33rd percentile, Green is met the goal, MPL met ++ measure triple weighted for Health Plan Ratings ↓↑ statistically higher or lower ↔ statistically no difference **HPR=Health plan ratings, MPL=DHCS Minimum Performance Level, P4V=Pay for Value*

BCS Table 2: BCS Measure OneCare and OneCare Connect Star rating, Goal and Reporting Requirements

HEDIS Measure: BCS	Projected 3-Star**	Projected 4-star**	Projected 5-star**	Goal	Reporting Requirements**
OneCare	66%	76%	83%	76%	Star
OneCare Connect	66%	76%	83%	76%	Star, P4V

**Red is less than 3-Star or 50th percentile, Green is met the goal **Star cut points are previous year ↓↑ statistically higher or lower ↔ statistically no difference, P4V=Pay for Value*

Medi-Cal

CalOptima's HEDIS MY2020 BCS rate for Medi-Cal was 59.52%. The rate decreased by 3.91 percentage points from the prior year. The rates have been steady for BCS for 2018–19 but, as anticipated, there was a significant decrease in the 2020 rate due to the impact of the COVID-19 pandemic. Regardless of the decrease, CalOptima did meet the goal of 58.82%. The rate exceeded the minimum performance level of 58.67%.

OneCare

CalOptima's HEDIS MY2020 BCS rate for OneCare was 66.84%. The rate decreased by 2.41 percentage points from the prior year. The rates have decreased for BCS from 2018–20, but there was no significant difference between 2019 to 2020. As anticipated, the decline in the 2020 rate is attributed to the COVID-19 pandemic, and the measure did not meet the goal of 76%. As a result, the Star rating is a 3.

OneCare Connect

CalOptima's HEDIS MY2020 BCS rate for OneCare Connect was 61.24%. The rate decreased by 5.06 percentage points from the prior year. The rates for BCS have gradually increased from 2018–2019 however, as anticipated, a significant decline occurred in the 2020 rate due to the COVID-19 pandemic, but did not meet goal of 76%. As a result, the Star rating is 2.

BCS Compliant Members for HEDIS MY2020: Medi-Cal, OC, OCC

Figure 2 below shows the number of unique members who received a BCS mammogram month by month and the impact of interventions throughout the year for Medi-Cal, OC and OCC.

BCS Figure 2: BCS Compliant Member for HEDIS MY2020: Medi-Cal

BCS Table 3: List of MY2020 Medi-Cal BCS Initiatives

Initiative	Start Date	End Date	Outreach Population	Description
Member Incentive	1/1/2020	12/31/2020	Total Submission: 681 Approved: 633	1) $25 member incentive for completing a screening mammogram Other impacted measures: 1) AAP[1]
Member Mailing	9/18/2020	9/21/2020	Total: 17,862	Member incentive mailings promoting Breast Cancer Screenings sent to eligible CalOptima members
Newsletter	7/13/2020	7/13/2020	HOH: 280,798	Medi-Cal Newsletter: 2020 CalOptima Health Rewards Programs
P4V	1/1/2020	12/31/2020	N/A	Pay 4 Value program
Provider Update Newsletter	12/20/2020	12/20/2020	All health networks and CCN providers	Provider Fax Blast (Provider Update): CalOptima 2021 Member Health Rewards Program
Social Media Posting 1	10/20/2020	10/20/2020	All, public	Breast Cancer Awareness Month (Instagram, Facebook, Twitter)
Social Media Posting 2	10/6/2020	10/7/2020	All, public	Breast Cancer Awareness Month (Instagram, Facebook, Twitter)
Website	3/1/2020	12/31/2020	All, public	Posted incentive forms on website

[1] *Adults' Access to Preventive/Ambulatory Health Services*

Medi-Cal

The data shows the declining number of members compliant for BCS began in March 2020. The lowest number of breast cancer screenings occurred in April 2020, which coincides with COVID-19 pandemic statewide mandated shutdowns that began mid-March. Breast cancer screenings began increasing in May, as preventive care screenings resumed, and peaked in October 2020. Overall, the number of newly completed breast cancer screenings month by month in 2020 was lower than the previous 2019 year except for February 2020, August 2020 and November 2020.

BCS Figure 3: BCS Compliant Member for HEDIS MY2020: OC

BCS Table 4: List of MY2020 OneCare BCS Initiatives

Initiative	Start Date	End Date	Outreach Population	Description
Member Incentive	1/1/2020	12/31/2020	Total Submission: 3 Approved: 2	1) $25 member incentive for completing a screening mammogram Other impacted measures: 1) AAP[1]
Member Mailing	9/18/2020	9/21/2020	Total: 74	Member incentive mailings promoting Breast Cancer Screenings sent to eligible CalOptima members
Social Media Posting 1	10/20/2020	10/20/2020	All, public	Breast Cancer Awareness Month (Instagram, Facebook, Twitter)
Social Media Posting 2	10/6/2020	10/7/2020	All, public	Breast Cancer Awareness Month (Instagram, Facebook, Twitter)
Website	3/1/2020	12/31/2020	All, public	Posted incentive forms on website

[1] *Adults' Access to Preventive/Ambulatory Health Services*

OneCare

The data shows the declining number of members compliant for BCS began in March 2020. The lowest number of breast cancer screenings occurred in April 2020, which coincides with COVID-19 pandemic statewide mandated shutdowns that began mid-March. Breast cancer screenings began increasing in May, as preventive care screenings resumed, and peaked in October 2020.

BCS Figure 4: BCS Compliant Member for HEDIS MY2020: OCC

BCS Table 5: List of MY2020 OneCare Connect BCS Initiatives

Initiative	Start Date	End Date	Outreach Population	Description
Member Incentive	1/1/2020	12/31/2020	Total Submission: 72 Approved: 62	1) $25 member incentive for completing a screening mammogram Other impacted measures: 1) AAP[1]
Member Mailing	9/18/2020	9/21/2020	Total: 1,411	Member incentive mailings promoting Breast Cancer Screenings sent to eligible CalOptima members
Newsletter	4/17/2020	4/17/2020	HOH: 14,217	OCC Newsletter: 2020 CalOptima Health Rewards Programs
Newsletter	8/6/2020	8/6/2020	HOH: 14,501	OCC Newsletter: 2020 CalOptima Health Rewards Programs
P4V	1/1/2020	12/31/2020	N/A	Pay 4 Value program
Social Media Posting 1	10/20/2020	10/20/2020	All, public	Breast Cancer Awareness Month (Instagram, Facebook, Twitter)
Social Media Posting 2	10/6/2020	10/7/2020	All, public	Breast Cancer Awareness Month (Instagram, Facebook, Twitter)
Website	3/1/2020	12/31/2020	All, public	Posted incentive forms on website

[1]*Adults' Access to Preventive/Ambulatory Health Services*

OneCare Connect

The data shows the declining number of members compliant for BCS began in March 2020. The lowest number of breast cancer screenings occurred in April 2020, which coincides with COVID-19 pandemic statewide mandated shutdowns that began mid-March. Breast cancer screenings began increasing in May, as preventive care screenings resumed, and peaked in October 2020.

Race/Ethnicity and Language Analysis: Medi-Cal, OneCare and OneCare Connect

BCS Table 6: Medi-Cal HEDIS MY2020 Rates by Race/Ethnicity

Admin	Race/Ethnicity									
HEDIS MY2020	Hispanic	Viet-namese	White	No response	Other	Korean	Asian or Pacific Islander	Filipino	Chinese	Black
Numerator	6,816	6,492	3,725	2,864	707	642	452	442	330	287
Denominator	10,923	9,416	7,734	4,818	1,382	1,121	815	755	661	542
Rate	62.40%	68.95%	48.16%	59.44%	51.16%	57.27%	55.46%	58.54%	49.92%	52.95%

BCS Table 7: Medi-Cal HEDIS MY2020 Rates by Threshold Language

Admin	Language						
HEDIS MY2020	English	Vietnamese	Spanish	Korean	Farsi	Arabic	Chinese
Numerator	8252	6083	5464	534	540	241	64
Denominator	16298	8748	8478	893	792	388	119
Rate	50.63%	69.54%	64.45%	59.80%	68.18%	62.11%	53.78%

Note: Based on written member language preference

Medi-Cal

Tables 6 examines the race/ethnicity rates for the top 10 race/ethnicity by denominator. Race/ethnicity rates that fell below MPL of 58.67% were White, Korean, Asian or Pacific Islander, Chinese and Black members. The lowest rate is for White members (48.16%) followed by Chinese members (49.92%). Vietnamese members have the highest rates (68.95%) followed by Hispanic members (62.40%). Table 7 examines rates by member written language, with the highest rate for Vietnamese (69.54%) and the lowest rate for English (50.63%).

BCS Table 8: OneCare HEDIS MY2020 Rates by Race/Ethnicity

Admin	Race/Ethnicity									
HEDIS MY2020	White	Hispanic	No response	Vietna-mese	Other	Filipino	Asian or Pacific Islander	Black	Chinese	Korean
Numerator	182	147	72	44	24	12	12	10	4	2
Denominator	297	225	94	64	29	14	12	12	8	6
Rate	61.28%	65.33%	76.60%	68.75%	82.76%	85.71%	100.00%	83.33%	50.00%	33.33%

BCS Table 9: OneCare HEDIS MY2020 Rates by Threshold Language

Admin	Languages				
HEDIS MY2020	English	Spanish	Vietnamese	Korean	Farsi
Numerator	183	56	21	1	1
Denominator	271	87	31	2	1
Rate	67.53%	64.37%	67.74%	50.00%	100.00%

Note: Based on written member language preference

OneCare

Table 8 examines the race/ethnicity rates for the top 10 race/ethnicity by denominator. Race/ethnicity rates that fell below 3-Star rating of 66% are for White, Hispanic, Chinese and Korean members. The lowest rate is for Korean members (33.33%) followed by Chinese members (50.00%), but these race/ethnicities have a low denominator count. The lowest rate with substantial membership is for White members (61.28%). Members who did not provide race/ethnicity information has highest rates (76.60%) followed by Vietnamese members (68.75%). Table 9 examines rates by member written language, with the highest rate for Vietnamese (67.74%) and the lowest rate for Korean (50%), but the group has a low denominator count.

BCS Table 10: OneCare Connect HEDIS MY2020 Rates by Race/Ethnicity

Admin	Race/Ethnicity									
HEDIS MY2020	Hispanic	White	No response	Vietna-mese	Other	Asian or Pacific Islander	Black	Filipino	Unknown	Chinese
Numerator	1,175	728	694	360	208	182	80	82	62	34
Denominator	1,725	1,420	1,160	546	348	322	124	106	90	48
Rate	68.12%	51.27%	59.83%	65.93%	59.77%	56.52%	64.52%	77.36%	68.89%	70.83%

BCS Table 11: OneCare Connect HEDIS MY2020 Rates by Threshold Language

Admin	Languages					
HEDIS MY2020	English	Spanish	Vietnamese	Farsi	Arabic	Korean
Numerator	846	648	304	25	9	7
Denominator	1535	903	494	43	17	11
Rate	55.11%	71.76%	61.54%	58.14%	52.94%	63.64%

Note: Based on written member language preference

OneCare Connect

Table 10 examines the race/ethnicity rates for the top 10 race/ethnicity by denominator. Race/ethnicity rates that fell below 3-Star rating of 66% are for White, Vietnamese, Asian or Pacific Islander and Black members. The lowest rate is for White members (51.27%) followed by Asian or Pacific Islander (56.52%). Filipino members have the highest rates (77.36%) followed by Chinese members (70.83%). Table 11 examines rates by member written language, with the highest rate for Spanish (71.76%) and the lowest rate for Arabic (52.94%), but the group has a low denominator count.

2020 BCS Initiatives: Medi-Cal, OneCare, OneCare Connect

1. **BCS Member Health Reward 1/1/2020–12/31/2020**
   - **A. Interventions**

     CalOptima offered a $25 gift card to eligible CalOptima members ages 50–74 who completed a breast cancer screening mammogram between January to December 2020. The 2020 BCS member health reward program was promoted through:

     1. CalOptima website
     2. Member newsletter article
        a. Better. Together. Medi-Cal Summer 2020. HOH 280,798
        b. OneCare Connections. OneCare Connect Spring 2020. HOH 14,217
        c. One Care Connections. OneCare Connect Summer 2020. HOH 14,501

3. Member mailing campaign: Medi-Cal: 17,862; OC: 74; OCC: 1,411

B. Findings

The BCS health reward mailing originally scheduled for March 2020 was delayed and mailed in September 2020 to all eligible members who were due for BCS. To address health network concerns about urging preventive screening, a COVID-19 disclaimer was added to all mailings encouraging members to discuss any risks with their doctors and to determine the best care plan weighing the risks against the benefits.

BCS Table 6: 2020 Breast Cancer Screening Health Reward Member Mailing Campaign

BCS LOB	Forms Mailed*	Forms Received*	HEDIS Qualified	HEDIS Denominator	HEDIS Eligible Participation Rate
Medi-Cal	17,862	681	471	39,110	1.20%
OneCare	74	3	0	392	0.00%
OneCare Connect	1,411	72	40	3,003	1.33%

NOTE: The HEDIS denominator was used to calculate the participation rate.
**Kaiser members were excluded from member mailing campaign and member health reward.*

C. Analysis

Medi-Cal

In 2020, of the 17,862 members who were mailed the health reward form in September 2020, 16,517 remained in the denominator for the HEDIS 2020 BCS measure. Of those, 1,234 members completed a BCS after the mail drop date with a rate of 3.46% (1,234/35,716). Of the 681 BCS health reward form submissions, 471 BCS health reward form submissions remained in the BCS measure denominator. The health reward participation rate for the HEDIS 2020 BCS measure was 1.32% (471/35,716).

OneCare

In 2020, of the 74 members who were mailed the health reward form in September 2020, 51 remained in the denominator for the HEDIS 2020 BCS measure. Of those, 3 members completed a BCS after the mail drop date with a rate of 0.77% (3/392). Of the 3 BCS health reward form submissions, 0 BCS health reward form submissions remained in the BCS measure denominator. The health reward participation rate for the HEDIS 2020 BCS was 0%.

OneCare Connect

In 2020, of the 1,411 members who were mailed the health reward form in September 2020, 1,264 remained in the denominator for the HEDIS 2020 BCS measure. Of those, 89 members completed a BCS after the mail drop date with a rate of 2.96% (89/3,003). Of the 89 BCS health reward form submissions, 40 BCS health reward form submissions remained in the BCS measure denominator. The health reward participation rate for the HEDIS 2020 BCS was 1.33%.

D. Barriers

1. Members may not complete their mammography screening because of the discomfort associated with the procedure and/or are afraid to know the result.

2. Members may not be aware of the frequency of screening especially after having a previous screening with a negative result. Approximately 40% of members who were noncompliant in 2020 had a history of previously completing a mammogram.
3. The BCS health reward mailing originally scheduled for March 2020 was delayed and mailed in September 2020 to all eligible members who were due for BCS.
4. The direct mailing to member tends to be past the mid-year mark due to the HEDIS eligible population not becoming available until the end of Q1 every year. Additionally, it is unknown what percentage of mail is returned due to wrong addresses.
5. The member health reward form requires a signed/stamped attestation by the PCP or imaging center, which may prevent some members from participating in the BCS health reward.
6. Health reward was not communicated to members or providers due to resource and budget limitations caused by the COVID-19 pandemic, which resulted in low participation. For instance, 10,903 Medi-Cal members completed their mammogram screening in 2020 but only 463 submitted their health reward form.
7. Due to many factors related to the COVID-19 pandemic such as quarantine, office closures, restrictions and general fear, there was a drop in breast cancer screening starting in March 2020. CalOptima's 2021 rate reports continue to show a decline when compared with the same time last year.

E. Opportunity for Improvement

1. Messaging can be more targeted for members previously compliant and provide health education on the frequency of screening.
2. Target our higher risk members due to health iniquities caused by age or race. For the Medi-Cal population, White members have the lowest rate of screening when compared with other race/ethnicity groups. In addition, women ages 56–64 are less likely to be compliant than women 65–75 years of age.
3. Continue the BCS health reward through 2021 and 2022 to allow more time for members to be aware of the health reward offered.
4. Conduct member reminders and enhance participation in the BCS member health reward by using multiple modes of communication via website, direct mailings, IVR campaigns, social media targeted campaign and mobile text messaging. CalOptima plans to use more strategic member engagement strategies.
5. Promote the BCS health reward among providers and radiology centers to increase participation in the program. Improve more direct collaboration with CCN providers and health network quality teams.
6. Due to new barriers experienced by COVID-19 in 2020, CalOptima will retain BCS on the 2021 and 2022 QI Work Plan and continue to focus on preventive care screenings to address expected dips in utilization through multimedia awareness messaging and communications.

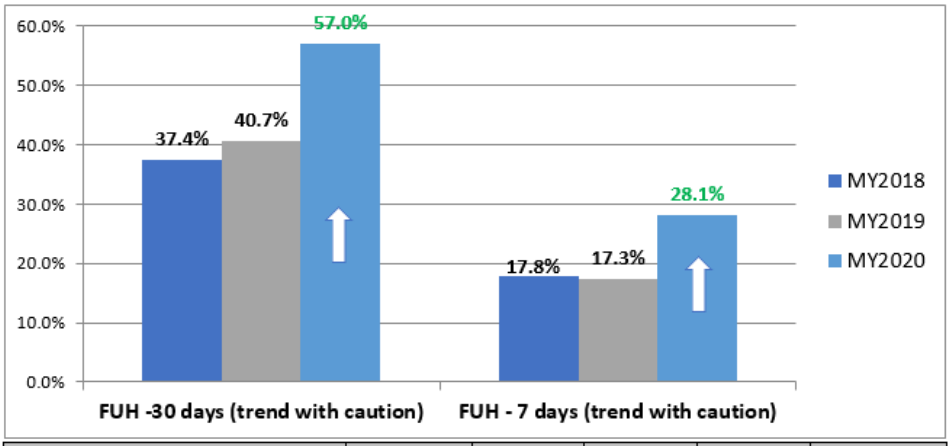
Behavioral Health Quality Initiatives

Follow-Up After Hospitalization for Mental illness Within 7 and 30 Days of Discharge (FUH)

A. Interventions

1. The Transition of Care Management (TCM) team continued outreach to members post-discharge to coordinate follow-up appointments and address potential barriers (e.g., transportation). The team continued to build relationships with facilities, behavioral health (BH) providers, and county staff that further increased engagement.
2. The TCM team continued to meet weekly with the BH medical director to discuss concurrent reviews and internal coordination interventions.
3. In January 2021, CalOptima launched the Behavioral Health Integration Incentive Program (BHIIP). The DHCS incentive program allowed plan providers to apply for various projects focused on improving health outcomes, care delivery efficiency and patient experience. Two provider groups were selected for the Improving Follow-Up After Hospitalization for Mental Illness project. In June, the Behavioral Health Integration (BHI) quality team attended a learning collaborative meeting and discussion occurred surrounding successes and barriers for the providers focused on follow-up visits post discharge.
4. BHI quality team researched and reviewed other health plan strategies to improve rates and motivate members to participate in care (e.g., offering member incentives), as well as challenges (e.g., member willingness to participate in own care).

B. Findings



HEDIS Measure	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
Follow-Up After Hospitalization for Mental Illness (FUH) - 30 days	40.16%	53.85%	71.43%	56%	Withhold
Follow-Up After Hospitalization for Mental Illness (FUH) - 7 days ++	20.98%	30.77%	45.62%	18.20%	CMS

*Red = less than 3-Star or 50th percentile, Green= met the goal **Star cut points are previous year ↑ ↓ statistically higher or lower ↔ statistically no difference

C. Analysis

In 2020, CalOptima's HEDIS goal for OCC FUH-30 days was 56%; CalOptima exceeded this goal with a rate of 57%. The goal for FUH-7 days was set at 18.20% and CalOptima also exceeded this goal with a rate of 28.1%. We have continued to establish a significant upward trend over the past few years in both the 30-day and 7-day follow-up.

D. Barriers

1. The discharge planning procedure is not standardized among the hospitals that serve members. In addition, resistance from a specific facility has been an issue (i.e., not sharing information regarding aftercare plan or post discharge appointment). This issue

has been shared with the Provider Relations department who provided information on the importance of coordination of care post hospitalization.
2. The TCM team was not always able to contact members after they had been discharged from the hospital, particularly when the members are experiencing homelessness or did not provide the hospital with their contact information.
3. Other health plan strategies (e.g., offering member incentives) were not an option due to lack of incentive funding.

E. Opportunities for Improvement

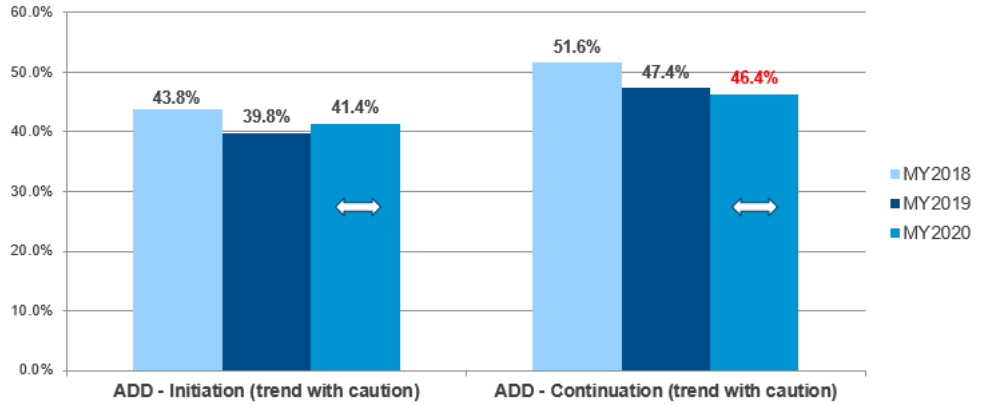
1. CalOptima can conduct more collaboration with provider groups selected for the BHIIP project to improve follow-up after hospitalization.
2. The TCM team will continue to conduct post discharge member outreach to ensure members are able to attend follow-up appointments.
3. The BHI management team can conduct additional hospital visits to educate discharge planning staff about FUH requirements and address any questions or concerns.

Follow-Up Care for Children With Prescribed ADHD Medication (ADD)

A. Interventions

1. Pharmacy-related intervention continued, placing a 30-day limit for the initial fill of Attention-Deficit Hyperactivity Disorder (ADHD) medication to encourage members to follow up with the prescriber within 30 days.
2. BHI quality team continued to track/trend providers who were noncompliant with this measure. Providers with high frequency of noncompliance were sent a letter to inform them about ADD requirements and the importance of follow-up visits with members prescribed ADHD medications.
3. BHI quality team updated prior report to track when members first filled ADHD medications and conducted member outreach to ensure a 30-day follow-up appointment had been scheduled.
4. BHI quality team created and submitted an article for the Spring edition of the CalOptima member newsletter to educate on the importance of attending follow-up visits with a provider.

B. Findings



HEDIS Measure	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
Follow-up Care for Children Prescribed ADHD Medication (ADD) - Initiation Phase	38.18%	46.53%	55.33%	42.95%	
Follow-up Care for Children Prescribed ADHD Medication (ADD) - Continuation Phase	48.65%	58.76%	67.98%	54.73%	HPR

*Red = less than 33rd percentile; Green= met goal, MPL met, ++ measure triple weighted for Health Plan Ratings ↑ ↓ statistically higher or lower ↔ statistically no difference **HPR=Health plan ratings, MPL=DHCS Minimum Performance Level, P4V=Pay for Value

C. Analysis

CalOptima's 2020 HEDIS Initiation Phase final rate was 41.4%, which did not meet the intended goal of 42.95%. The 2020 HEDIS Continuation Phase final rate was 46.4%, which also did not meet the intended goal of 54.73%. The Initiation Phase has a trend that has been fluctuating the past three years. The Continuation Phase has been trending downward for the past three years.

D. Barriers

1. The provider letter was faxed to the number on record. We are aware that the fax may not always go to the intended provider to whom the letter was faxed.
2. Due to the ongoing PHE, there was limited access to appointment scheduling in a timely manner for the member.
3. Due to limited resources, reporting needs were delayed impacting provider outreach intervention targeted to improve Continuation Phase numbers as initially intended. As a result, the shift to update a prior report allowed member outreach to target Initiation Phase did not occur until later in the year.
4. Pharmacy-related intervention (i.e., 30-day limit for the initial fill of ADHD medication) will discontinue due to the new pharmacy benefit carve out (i.e., Medi-Cal Rx) beginning 1/1/2022.

E. Opportunities for Improvement

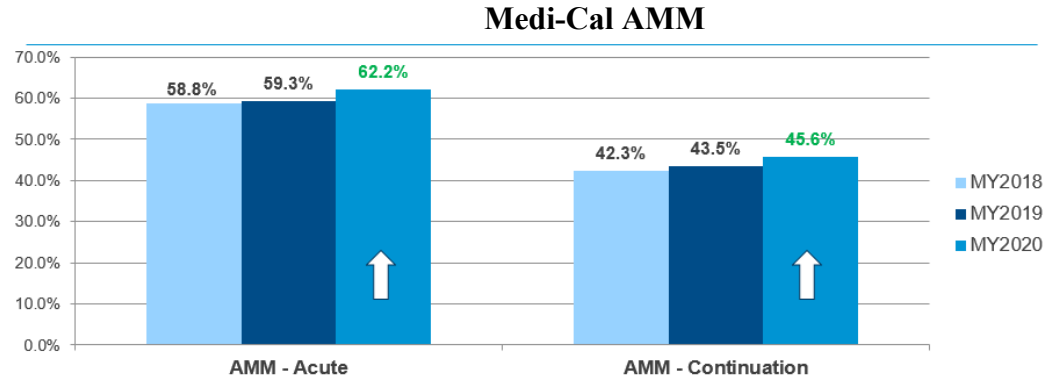
1. The BHI quality team will continue to send letters to providers who are not meeting the ADD requirements.
2. The BHI quality team will explore opportunities to continue member outreach to identify barriers and assist members with appointment scheduling if necessary.
3. ADD materials will be updated yearly and the team will distribute new materials to providers and members as part of the outreach effort.

Antidepressant Medication Management (AMM)

A. Interventions

1. The BHI quality team created a depression factsheet and posted it to the CalOptima website for virtual distribution to allow providers to share with members during telehealth visits. The factsheet included information on depression and importance of treatment compliance.
2. The BHI quality team created and distributed a provider letter on reminding members of importance of medication adherence as well as communicate standards and guidelines regarding the measure. The letter also included a link to the depression factsheet located on the CalOptima website to share with the members they serve.
3. The BHI quality team created an article, "Understanding Depression," for the Summer 2021 Medi-Cal member newsletter. The article included a section on how to manage your medicines.
4. Additional member materials were posted on social media (e.g., Facebook and Instagram).
5. BHI quality team developed HEDIS reporting tip sheet for provider education.

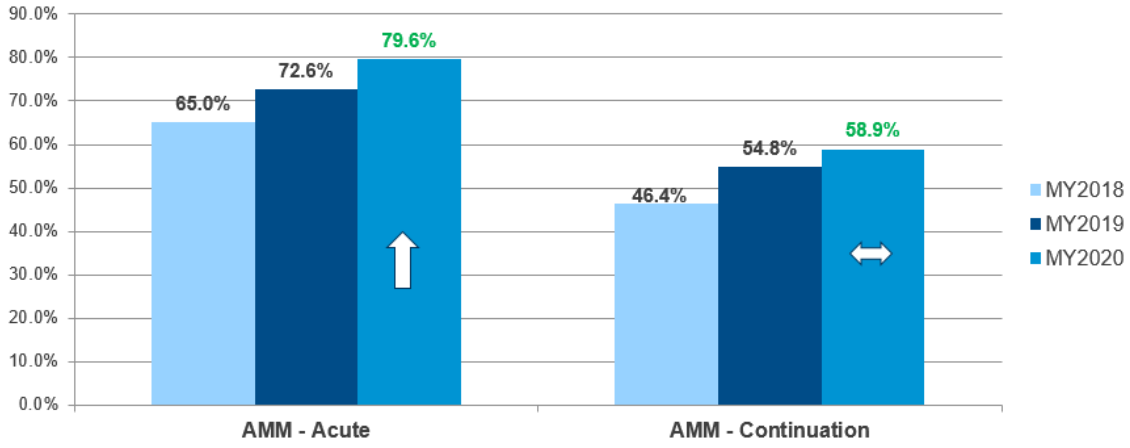
B. Findings



HEDIS Measure	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
Antidepressant Medications Management (AMM) - Acute Phase Treatment	51.47%	56.85%	64.29%	61.61%	MPL, P4V
Antidepressant Medications Management (AMM) - Continuation Phase Treatment	35.76%	41.17%	49.37%	38.18%	HPR, MPL, P4V

*Red = less than 33rd percentile; Green= met goal, MPL met, ++ measure triple weighted for Health Plan Ratings ↑ ↓ statistically higher or lower ↔ statistically no difference **HPR=Health plan ratings, MPL=DHCS Minimum Performance Level, P4V=Pay for Value

OCC AMM



HEDIS Measure	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
Antidepressant Medications Management (AMM) - Acute Phase Treatment	68.93%	74.78%	83.33%	74.78%	CMS
Antidepressant Medications Management (AMM) - Continuation Phase Treatment	52.13%	58.82%	67.07%	56.17%	CMS

*Green= met the goal **Star cut points are previous year.
↑ ↓ statistically higher or lower ↔ statistically no difference

C. Analysis

Medi-Cal AMM: CalOptima's 2020 HEDIS acute phase final rate was 62.2%, exceeding the intended goal of 61.61%. The continuation phase final rate was 45.6%, exceeding the intended goal of 38.18%. Both the acute phase and continuation phase continue to demonstrate an upward trend over the past several years.

OCC AMM: CalOptima's 2020 HEDIS acute phase final rate was 79.6%, exceeding the intended goal of 74.78%. The continuation phase final rate was 58.9%, exceeding the intended goal of 56.17%. Both the acute phase and continuation phase continue to demonstrate an upward trend over the past several years.

D. Barriers

The COVID-19 pandemic dramatically changed provider educational events. As a result, there was no opportunity to promote provider education on the AMM measure. Planning for future educational activities may be a challenge considering the unknown impact of the current health crisis.

E. Opportunities for Improvement

1. Conduct member outreach to remind members of the importance of medication adherence.
2. Continue to educate members about the importance of depression medication adherence via member newsletters and social media.
3. Continue to work with Provider Relations on identifying alternative ways of hosting educational events.

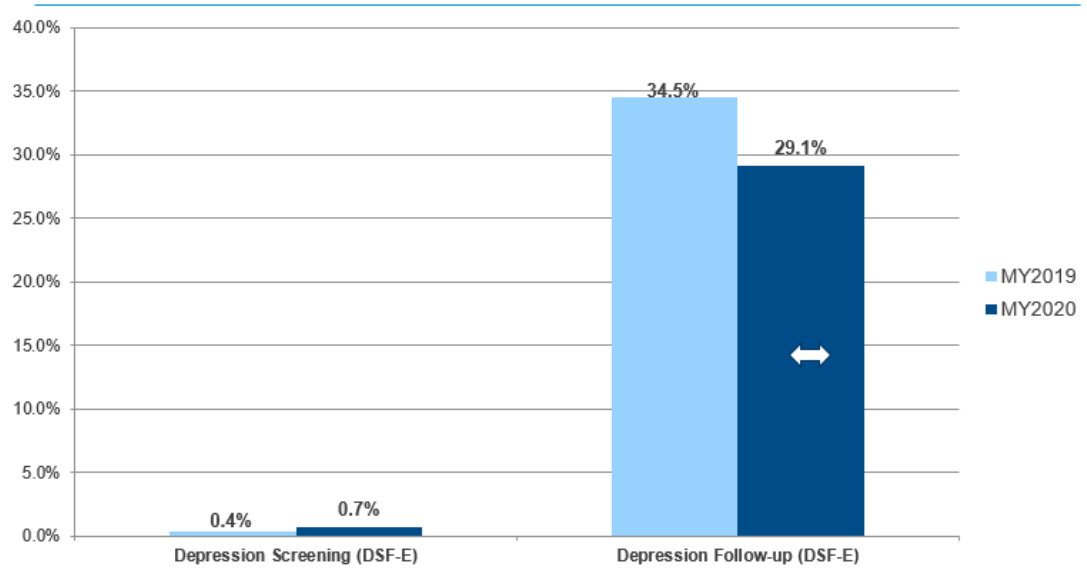
Depression Screening and Follow-Up for Adolescents (12+) and Adults (DSF)

The U.S. Preventive Services Task Force (USPSTF) recommends screening for depression among adolescents 12–18 years and the general adult population, including pregnant and postpartum women. The USPSTF also recommends that screening be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment and appropriate follow-up. DSF requires providers to screen patients ages 12 years and older for clinical depression using standardized depression screening tools AND if positive, provide and document a follow-up plan. Since DSF is still a relatively new measure, there is currently no benchmark to evaluate performance. CalOptima had been tracking the measure and conducted improvement activities.

A. Interventions

1. The BHI quality team created a depression factsheet and posted to the CalOptima website for virtual distribution to allow providers to share information with members during telehealth visits. The factsheet included information on depression screenings.
2. The BHI quality team created and distributed a provider letter to remind providers of the importance of depression screenings as well as communicate standards and guidelines regarding the measure. The letter also included a link to the depression factsheet located on the CalOptima website to share with members they serve.
3. The BHI quality team created an article, "Understanding Depression," which included information on depression screenings. The article was included in the Summer 2021 Medi-Cal member newsletter.

B. Findings



*Red = less than 33rd percentile; Green= met goal, MPL met, ++ measure triple weighted for Health Plan Ratings ↑ ↓ statistically higher or lower ↔ statistically no difference **HPR=Health plan ratings, MPL=DHCS Minimum Performance Level, P4V=Pay for Value

C. Analysis

For MY 2020, CalOptima's HEDIS rate for the Depression Screening was 0.7% for members who were screened for clinical depression using a standardized instrument while the Follow-Up on Positive Screen rate was 29.1%. The table shows an

improved rate for the Depression Screening phase, but the rate decreased by 5.4% for the Follow-Up care from the prior year. The drop in the percentage rate for members who received follow-up care within 30 days is attributed to COVID-19 pandemic and related social distancing requirements. Currently, NCQA has not released the percentile for DSF, which is used for benchmark. We are not able to set the goal because the goal is based on the percentile.

D. Barriers

1. Data collection from providers continues to be a barrier because of the lack of a mechanism for capturing provider data. The BHI quality team is exploring alternate solutions to incorporate tools into CalOptima's internal system to collect data from providers.
2. The COVID-19 pandemic dramatically changed provider educational events. As a result, there was no opportunity to promote depression screening and treatment in the community. Planning for future educational activities may be a challenge considering the unknown impact of the current health crisis.
3. Due to the COVID-19 pandemic, the number of members scheduling routine/preventive care appointments (i.e., well-child visits, annual physical exams) declined resulting in fewer opportunities for providers to conduct depression screenings.

E. Opportunities for Improvement

1. Develop member information encouraging them to schedule routine/annual visits to increase opportunities for depression screenings.
2. Develop a HEDIS reporting tip sheet to educate providers on the importance of depression screening, available screening tools and treatment options.
3. Continue to explore how to incorporate tools into CalOptima's internal system to gather data from providers.
4. Continue to work with Provider Relations on identifying alternative ways of hosting educational events.

Chronic Conditions

Improve HEDIS Measures Related to Comprehensive Diabetes Care (CDC): HbA1c Poor Control

Comprehensive Diabetes Control (CDC): HbA1c Testing and Eye Exam

The HbA1c Testing HEDIS and MCAS measure is classified as members 18–75 years of age with diabetes (type 1 and type 2) who had an HbA1c test within the measurement year. HbA1c Poor Control (>9.0%) is defined as members 18–75 years of age with diabetes (type 1 and type 2) who had a recent HbA1c level of >9.0% or is missing a result, or if an HbA1c test was not done during the measurement year (lower is better). HbA1c Adequate Control (HbA1c <8.0%) is for members 18–75 years of age with diabetes (type 1 and type 2) who had an HbA1c test result of <8.0% within the measurement year.

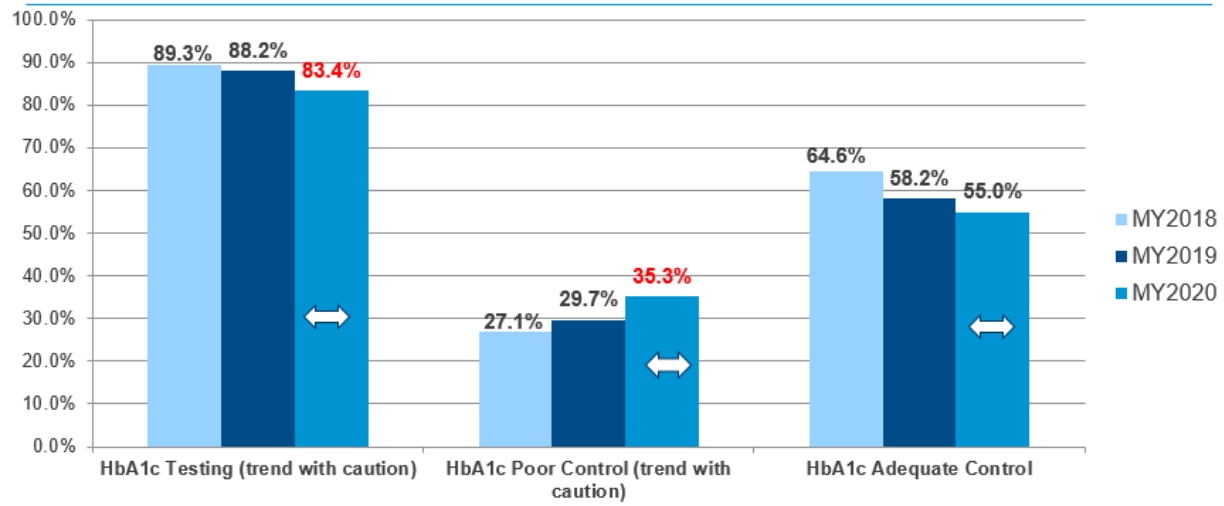
HbA1c Testing and Control

Medi-Cal

The CDC Figure 1a below shows the trend analysis for the Medi-Cal CDC HbA1c Testing measure for MY2018–20. HbA1c Testing measure did not met the 33rd percentile meeting the MPL. HbA1c Poor Control met the 33rd percentile (lower is better). HbA1c Adequate Control sub-measure met the 66th percentile.

CDC Figure 1a: Medi-Cal HbA1c Testing and Control

HEDIS MY 2020 Results: Medi-Cal Comprehensive Diabetes Care HbA1c



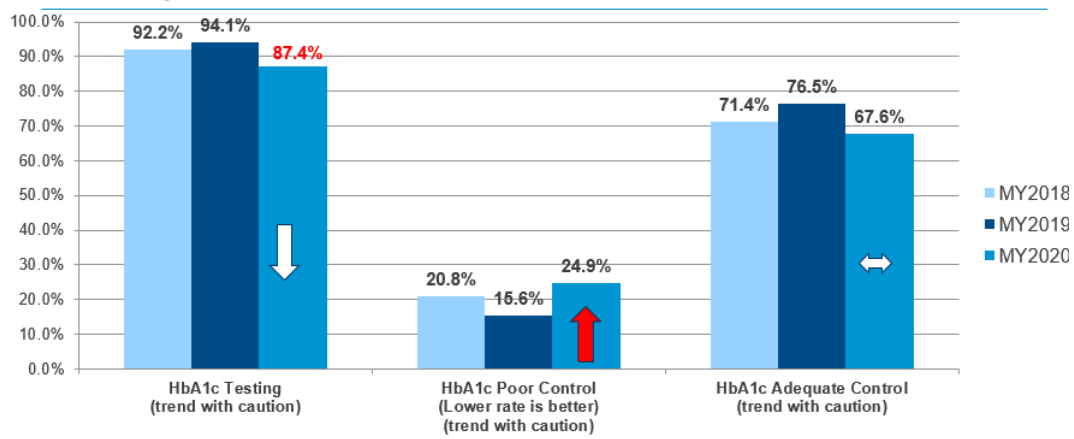
HEDIS Measure	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
HbA1c Testing	86.86%	90.27%	92.70%	88.79%	
HbA1c Poor Control (>9.0%) (Lower is better)	42.58%	33.80%	27.98%	37.47%	MPL, P4V
HbA1c Adequate Control (<8.0%) ++	47.69%	54.26%	60.77%	58.37%	HPR

**Red is less than 33rd percentile; Green is met the goal; Purple is MPL met, ++measure triple weighted for Health Plan Ratings ↓↑ statistically higher or lower ↔ statistically no difference ** HPR is Health Plan Ratings, MPL is DHCS Minimum Performance Level, P4V is Pay for Value*

OneCare

The CDC Figure 1b below shows the trend analysis for the OneCare CDC HbA1c Testing measure for MY2018–2020. A1c Testing measure did not met the goal of 94.89%. HbA1c Poor Control met the 66th percentile. HbA1c Adequate Control sub-measure met the 33rd percentile.

CDC Figure 1b: OC HbA1c Testing and Control



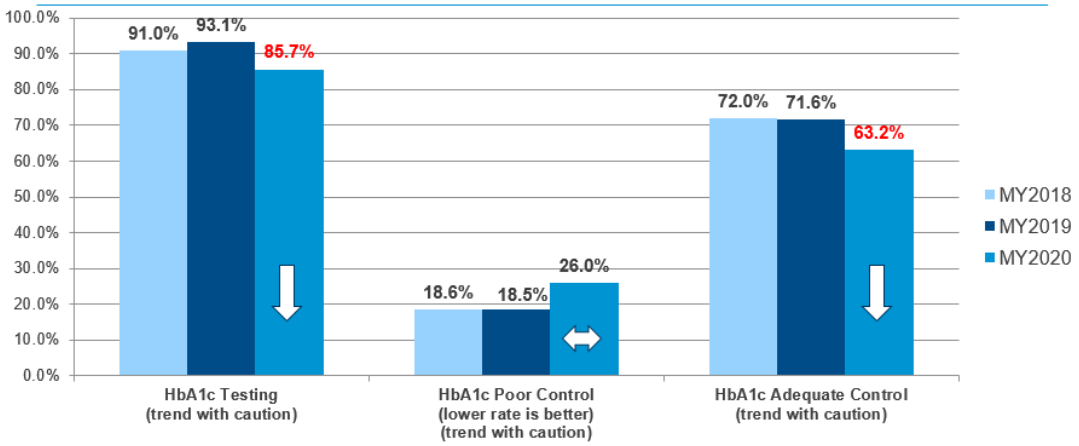
HEDIS Measure	3-Star/ 33rd percentile	4-Star/ 66th percentile	5-Star/ 90th percentile	Goal	Reporting Requirements**
Comprehensive Diabetes Care (CDC) - HbA1c Testing	93.75%	95.82%	97.32%	94.89%	CMS
Comprehensive Diabetes Care (CDC) - HbA1c Poor Control (>9.0%) #	39%	28%	15%	15%	Star
Comprehensive Diabetes Care (CDC) - HbA1c Adequate Control (<8.0%)	63.26%	71.97%	77.78%	77.78%	CMS

**Red is less than 33rd percentile; Green is met the goal; ***Star cut points are previous year*
↓↑ statistically higher or lower ↔ statistically no difference

OneCare Connect

The CDC Figure 1c below shows the trend analysis for the OneCare Connect CDC HbA1c Testing measure for MY2018–2020. HbA1c Testing measure did not met the goal of 94.89%. HbA1c Poor Control met the 66th percentile (lower is better). HbA1c Adequate Control sub-measure did not meet the goal of 71.97%.

CDC Figure 1c: OCC HbA1c Testing and Control



HEDIS Measure	3-Star/ 33rd percentile	4-Star/ 66th percentile	5-Star/ 90th percentile	Goal	Reporting Requirements**
Comprehensive Diabetes Care (CDC) - HbA1c Testing	93.75%	95.82%	97.32%	94.89%	CMS
Comprehensive Diabetes Care (CDC) - HbA1c Poor Control (>9.0%) **	39%	28%	15%	15%	Star, P4V
Comprehensive Diabetes Care (CDC) - HbA1c Adequate Control (<8.0%)	63.26%	71.97%	77.78%	71.97%	CMS

**Red is less than 33rd percentile; Green is met the goal; ***Star cut points are previous year*
↓↑ statistically higher or lower ↔ statistically no difference

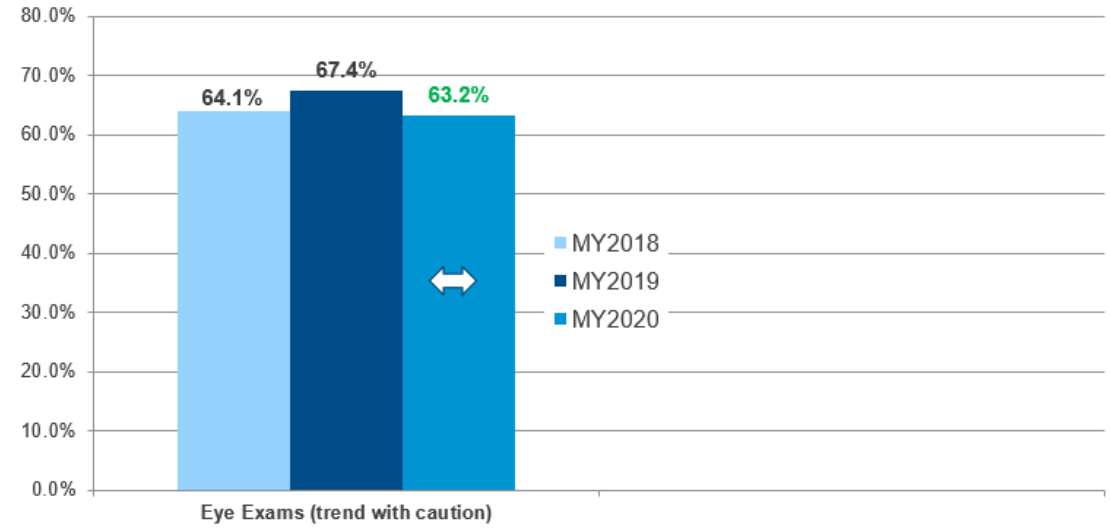
Improve HEDIS Measures Related to Comprehensive Diabetes Care (CDC): Eye Exam

CDC Eye Exam
The CDC Eye Exam measure includes members 18–75 years of age with diabetes mellitus (type 1 and type 2) who had one of the following:
• A retinal or dilated eye exam in the measurement year.
• Tested negative for retinopathy in the year prior to the measurement year.
• Bilateral eye enucleation any time during the member's history through December 31 of the measurement year.

Medi-Cal
The CDC Figure 2a below shows the trend analysis for the Medi-Cal CDC Eye Exam measure for MY2018–2020. Eye Exam measure met the 66th percentile of the MPL.

CDC Figure 2a: Medi-Cal Eye Exam

HEDIS MY2020 Results: Medi-Cal Comprehensive Diabetes Care



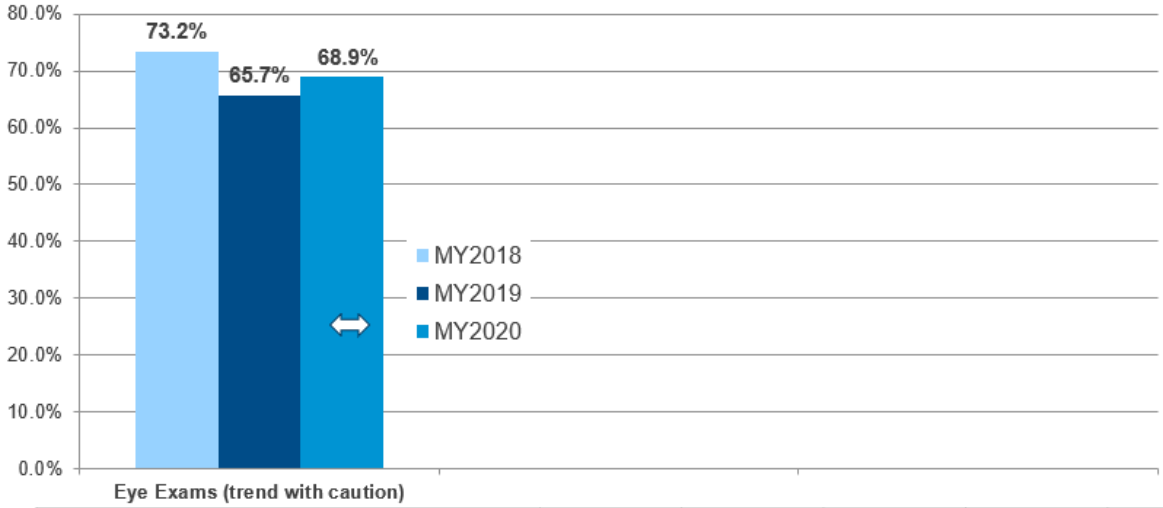
HEDIS Measure	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
Eye Exams	54.55%	61.56%	69.59%	58.64%	HPR

**Red is less than 33rd percentile; Green is met the goal; Purple is MPL met, ++measure triple weighted for Health Plan Ratings*
*↓↑ statistically higher or lower ↔ statistically no difference ** HPR is Health Plan Ratings, MPL is DHCS Minimum Performance Level, P4V is Pay for Value*

OneCare
The CDC Figure 2b below shows the trend analysis for the OneCare CDC Eye Exam measure for MY2018–2020. Eye Exam measure did not meet the 33rd percentile and did not meet the goal of 78%.

CDC Figure 2b: OneCare Eye Exam

HEDIS MY2020 Results: OC Comprehensive Diabetes Care



HEDIS Measure	3-Star/ 33rd percentile	4-Star/ 66th percentile	5-Star/ 90th percentile	Goal	Reporting Requirements**
Comprehensive Diabetes Care (CDC) - Eye Exams	69%	73%	78%	78%	Star

**Red is less than 3-Star or 50th percentile; Green is met the goal; ** Star cut points are previous year*

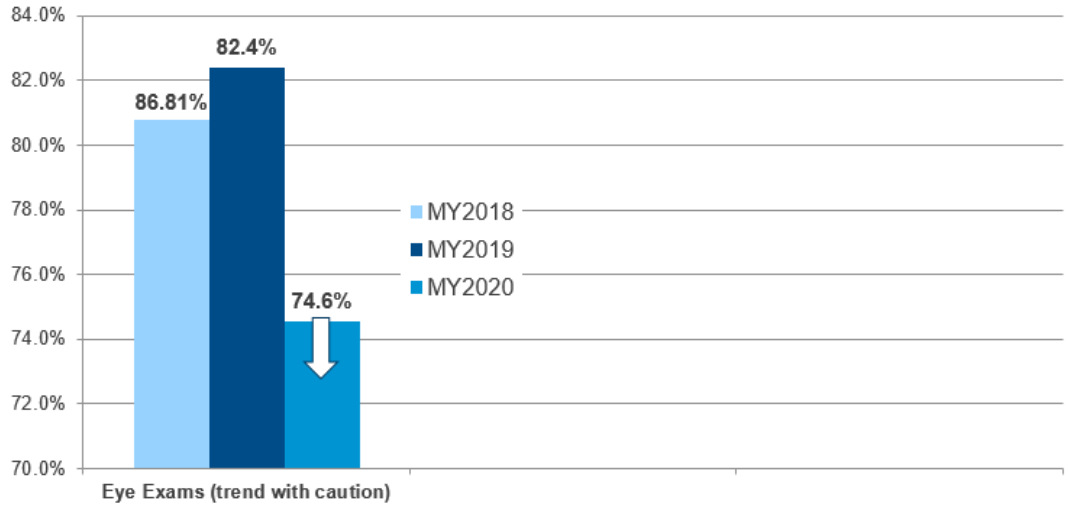
↓↑ statistically higher or lower ↔ statistically no difference

OneCare Connect

The CDC Figure 2c below shows the trend analysis for the OneCare Connect CDC Eye Exam measure for MY2018–2020. Eye Exam measure met the 66th percentile but did not meet goal of 78%.

CDC Figure 2c: OneCare Connect Eye Exam

HEDIS MY2020 Results: OCC Comprehensive Diabetes Care



HEDIS Measure	3-Star/ 33rd percentile	4-Star/ 66th percentile	5-Star/ 90th percentile	Goal	Reporting Requirements**
Comprehensive Diabetes Care (CDC) - Eye Exams	69%	73%	78%	78%	Star, P4V

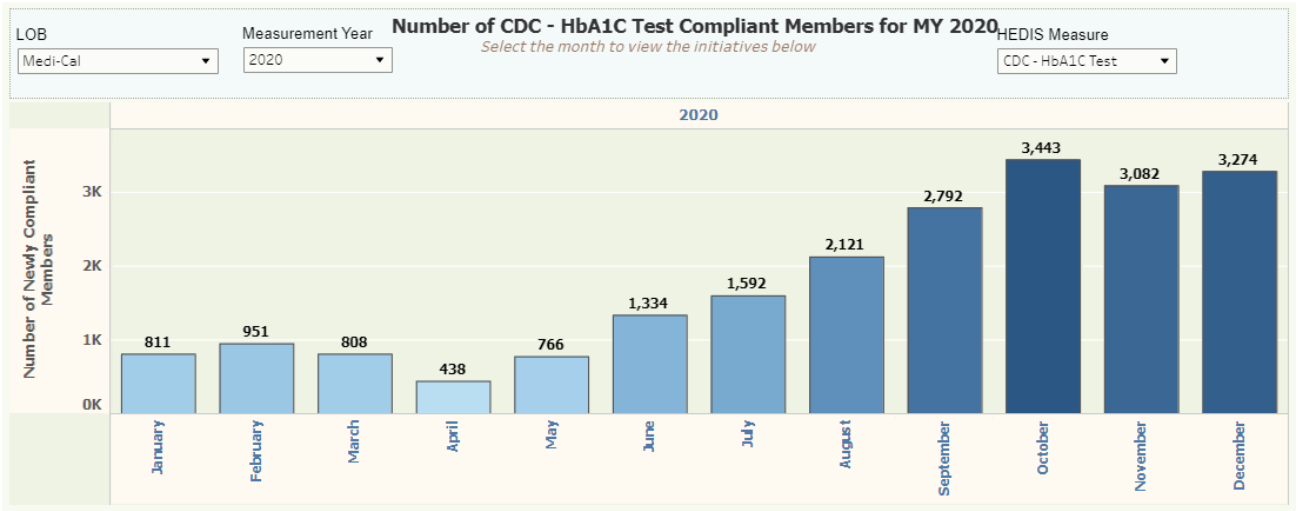
**Red is less than 3-Star or 50th percentile; Green is met the goal; ** Star cut points are previous year*

↓↑ statistically higher or lower ↔ statistically no difference

CDC HbA1c Compliant Members for HEDIS 2020

Figure 3 below shows the HbA1c initiatives for the HEDIS 2021 (MY2020) year. The data shows a gradual increase on a month-to-month basis. The largest increase is evident from June 2020 to October 2020. A slight decrease occurred in November 2020. The implementation of the Member Health Reward and Diabetes Health Coaching initiative helped with increasing member compliance in December 2020.

CDC Figure 3: HbA1c Compliant Members for HEDIS 2020



CDC Table 1: CDC HbA1c 2020 Interventions

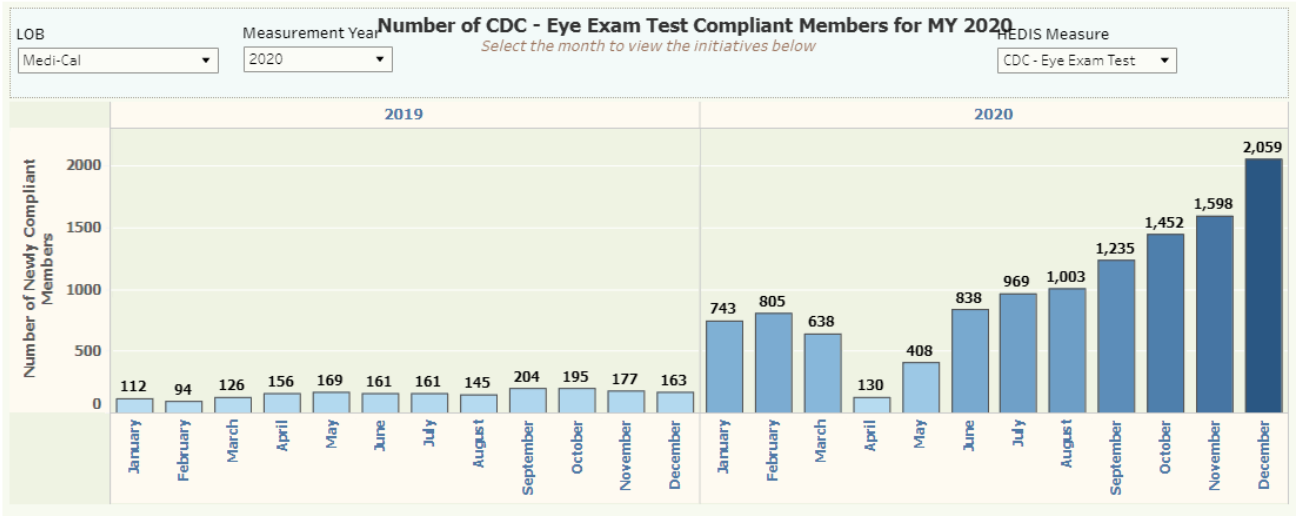
Initiative	Start Date	End Date	Outreach Population	Description
Member Health Reward	1/1/2020	12/31/2020	20,532 members	$25 member health reward for completing a HbA1c Test
Member Outreach	1/1/2020	12/31/2020	Members: MC: 874; OC: 8; OCC: 88	Diabetes educational mailings
			Members: MC: 1,014; OC: 8; OCC: 107	Health Coach Care Plan outreach for Diabetes
Provider Update Newsletter	12/20/2020	12/20/2020	All health networks and CCN providers	Provider Fax Blast (Provider Update): CalOptima 2021 Member Health Rewards Program
Social Media Posting	11/9/2020	11/9/2020	All, public	Diabetes Awareness Month (Instagram, Facebook, Twitter)
Website	3/1/2020	12/31/2020	All, public	(Posted member health reward forms on website)

CDC: Exam Compliant Members for HEDIS 2020

CDC Figure 4 below shows the Eye Exam initiatives for the HEDIS 2020 reporting year. The bar graph is split into two sections: the 2019 measurement year section contains the number of members that had a negative retinal or dilated eye exam (negative for retinopathy) which would count toward HEDIS 2021 reporting year. The 2020 measurement year section contains the number of members

who had a diabetic retinal eye exam due to a date of service in 2020. For 2019, the rates varied from one month to another, though the data shows a gradual increase month to month from May 2020 to December 2020. The implementation of the Diabetes Health Coaching initiative helped with increasing the figures gradually month to month in 2020. During the months of April and May 2020 there was a significant delay in the rates as a consequence of the COVID-19 pandemic.

CDC Figure 4: Eye Exam Compliant Members for HEDIS 2020



CDC Table 2: CDC Eye Exam 2020 Interventions

Initiative	Start Date	End Date	Outreach Population	Description
Member Health Rewards	1/1/2020	12/31/2020	15,196 members	$25 member health reward for completing a Diabetes Eye Exam
Member Outreach	1/1/2020	12/31/2020	Members: MC: 874; OC: 8; OCC: 88	Diabetes educational mailings
			Members: MC: 1,014; OC: 8; OCC: 107	Health Coach Care Plan outreach for Diabetes
Provider Update Newsletter	12/20/2020	12/20/2020	All health networks and CCN providers	Provider Fax Blast (Provider Update): CalOptima 2021 Member Health Rewards Program
Social Media Posting	11/9/2020	11/9/2020	All, public	Diabetes Awareness Month (Instagram, Facebook, Twitter)
Website	3/1/2020	12/31/2020	All, public	(Posted member health reward forms on website)

2020 Diabetes HbA1c Testing and Eye Exam Initiatives: Medi-Cal, OC and OCC

1. HbA1c and Diabetic Eye Exam Member Health Rewards

A. Intervention

In 2019, the targeted member health rewards population was eligible members who were non-compliant in the HEDIS 2020 CDC HbA1c testing (n=15,196) measure and the CDC Eye Exam (n=15,196) measure. In 2020, targeted eligible members who were non-compliant

in the HEDIS 2021 CDC HbA1c testing (n=20532) and CDC Eye Exam (n=15,196) measures were eligible for the $25 gift card member health reward if they completed the HbA1c Test and/or diabetic eye exam. In addition to the member health rewards, the members received information on statin medication and diabetes health coaching services. Both HbA1c Test and Diabetic Eye Exam member health reward programs were only for Medi-Cal.

B. Findings

CDC Table 7 shows the Medi-Cal members who were eligible for the member incentive for HbA1c Testing and Diabetic Eye Exams, and the response rate for each respective incentive.

CDC Table 7: MY2019–20 Member Incentive Medi-Cal
Medi-Cal HbA1c and Eye Exam Member Incentive

Measure	HEDIS Non-Compliant Members Eligible		Health Reward Forms Received		Response Rate	
	2019	2020	2019	2020	2019	2020
HbA1c Test	15,196	20,532	510	863	3.36%	4.20%
Diabetic Eye Exam	5,466	15,196	163	736	2.98%	4.84%

CDC Table 8 shows the counts of Medi-Cal member incentives received and the response rate.

CDC Table 8: MY2019–20 HbA1c Testing and Eye Exam Member Incentive Medi-Cal HEDIS Participation Rates

HbA1c Test Health Reward Forms	Forms Received	HEDIS Qualified	HEDIS Denominator	HEDIS Health Reward Participation Rate
2019	510	455	25,338	1.80%
2020	863	843	26,487	3.18%
Eye Exam Health Reward Forms	**Forms Received**	**HEDIS Qualified**	**HEDIS Denominator**	**HEDIS Health Reward Participation Rate**
2019	163	152	25,338	0.60%
2020	736	685	26,487	2.59%

C. Analysis

1. In MY 2019 of the 15,196 who were eligible for the HbA1c Test reward, 510 submitted HbA1c Test reward forms, yielding a 3.36% response rate. Out of the 510 submitted A1c Test reward forms, 455 remained as HEDIS Qualified (counted toward HEDIS measure). The 455 HEDIS Qualified out of the 25,338 denominator yielded a 1.80% response rate of HEDIS eligible submissions.

2. In MY 2019 of the 5,466 who were eligible for the Eye Exam reward, 163 submitted Eye Exam reward forms, yielding a 2.98% response rate. Out of the 163 submitted Eye Exam reward forms, 152 remained as HEDIS Qualified (counted toward HEDIS measure). The 152 HEDIS Qualified out of 25,338 denominator yielded a 0.60% response rate of HEDIS eligible submissions.
3. In MY 2020 of the 20,532 who were eligible for the HbA1c Test reward, 863 submitted HbA1c Test reward forms, yielding a 4.20% response rate. Out of the 863 submitted A1c Test reward forms, 843 remained as HEDIS Qualified (counted toward HEDIS measure). The 843 HEDIS Qualified out of 26,487 denominator yielded a 3.18% response rate of HEDIS eligible submissions.
4. In MY 2020 of the 15,196 who were eligible for the Eye Exam reward, 736 submitted Eye Exam reward forms, yielding a 4.84% response rate. Out of the 736 submitted Eye Exam reward forms, 685 remained as HEDIS Qualified (counted toward HEDIS measure). The 685 HEDIS Qualified out of 26,487 denominator yielded a 2.59% response rate of HEDIS eligible submissions.
5. Overall Response Rate and HEDIS Member Health Reward Participation Rate increased when comparing the results between MY 2019 and MY 2020.

D. Barriers

1. One of the largest barriers for the Eye Exam incentive program was the delay with the VSP contracted vision provider not permitting members with diabetes to get an annual diabetic eye exam in 2020. Although efforts to correct the contract have permitted diabetic members to get their exam on an annual basis, due to a delay in updating the eligibility file sent to VSP with a diabetes identifier, CalOptima members were being turned away by VSP, although eligible for the exam. This was addressed in 2021 with an update to the contract as well as visibility added to the eligibility file.
2. Members may still be reluctant to go to their provider's office due to the COVID-19 pandemic.
3. Incomplete Forms: HbA1c Test reward forms regularly came back with the HbA1c value field empty, or it was clear members had filled out the form themselves with a blood sugar value reading instead of an HbA1c Test value. In addition, some of the providers did not complete the retinopathy exam result on the form, often returning the forms with that field blank. With eye exam reward forms, there were some providers who did not stamp the forms. Many scribble initials and it is hard to figure out who performed the eye exam.
4. Incorrect Information: Many members received the forms in the mail and simply filled out their information and submitted without having the service done. Some of those submitted forms used old dates of service that do not qualify.
5. Members give the form to their doctor assuming the provider will fax to CalOptima. CalOptima often does not gets those submissions.
6. HbA1c testing is usually done quarterly or as directed by a provider. This may lead to member lab visit fatigue due to frequent lab visits for testing.
7. In 2020, CalOptima did not conduct member mailers for HbA1c and Eye Exam due to budget limits with mailing health reward forms to eligible members.
8. Data access issues: lack of data or missing lab data in the Electronic Health Record (EHR) impacted the measure by not showing members who were truly compliant and/or noncompliant.

E. Opportunities for Improvement

1. In an effort to promote the importance of annual diabetic eye exams, regardless of whether the member falls into the HEDIS denominator or not, the diabetes reward will be available to all CalOptima members identified with diabetes mellitus to encourage yearly eye exams.
2. Improve and place a greater emphasis on compliance with Diabetes HbA1c Testing and Eye Exam. Along with all other incentives, there will be a concerted effort for greater promotion and marketing of the diabetes member rewards through the health networks, CCN providers and in the community.
3. Reiterate the importance of completely filling out the member health reward forms and following through with the submission of forms given by the member to all contracted providers, through provider fax updates or provider outreach calls.
4. Consider room in the budget for mailing out health reward forms to eligible members to increase awareness.
5. Leverage social media as a platform to encourage HbA1c Tests and Eye Exams.
6. Seek an allocation of resources to resolve the lack of data/missing lab data and access to EHR to improve data collection.
7. Collaborate closely with community partners when implementing health rewards to raise awareness.
8. Conduct current member data analysis considering age groups, ethnicity and ZIP codes for noncompliance trends and to strategize for better outcomes.

2021 Diabetes HbA1c Testing and Eye Exam Initiatives: Medi-Cal, OC and OCC

1. Emerging Risk Health Coaching Telephonic Outreach

A. Intervention

In an effort to address emerging risk in a timely fashion, eligible members with diabetes who had an HbA1c test result below 8.0% but tested between 8.0% and 9.0% in their most recent HbA1c test were identified as emerging risk members. Telephonic outreach is conducted by a health coach to identify solutions for emerging risk members to manage their HbA1c levels below 8.0%.

B. Findings

CDC Table 9: 2021 Health Coaching Outreach for All Programs: MC, OC and OCC

Year	Qtr	LOB	Starting Denominator	Members assigned to a Health Coach	Emerging Risk Members Successful Outreach	Emerging Risk Members Unsuccessful Outreach
2021	Q1	OC	5	5	3	0
2021	Q1	OCC	94	20	10	3
2021	Q1	MC	817	75	47	2
2021	**Q1**	**Total**	**916**	**100**	**60**	**5**

2021	Q2	OC	5	5	4	1
2021	Q2	OCC	108	55	34	3
2021	Q2	MC	712	148	99	11
2021	**Q2**	**Total**	**825**	**208**	**137**	**15**

C. Analysis

In Q1 2021 for OneCare (OC), five emerging risk members were assigned for telephonic Health Coaching outreach with three successful outreach calls. In Q2 2021, five emerging risk members were assigned for telephonic Health Coaching outreach with four successful outreach calls. This resulted in a 60% successful outreach rate in Q1 2021 and an 80% successful outreach rate in Q2 2021 for OC.

In Q1 2021 for OneCare Connect (OCC), 20 emerging risk members were assigned for telephonic Health Coaching outreach with 10 successful outreach calls. In Q2 2021, 55 emerging risk members were assigned for telephonic Health Coaching outreach with 34 successful outreach calls. This resulted in a 50% successful outreach rate in Q1 2021 and a 61.81% successful outreach rate in Q2 2021 for OCC.

In Q1 2021 for Medi-Cal (MC), 75 emerging risk members were assigned for telephonic Health Coaching outreach with 47 successful outreach calls. In Q2 2021, 148 emerging risk members were assigned for telephonic Health Coaching outreach with 99 successful outreach calls. This resulted in a 62.67% successful outreach rate in Q1 2021 and a 66.89% successful outreach rate in Q2 2021 for MC.

When comparing Q1 2021 and Q2 2021 results collectively, among those that were assigned to a Health Coach, the successful outreach rate increased from 60% (60/100) in Q1 2021 to 65.87% (137/208) a 5.87 percentage point increase.

D. Barriers

1. Limited capacity for the health educators to conduct outbound calls due to their competing volume of daily tasks.
2. Difficulty with scheduling appointments. Appointments are very far away, especially with endocrinologist due to limited office hours.
3. With the COVID-19 pandemic, telehealth appointments were difficult for some members due to the lack of access to a smartphone or not understanding the instructions on how to connect to video calls.
4. Members relying more on natural remedies to reduce their blood sugar.
5. Members face challenges with access to broadband/internet based on their economic status or place of residence.
6. Members may require transportation to attend appointments and may not be aware about their transportation benefits.

E. Opportunities for Improvement

1. Instruct Health Coaches to assist members with scheduling appointments whenever possible. Teach members how to navigate the health system and telehealth appointments. Encourage members to communicate needs and challenges timely to their provider.
2. During outbound calls conduct a short questionnaire screening for SDOH and connect members with other resources to assist specific needs.
3. Update telephonic scripting to mention resources and telehealth.
4. Seek ways to improve data needs and streamline how members are assigned moving away from manual assigning to a more automated method.
5. Conduct a multilayered analysis of membership data by volume, ZIP code, ethnicity and age groups to determine additional SDOH that may be creating barriers for CalOptima members. Moving forward, additional analysis is needed to create appropriate programs that will make an impact to address barriers and inequities among the targeted groups in the regions we serve.

CDC Table 10 below shows the 10 highest volume groups by member ethnicity. Future targeted outreach should factor in member demographics (e.g., ethnicity and ZIP code) to improve outreach efforts. Based on the data shown below, the Black population had the lowest CDC rate (75.96%), which indicates the need to focus on that group and develop a targeted strategy for improvement.

CDC Table 10: 2021 Health Coaching Outreach for All Programs: MC, OC and OCC

Ethnicity Code (group)	CDC A1c Testing Numerator Rate	Numerator Count	Denominator Count	Percentage of Total Population	Impact on HEDIS Rate
Hispanic	82.57%	11,988	14,519	41.99%	34.67%
White	77.27%	4,228	5,472	15.83%	12.23%
Vietnamese	87.25%	4,271	4,895	14.16%	12.35%
No response, client declined to state	81.84%	3,551	4,339	12.55%	10.27%
Other	78.04%	910	1,166	3.37%	2.63%
Filipino	85.25%	734	861	2.49%	2.12%
Asian or Pacific Islander	82.30%	693	842	2.44%	2.00%
Black	75.96%	496	653	1.89%	1.43%
Korean	88.23%	517	586	1.69%	1.50%
Asian Indian	84.19%	378	449	1.30%	1.09%

Additional Planned Diabetes Activities for 2021:

1. Publish articles in the Medi-Cal newsletter about the importance of staying healthy by managing diabetes during the COVID-19 pandemic.
2. Collaboration with various health networks on promoting health rewards via multiple ongoing campaign outreach efforts.
3. Targeted round-robin identification of high-risk members with diabetes for telephonic health coaching on outstanding exams and tests needed.
4. Ongoing outreach calls to emerging risk population of diabetics who were well controlled, but now have an A1C between ≥8.0% and ≤9.0%.

5. Ongoing quarterly provider fax reports of diabetic members NOT on a statin.
6. Ongoing SPD quarterly mailings to educate members with diabetes NOT on a statin about the benefits of statin use in preventing cardiovascular risk and the importance of having the discussion with their provider.
7. Social media messages for diabetes awareness month slated for November 2021.

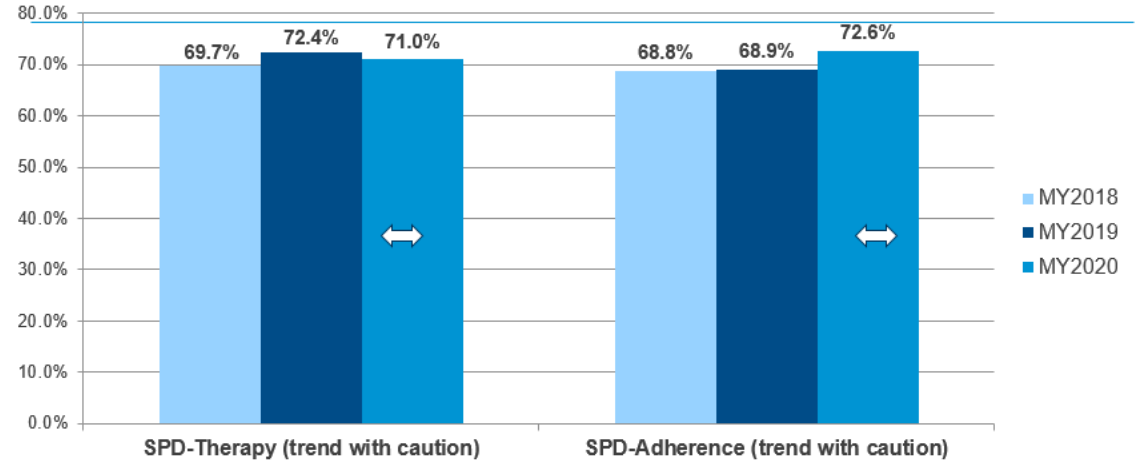
Statin Therapy for Patients with Diabetes (SPD)

SPD Therapy measure is classified as members 40–75 years of age with diabetes mellitus who do not have clinical atherosclerotic cardiovascular disease (ASCVD) and who received Statin Therapy during the measurement year. This measure includes members who were dispensed at least one statin medication of any intensity during the measurement year.

SPD Adherence measure is described as members 40–75 years of age with diabetes mellitus who do not have ASCVD and who received Statin Therapy during the measurement year. Statin Adherence is further classified as members who remained on a statin medication of any intensity for at least 80% of the treatment period.

SPD Figure 1 below shows a trend analysis for Medi-Cal SPD measure for MY2018–20. SPD therapy sub-measure met the 66th percentile for MY2020 but did not meet the goal of 71.82%. For the SPD adherence sub-measure MY2020, CalOptima did achieve the 66th percentile and met the goal of 69.58%.

SPD Figure 1: HEDIS Trending Rates 2018–20



HEDIS Measure	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
Statin Therapy for Patients with Diabetes (SPD) — therapy	63.45%	67.59%	71.82%	71.82%	HPR
Statin Therapy for Patients with Diabetes (SPD) — adherence	60.81%	67.43%	75.72%	69.58%	HPR

**Red is less than 33rd percentile; Green is met the goal; Purple is MPL met, ++measure triple weighted for Health Plan Ratings*
*↓↑ statistically higher or lower ↔ statistically no difference ** HPR is Health Plan Ratings, MPL is DHCS Minimum Performance Level, P4V is Pay for Value*

SPD Table 1: SPD List of Initiatives

Initiative	Start Date	End Date	Outreach Population (By LOB)	Description
SPD Statin Member Mailing	1/1/2020	12/31/2020	MC: 5,047 members OC: 63 members OCC: 603 members	Quarterly mailings sent to members to improve SPD Statin Therapy and Statin Adherence measures
SPD Provider Fax	1/1/2020	12/31/2020	**MC 2020** Q1: 5,665 Q2: 5,989 Q3: 6,086 Q4: 5,807 **OC 2020** Q1: 64 Q2: 69 Q3: 88 Q4: 88 **OCC 2020** Q1: 663 Q2: 722 Q3: 744 Q4: 700	CalOptima's Pharmacy Management department sent a list of members to providers for member outreach in order to improve SPD Statin Therapy and Statin Adherence measures. These members were either missing statin therapy or on a current statin with a calculated adherence rate <80%, suggesting non-adherence.

2020–21 Statin Therapy for Patients With Diabetes (SPD) Initiatives: Medi-Cal, OC, and OCC

1. Pharmacy Management Department SPD Provider Faxes 2021

A. Intervention

CalOptima's Pharmacy Management department sent a list of members to providers for member outreach to improve SPD Statin Therapy and Statin Adherence measures. These members were either missing statin therapy or on a current statin with a calculated adherence rate <80%, suggesting non-adherence. The lists are provided to ask providers to follow-up with members out of adherence.

B. Findings

SPD Table 2: Pharmacy Management Department SPD Provider Faxes Membership Breakdown by Line of Business

Number of Members Faxed to Providers												
	Quarter 1 2021				Quarter 2 2021				Quarter 3 2021			
Sub-measure	MC	OC	OCC	Total	MC	OC	OCC	Total	MC	OC	OCC	Total
Statin Needed	3,285	58	376	3,719	3,280	58	360	3,698	4,239	61	455	4,755
Statin Non-Adherence	2,244	27	299	2,570	1,500	23	202	1,725	2,044	19	267	2,330
Total	5,529	85	675	6,289	4,780	81	562	5,423	6,283	80	722	7,085

C. Analysis

As of Quarter 3 2021, HEDIS prospective rates, as outlined in the introduction above, for the number of Medi-Cal members receiving statins is 68.34% (slightly higher compared with August 2020 at 67.70%). The rate for OneCare members is 79.14% (higher compared with

August 2020 at 72.73%). The rate for OneCare Connect members is 78.12% (slightly higher compared with August 2020 at 77.95%).

D. Barriers

1. Members may be reluctant to go to their provider office due to the COVID-19 pandemic.
2. Members may have neglected going to their pharmacy to fill and obtain statin medication due to COVID-19 pandemic.
3. Members are not aware of the increased risk of cardiovascular complications associated with diabetes mellitus.

E. Opportunities for Improvement

1. The quarterly faxes will continue to be sent to providers for members who are missing or who are non-adherent to their statin medication in a continued effort to coordinate care and ensure providers are aware of current clinical standards for diabetes care.
2. Continue sending educational newsletters to primary care providers outlining the importance of statin use for cardiovascular risk reduction and formulary medication options.

2. Quarterly SPD Statin Member Mailings

A. Intervention

To reinforce the SPD provider faxes, a quarterly complementary member mailing was created. The main purpose of the mailing is to educate members with diabetes mellitus who are missing a statin prescription or who are non-adherent to their statin prescription. Efforts aim to encourage members to have a conversation with their PCP about whether a statin is right for them to reduce cardiovascular risk as a preventative measure. The PHM department sent quarterly mailings to members to improve SPD Statin Therapy and Statin Adherence measures. Identified members were either missing statin therapy or on a current statin prescription with a calculated adherence rate <80%, suggesting non-adherence. The mailer included a cover letter prompting the member to ask their doctor if a statin medication was right for them along with educational material about statin medications.

B. Findings

SPD Table 3: SPD Quarterly Statin Member Mailings

	Q1 2021			Q2 2021		
LOB	Letters Sent: Non-Adherent Members	Adherent Members After Mailing	Adherence Rate by Q2 2021	Letters Sent: Non-Adherent Members	Adherent Members After Mailing	Adherence Rate by Q3 2021
OC	27	17	62.96%	71	18	25.35%
OCC	290	197	67.93%	464	84	18.10%
Medi-Cal	2,183	1,348	61.75%	3,947	402	10.18%
Total	**2,500**	**1,562**	62.48%	**4,482**	**504**	11.24%

C. Analysis

In Q1 2021, the adherence rate by Q2 2021was 62.96% for OC, 67.93% for OCC and 61.75% for Medi-Cal. Overall, there was a 62.48% adherence rate across the lines of business, by the next quarter. In Q2 2021, the adherence rate by next quarter was 25.35% for OC, 18.10% for OCC and 10.18% for MC. Overall, we had a 11.24% adherence rate by the next quarter in Q2 2021. Adherence rates declined from Q1 2021 to Q2 2021.

D. Barriers

1. Members may be reluctant to go to their provider office due to the COVID-19 pandemic or provider offices may not have been open or readily scheduling appointments.
2. Members may have neglected going to their pharmacy to fill and obtain statin medication due to COVID-19 pandemic.
3. Members are not aware of the increased risk of cardiovascular complications associated with diabetes mellitus.
4. Member mailings cannot be directly correlated with adherence.
5. The data for the quarterly member mailing lists heavily depends on when the provider fax list from the Pharmacy Management department are received.
6. The member mailing for Q3 2021 was delayed due to other competing member communication priorities related to the COVID-19 pandemic.
7. SDOH impact the adherence and ability to maintain a healthy lifestyle for Medi-Cal members. General economic stability is a struggle for Medi-Cal members. Income instability directly impacts the ability to purchase food and may result in food insecurity, which affects members' ability to maintain a healthy lifestyle.
8. Another SDOH that impacts Medi-Cal members' ability to maintain a healthy lifestyle is the access to healthy food options. Healthy foods have a positive impact on a members' overall cardiovascular health.

E. Opportunities for Improvement

1. Continue to publish newsletter articles about the importance of obtaining diabetic laboratory testing and regular physician examinations, and the impact of statin use on heart health for members with diabetes mellitus.
2. Obtain the membership data from the Pharmacy Management department sooner to give additional time for the member mailing logistics preparations.
3. Continue the quarterly mailers to members in 2022 who are non-adherent with their statin medications.
4. The Pharmacy Management department sends communications to members to ensure awareness about the ability to get medications for several months instead of only a one-month supply.
5. Conduct a multilayered analysis of membership data by volume, ZIP code, ethnicity and age groups to determine additional social determinants of health that may be creating barriers for CalOptima members. Moving forward, additional analysis is needed to create appropriate programs that will make an impact to address barriers and inequities among the targeted groups in the regions we serve.

SPD Table 4 below shows the 10 highest volume groups by member ethnicity. Future targeted outreach should factor in member demographics (e.g., ethnicity and ZIP code) to improve outreach efforts. This allows CalOptima to have a deeper understanding about the membership composition, ethnic populations to focus on, and develop programs that address equity opportunities. As an example, based on the data shown below, the Black population had the lowest SPD rate (62.81%). This indicates a need to focus on this membership composition and develop a targeted strategy to help improve outcomes.

SPD Table 4: MY2020 SPD Therapy Rate by Member Ethnicity, 10 Highest Volume Groups

Ethnicity	SPD Numerator Rate	Numerator Count	Denominator Count	Percentage of Total Population	Impact on HEDIS Rate
Hispanic	69.30%	5,869	8,469	39.18%	27.15%
Vietnamese	82.61%	3,073	3,720	17.21%	14.22%
White	64.50%	2,142	3,321	15.36%	9.91%
No response, client declined to state	70.50%	1,921	2,725	12.61%	8.89%
Other	73.34%	531	724	3.35%	2.46%
Asian or Pacific Islander	75.93%	467	615	2.85%	2.16%
Filipino	84.14%	435	517	2.39%	2.01%
Korean	76.62%	295	385	1.78%	1.36%
Black	62.81%	228	363	1.68%	1.05%
Asian Indian	71.17%	200	281	1.30%	0.93%

2021 Statin Therapy for Patients With Cardiovascular Disease (SPC) Initiatives: Medi-Cal, OC and OCC

Pharmacy Management Department SPC Provider Faxes 2021

A. Intervention

CalOptima's Pharmacy Management department sent a list of members to providers for member outreach in order to improve SPC Statin Therapy and Statin Adherence measures. These members were either missing a moderate to high intensity statin therapy or were identified as non-adherent to a moderate to high intensity statin using a proportion of days covered (PDC) calculation rate of <80%.

B. Findings

Table 2 shows the number of faxes by the Pharmacy Management department sent to targeted providers for members needing statins or members who were non-adherent with statins.

SPC Table 2: Pharmacy Management Department SPC Provider Faxes 2021

Pharmacy Management Department SPC Provider Faxes 2021												
Number of Unique Member Faxes												
	Quarter 1 2021				Quarter 2 2021				Quarter 3 2021			
Sub measure	MC	OC	OCC	Total	MC	OC	OCC	Total	MC	OC	OCC	Total
Statin Needed	216	16	77	309	284	2	31	317	238	5	75	318
Statin Non-Adherence	236	7	59	302	81	2	13	96	168	4	32	204
Total	452	23	136	611	365	4	44	413	406	9	107	522

C. Analysis

As of Quarter 3 2021, HEDIS prospective rates for the number of Medi-Cal members receiving a moderate to high intensity statin is 78.76% (slightly higher compared with August 2020 at 78.34%). The rate for OneCare members is 87.27% (higher compared with August 2020 at 71.15%). The rate for OneCare Connect members is 79.47% (higher compared with August 2020 at 78.46%).

D. Barriers

1. Members may be reluctant to go to their provider office due to the COVID-19 pandemic.
2. Members may have neglected going to their pharmacy to fill and obtain statin medication due to COVID-19 pandemic.
3. Members are not aware of the decreased morbidity and mortality associated with moderate to high intensity statin use in the presence of cardiovascular disease.

E. Opportunities for Improvement

1. Quarterly faxes will continue to be sent to providers for members who are missing a moderate to high intensity statin prescription or those who are identified as non-adherent to a moderate to high intensity statin in a continued effort to coordinate care and ensure providers are aware of current clinical standards for cardiovascular disease management.
2. Continue sending educational newsletters to primary care providers outlining the importance of statin use for cardiovascular risk reduction and formulary medication options.

Maternal Child Health

Prenatal and Postpartum Care Services (PPC)

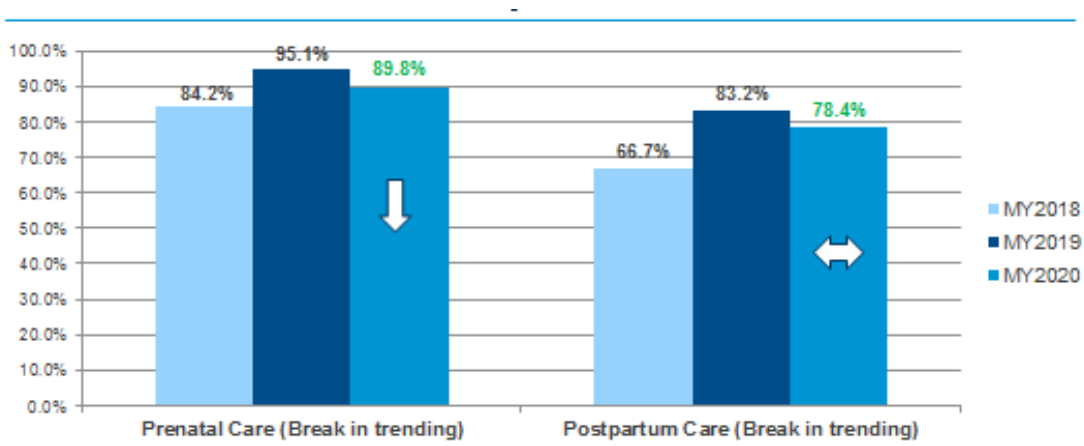
The hybrid HEDIS and MCAS measure, PPC, measures the percentage of deliveries on or between October 8 of the year prior to the measurement year and October 7 of the measurement year that 1)

received a prenatal care visit in the first trimester and 2) obtained a postpartum care visit on or between 7 and 84 days (1–12 weeks after delivery).

The figure below shows the trend analysis for the Medi-Cal PPC measure for MY2018–20. The Prenatal and Postpartum Care measure both met the 33rd percentile for MPL and the organization's percentile goal. While the Prenatal Care measure met the MPL, the final percentile was statistically lower than MY2019.

Figure 1: PPC HEDIS Rates MY 2018–20

HEDIS MY 2020 Results: Medi-Cal Prenatal and Postpartum Care



HEDIS Measure	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
Prenatal Care	86.86%	91.73%	95.86%	89.05%	HPR, MPL, P4V
Postpartum Care	73.72%	79.32%	84.18%	76.40%	HPR, MPL, P4V

**Red is less than 33rd percentile; Green is met the goal; Purple is MPL met, ++measure triple weighted for Health Plan Ratings*
*↓↑ statistically higher or lower ↔ statistically no difference ** HPR is Health Plan Ratings, MPL is DHCS Minimum Performance Level, P4V is Pay for Value*

Figure 2 below represents all Medi-Cal members with live births between October 8, 2019, and October 7, 2020, that met the continuous enrollment criteria and were compliant with the HEDIS measure.

Figure 2: PPC Compliant Members in HEDIS MY2020

Note: The table does not include Kaiser members as they are not outreached for quality initiatives

Table 1: List of 2020 PPC Initiatives

The PPC initiatives listed correspond to the 2020 calendar year from January 1 through December 31. The PPC HEDIS measures births between 10/8/2019–10/7/2020 that were compliant with a postpartum visit between 10/15/2019–12/31/2020 (1–12 weeks after delivery). The initiatives noted with an asterisk * were offered between 10/15/2019–12/31/2019.

Initiative	Start Date	End Date	Outreach Population	Description
Member Health Reward*	1/1/2020	12/31/2020	425	$50 member reward for completing a postpartum visit 1–12 weeks after delivery
Member Outreach*	1/1/2020	12/31/2020	2,421	Bright Steps program for moms and babies
P4V*	1/1/2020	12/31/2020	N/A	Pay 4 Value program
Summer 2020 Medi-Cal Newsletter	7/13/2020	7/16/2020	HOH: 454,854	Medical newsletter targeting prenatal and postpartum health: • Article highlighting maternal mental health • Call out in "New Members Start Here" to encourage prenatal care • 2020 CalOptima Health Rewards highlighting the postpartum reward
Website*	1/1/2020	12/31/2020	All, public	Promotion of member health reward forms and Bright Steps program
Social Media	6/24/2020	6/24/2020	All, public	Telehealth and prenatal care video

Table 2 examines compliance with the postpartum measure (PPC) for the top 10 race/ethnicities by denominator. The lowest rate with substantial members is for White members (64.18%). Member who did not provide race/ethnicity information is among the groups with the highest rates of

compliance with 70%, followed by Vietnamese members (82.30%).Table 3 examines PPC rates by member written language. The highest rate of compliance is among Vietnamese members (83.04%), although this group only represents close to 5% of the total denominator (7,223). The lowest rate is English (68.23%); however, this group represents 55% of the total denominator.

Table 2: Medi-Cal PPC HEDIS MY2020 Rates by Race/Ethnicity

Admin	Race/Ethnicity									
HEDIS MY2020	Hispanic	No Response	White	Vietna-mese	Other	Black	Filipino	Korean	Asian or Pacific Islander	Asian Indian
Numerator	2,799	793	593	386	179	85	55	44	38	19
Denominator	3,992	1,133	924	469	253	133	77	60	57	25
Rate	70.11%	70%	64.18%	82.30%	70.75%	63.91%	71.43%	73.33%	66.67%	76%

Note: Includes Kaiser members

Table 3: Medi-Cal PPC HEDIS MY2020 Rates by Threshold Language

Admin	Languages					
HEDIS MY2020	English	Spanish	Vietnamese	Farsi	Arabic	Korean
Numerator	3,617	1,039	284	20	35	20
Denominator	5,301	1,406	342	26	51	26
Rate	68.23%	73.90%	83.04%	76.92%	68.63%	76.92%

Note: Based on written member language preference; includes Kaiser members

2020 Prenatal and Postpartum Initiatives: Medi-Cal

1. Intervention: Bright Steps Program (BSP)

A. Description

Bright Steps is a CalOptima program for prenatal and postpartum Medi-Cal members. The program offers education, educational materials, resources and support for mom and baby through trimester and postpartum phone calls. BSP was launched in September 2018. Since its inception, the outreach to pregnant and postpartum mothers has continued to grow each measure year. The data presented in this report is not reflective of the vast program outreach and member engagement efforts as not all members that are compliant with the PPC HEDIS measure take part in BSP.

B. Reporting

In March 2020, BSP launched new CORE report, CC0226, to document member outreach attempts and engagement throughout trimester and postpartum calls. In the previous process, BSP did not count on sophisticated reporting and only had the ability to identify the outreach efforts made by program staff. Consequently, when identifying member participation efforts for purposes of this report, there are differences as true engagement prior to March 2020 was not able to be measured.

C. Findings

PPC Table 4. BSP Engagement — MY2019 and MY2020

HEDIS MY	BSP Participation Includes Members Non-Compliant with PPC Measure	HEDIS Denominator	BSP Participation Rate
2019	631	**6,628**	9.52%
2020	787	**7,223**	10.90%

PPC Table 5. Postpartum Compliance and Postpartum Member Health Reward Participation Among Members that Completed a BSP Postpartum Assessment — MY2020

HEDIS MY	Members that Completed a BSP Postpartum Assessment	Members Compliant with Postpartum Visit	Health Reward Participation
2020	664	519 519/664 (78.16%)	126 126/664 (18.98%)

PPC Table 6. PPC Compliance Among BSP Participants

HEDIS MY 2020				
Variables	Total	Denominator (BSP Participants)	MY2020 Rate	MY2019 Rate
BSP participants compliant with PPC HEDIS measure	605	787	605/787 (76.87%)	74.96%
BSP participants not compliant with PPC HEDIS measure	182	787	182/787 (23.13%)	25.04%

D. Analysis

1. In MY2020, 76.87% of BSP participants were compliant with the PPC HEDIS measure. This suggests that BSP participation is associated with an increased likelihood of being compliant with the PPC HEDIS measure.
2. Compared with MY2019, there was a slight increase (1.91%) of PPC compliance among members that participated in BSP.
3. There was an increase in outreach efforts to engage members in BSP. In MY2019, BSP outreached to 2008 members. In turn, during MY2020, BSP outreached to a total of 2,421 members, up 20.57%. While outreach efforts increased, there was only a 1.38% increase in actual BSP participation.
4. PPC compliance was assessed among all BSP participants. Completion of a postpartum assessment with BSP was associated with being compliant with a postpartum visit. (Refer to Table 6)
5. Postpartum member health reward participation among members that completed a Bright Steps postpartum assessment was less than 20%. This suggests that members who are achieving the postpartum measure compliance may be opting not to participate in the reward program or the postpartum member health reward may not be a contributing factor to measure compliance.

D. Barriers

1. Concerns about maternal and newborn safety during COVID-19 may have contributed to limited or reduced provider visits and reduced provider promotion of CalOptima's BSP.
2. The pandemic exacerbated the social and economic challenges already faced by the vulnerable population we serve. Subsequently, the pandemic may have contributed to a rise in competing priorities for our membership base, which may have limited the participation in this program.
3. COVID-19 changed the health environment. The pandemic placed expectant members at higher risk of potential complications from the virus. It impacted the way providers were able to deliver care to members and how members accessed prenatal care.
4. The PPC HEDIS measure changed to allow telehealth for prenatal and postpartum visits. While this improves access for some segments of the population, telehealth also presents barriers for segments of the population with low or limited technical literacy.
5. The COVID-19 pandemic has highlighted social inequities and negative experiences that create a challenging environment for expectant mothers. Barriers such as limited or no income, limited ability to afford transportation to and from medical appointments, lack of childcare support, among others creates conditions where it is difficult to access prenatal programs and care or access it in a timely manner.
6. BSP outreach is predominantly driven by a pregnancy notification report (PNR) to CalOptima. No notification results in a missed opportunity for outreach and program engagement.
7. Similarly, a late pregnancy notification results in a missed opportunity to provide support and critical information early in the member's pregnancy. COVID-19 may have contributed to instances where members sought care in later stages of their pregnancy, thus impacting the timeline in which a PNR was received, and outreach initiated.
8. BSP engages only a small portion of the HEDIS denominator. Engagement in the Bright Steps and Postpartum member health reward have increased, but overall participation rates remain low among members compliant with the PPC HEDIS measure indicating that members may not be aware of or may not be taking advantage of these programs. Limited participation creates challenges in identifying the impact of these programs on PPC HEDIS measure compliance.

E. Opportunities for Improvement

1. Identify ways to increase member awareness and augment Bright Steps program participation. Strategies may include increasing PNR submissions and, improving the timeliness of PNR submissions.
    a. During 2021, efforts have gone underway to augment awareness of Bright Steps, PNRs, provide Bright Steps fliers and brochures to OB provider offices.
2. COVID-19 has not only exacerbated inequities that are intertwined with negative health outcomes, but the pandemic also imposed long-term effects on health care systems. Continuing to offer BSP will support the promotion of healthy pregnancies and babies during a time where it is evident that there is an increased need for flexibility in the delivery mode of health services and to remediate the effects of the pandemic.
3. Create awareness campaigns that target members that are at higher risk of maternal health complications due to inequities associated with demographic factors such as age, race/ethnicity.

4. Continue BSP promotion efforts among, health networks, providers and community organizations by leveraging the existing communication avenues such as: Provider Update, Health Network Weekly Communication, Health Network quality meetings, and information sharing through community collaboratives focused on maternal health.
5. Augmenting CalOptima's website to have a dedicated webpage with information that supports the various prenatal stages and available in the Medi-Cal threshold languages. The Bright Steps program booklet and CalOptima's Instagram, Facebook and Twitter media pages can be leveraged to drive webpage promotion and user traffic.
6. Shift to a multilayered outreach approach that targets members, providers, the community partners and health care partners. Approach should include community events that address the needs within the environment and enable the delivery of education and health care services where members reside. Community events also provide an opportunity for members to have a positive member experience with their health plan.
7. Research suggests that access to insurance alone will not remove barriers to care. Further assessment among noncompliant members is necessary to better understand the barriers to postpartum care and implement strategies to reduce those barriers. Additional opportunities to understanding challenges from member's point of view may include conducting outreach by mail, supplemented with telephonic outreach or conducting electronic/online surveys.

2. Intervention: Postpartum Checkup Member Health Reward MY2019–20

A. Description

The Postpartum Checkup Member Health Reward Program is a member health reward program that provides $50 to members who gave birth between October 8, 2019, and October 7, 2020, and complete a postpartum visit between 1–12 weeks after delivery.

B. Findings

The table below shows the participation rates in the Postpartum Checkup Incentive Program. Participation rates have increased since the program start in September 2018. The MY2020 participation rate represents a 4.14% increase from the previous measure year.

PPC Table 3. Postpartum Checkup Member Health Reward Submissions MY2020

HEDIS MY	PPC Incentive Submissions	PPC Measure Denominator (Total births)	Response Rate
2020	425	7,223	**(425/7,223) 5.88%**

PPC Table 5. PPC Incentive Submissions by Members Compliant with MY2020

HEDIS MY	Members in Compliance with PPC Measure that Participated in PPC Incentive	Total Members in Compliance with PPC Measure	PPC Incentives Submitted by Members Compliant with PPC Measure
2018	56	3,954	**(56/3,954) 1.41%**
2019	102	4,743	**(102/4,743) 2.15%**
2020	396	5,060	**(396/5,060) 7.82%**

The table below indicates the cities with the highest percentage of members who are not compliant with postpartum care within the recommended timeframe. A total of 2,163 members were not compliant with the PPC HEDIS postpartum measure.

PPC Table 6. Members Non-Compliant with Postpartum Care MY2020

City	Total Members Non-Compliant with Postpartum Visit	Total Percent Non-Compliant with Postpartum Visit
Garden Grove	164	**(164/2,163) 7.58%**
Santa Ana	418	**(418/2,163) 19.33%**
Anaheim	429	**(429/2,163) 19.83%**

C. Analysis

1. Participation in the Postpartum Member Health Reward program during 2020 has increased by 5.67% from 2019.
2. When assessing health reward participation among members compliant with the postpartum visit (n=5060), 7.82% of members engaged in the reward program indicating that most members in compliance are not aware of this program or are not taking advantage of it.
3. Participation in the reward program was highest among Hispanic members (68.71%). On the contrary, program participation among other ethnic groups was low: Black (0.47%), White (7.53%) and Asian (7.53%). Note, the Asian ethnic group aggregates members who identify as Asian Indian, Asian or Pacific Islander, Filipino, Cambodian, Vietnamese, Chinese and Korean.
4. There are varying timeframes for completing the recommended postpartum visit. Most members (36.67%) are completing a postpartum visit between 3–4 weeks after delivery. Less than 5% of compliant members are getting a postpartum visit after 9 weeks indicating that providers are making efforts to complete visits earlier.
5. Members between the ages 18–29 were the age group most non-compliant with postpartum care representing 61.63% of the non-compliant cases.
6. Santa Ana (19.33%) and Anaheim (19.83%) represent the two cities with the highest rates of members who are non-compliant with postpartum care 1–12 weeks after delivery.
7. When it comes to postpartum care, disparities exist between racial/ethnic groups. Hispanic women represent the highest percentage (55.10%) of members who are not compliant with care.
8. Hispanic women account for 46.96% of the births in MY2020, however, almost one third of those births are not compliant with a postpartum visit (29.86%).
9. Black women account for <2% of the births. Of those births among Black women, more than one-third (35.82%) are not complaint with postpartum care.
10. Compliance with prenatal care visits was associated with increased likelihood of compliance with a postpartum care visit.

D. Barriers

1. The COVID-19 pandemic may have changed the way members accessed postpartum care. Concerns about maternal and newborn safety during COVID-19 contributed to limited or reduced provider visits and may have reduced the promotion of CalOptima's Postpartum Checkup Incentive Program.

2. Increase in COVID-19 transmissions and a statewide lockdown mandate during the MY2020 may have been contributing factors for noncompliance with postpartum visits.
3. PPC HEDIS measure changed to allow telehealth for postpartum visits. While this improves access for some segments of the population, telehealth also presents barriers for segments of the population with no or limited access to reliable internet as well as those with low or limited technical literacy.
4. BSP outreach during the postpartum period is predominantly driven by a pregnancy notification report (PNR) to CalOptima. No notification results in a missed opportunity for outreach at the postpartum timeframe.
5. The Postpartum member health reward effort engages only a small portion of the HEDIS denominator (5.88%). Most members that do engage in PCIP are compliant with the postpartum measure (93.18%).
6. Engagement in the Bright Steps and health rewards have increased, but overall participation rates remain low among members compliant with the PPC HEDIS measure indicating that members may not be aware of or may not be taking advantage of these programs. Similarly, limited participation creates challenges in identifying the impact of these programs on PPC HEDIS measure compliance.

E. Opportunities for Improvement

1. While most members are compliant with the postpartum visit and do not take advantage of the health rewards program, this suggests that there is a need continue to promote the health rewards through the available platforms (member newsletters, CalOptima website, provide offices, etc.). It is an opportunity to engage those members who are not compliant.
2. Improved data sharing with CalOptima providers may increase PNR rates and augment outreach efforts to enroll members in health rewards and BSP.
3. Augment the promotion avenues of health rewards. Additional channels may include direct mailings, targeted social media campaigns, IVR calls, mobile text messages and leverage existing health network quality meetings to enhance collaborative efforts.
4. To maximize outreach efforts, consider targeted messaging to focus on the 18–29 age group and regions where members with the highest non-compliance rates reside. In addition, increase targeted messaging to Hispanic members that represent more than half of the rates of non-compliance.
5. Continue to leverage BSP to help close gaps in care.
6. To support a continuum of care all the way through the postpartum period, there is a need to implement or enhance strategies that focus on ensuring timely prenatal care. Need to continue to drive PNR completion among providers.
7. Augment community partnerships with organizations that work with our membership base to increase program awareness.

Additional PPC Activities in 2020

1. CalOptima-sponsored Facebook, Twitter and Instagram posts related to telehealth and prenatal care.
2. Presentations at community-based organizations.
3. Promotion of Bright Steps across seven WIC offices. BSP posters were provided to OCHCA WIC offices.

Additional PPC Activities in 2021

This activity list is based on the 2021 (January 1 through December 31) calendar year. MY2021 for PPC postpartum runs on a different timeline, as it is looking for postpartum compliance between October 15, 2020, to December 31, 2021 (1–12 weeks after delivery). The initiatives noted with an asterisk * were offered between 10/15/2020–12/31/2020.

Table 7: List of 2021 PPC Initiatives

Initiative	Start Date	End Date	Description
Member Health Reward*	1/1/2021	12/31/2021	$50 member reward for completing a postpartum visit 1-12 weeks after delivery
Member Outreach*	1/1/2021	12/31/2021	Bright Steps program for moms and babies
P4V*	1/1/2021	12/31/2021	Pay 4 Value program
Spring 2021 Medi-Cal Newsletter	March 2021	March 2021	Medical newsletter targeting prenatal and postpartum health: • Article highlighting importance of prenatal care • Call out in "New Members Start Here" to encourage prenatal care
Website*	1/1/2021	12/31/2021	Promotion of member health reward forms and Bright Steps program
Social Media	1/1/2021	12/31/2021	Facebook, Twitter and Instagram posts related to prenatal and postpartum health
CalOptima Diaper Days	Quarterly	Quarterly	Community events that provide OC families with diapers, education and access to resources. Events will target areas where our pregnant and recently delivered moms live
OB Provider PPC Mailings	06/23/2021	06/23/2021	PPC mailings to OB provider offices with information on Bright Steps, PNRs, Postpartum Member Health Reward Forms
PPC Provider Fax Blast	07/2021	07/2021	Provider fax blast emphasizing message to OB providers on PPC program and information shared in the PPC mailings
Targeted social media promotional campaigns *(new)*	TBD	TBD	Leveraging geomapping to identify areas of low compliance for targeted advertisement campaigns

Pediatric/Adolescent Wellness

Well-Child Visits in the First 30 Months of Life (W30)

In October 2020, Well-Child Visits in the First 15 Months of Life (W15) was retired and revised to Well-Child Visits in the First 30 Months on Life (W30). The HEDIS and MCAS W30 measure reports two rates: (1) Well-Child Visits in the First 15 Months and (2) Well-Child Visits for Age 15

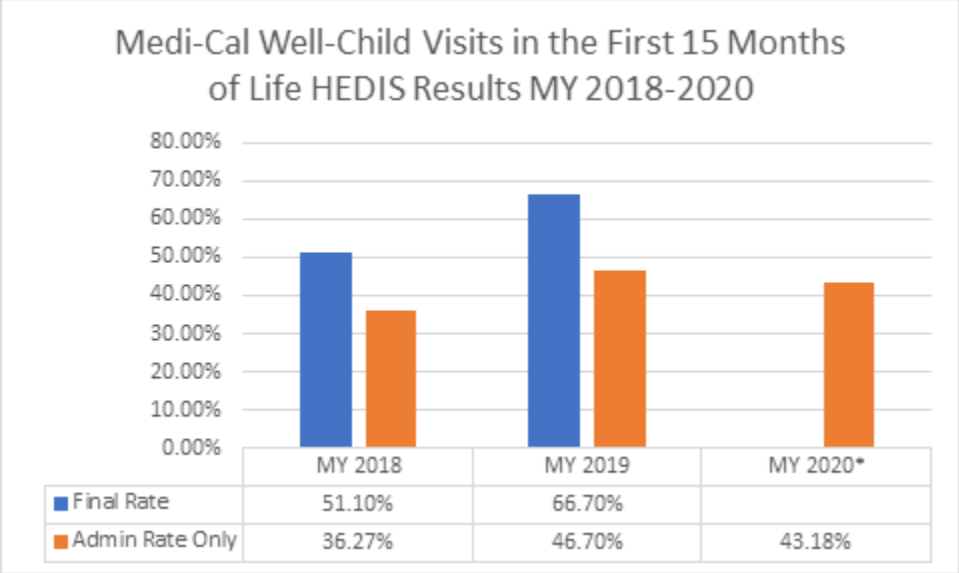
Months–30 Months. Well-child visits continued to be a top priority for CalOptima during 2020. The focus was on increasing compliance for the sub-measure, which requires the completion of six well-child visits for members from birth to before their 15-month birthday.

Performance Against Goal:
There are no benchmarks for comparison of the W30 measure since it's treated as a first-year measure. The W15 measure met the MPL for MY 2019. CalOptima proactively monitored prospective rates on a monthly basis and ensured active trend analysis for outliers. In Table 1 below, the final W30 HEDIS rates for MY 2020 are identified. Furthermore, Figure 1 provides an overview of pediatric well-child visit trends from MY 2018 to MY 2020. Please note W30 First 15 Months HEDIS measure was pulled in place of W15 to evaluate MY2020.

W15 Table 1: Well-Child Visits in the First 30 Months of Life (W30) Final HEDIS 2020 Rate

Well-Child Visits in the First 30 Months of Life (W30)	Rate
Well-Child Visits in the First 30 Months of Life (First 15 Months)	43.18%
Well-Child Visits in the First 30 Months of Life (15 Months–30 Months)	71.76%

W15 Figure 1: Final HEDIS Rates for Well-Child Visits in the First 15 Months of Life 2018–20



W15 measure specifications were used to identify MY2018–19 final HEDIS rates.
**MY2020 administrative rate is based on W30-First 15 Months measure.*

W15 Figure 2: Number of Members Compliant for W15 (Well-Child 6+ Visits) for MY2020

W15 Figure 2 represents all new compliant (six or more visits by 15 months) members by month between March 2019 and December 2020 ($n_{outreached}$=3531) for MY2020. These members fall in the HEDIS 2020 ***W30-First 15 Months*** *denominator (N=8,669). The* ***W30-First 15 Months*** *administrative rate is 43.18%. *Note, Kaiser members are excluded from this data set since they are not outreached for initiatives. Numerator reflected here is lower than final administrative rate numerator (n_{actual}=3,743).*

W15 Table 2: Well-Child Visits in the First 15 Months Initiatives in 2020

Initiative	Start Date	End Date	Outreach Population	Description
Well-Child Visits 1–3 Member and Provider Incentive Program	1/1/2020	12/31/2020	1,674 members approved	Member and provider incentive program for completing 1st, 2nd and 3rd well-child visits. Members received a $50 gift card. Providers receive a $50 check.
Well-Child Visits 4–6 Member and Provider Incentive Program	1/1/2020	12/31/2020	793 members approved	Member and provider incentive program for completing 4th, 5th and 6th well-child visits. Members received a $50 gift card. Providers receive a $50 check.
Posted incentive forms on website	3/1/2020	12/31/2020	All, Public	Well-Child Visits 1–3 promoted on Health Rewards Program landing page.
Posted incentive forms on website	3/1/2020	12/31/2020	All, Public	Well-Child Visits 4–6 promoted on Health Rewards Program landing page.
CalOptima Days - W15 Only (CHOC Health Alliance)	3/4/2020	3/5/2020	125 eligible CalOptima Medi-Cal members	A collaboration with CHOC Health Alliance to host a health and wellness event focused on children and adolescents due for W15, W34 and All Well Child (AWC).
Spring 2020 Medi-Cal Newsletter	3/19/2020	3/19/2020	HOH: 441,196 Medi-Cal Members	Newsletter included articles on: (1) Stay Well, Play Well ad. (2) Well-Child Visits, getting well-child visits are a key part of your child's health. (3) Infant and Child Car Seat Safety
Provider Fax Blast: Well-Child Visits During COVID-19 Pandemic	5/20/2020	5/20/2020	All health networks and CCN providers	Well-Child Visits During the COVID-19 article was included in the Provider Update via fax blast.

Provider Fax Blast: 2020 CalOptima Member and Provider Incentive Programs	7/20/2020	7/20/2020	All health networks and CCN providers	CalOptima Member and Provider Incentive Programs article was included in the Provider Update via fax blast.
Health Guide 0–2 Newsletter + W15 Incentive Mailing	7/24/2020	7/24/2020	8,960 Medi-Cal members	Newsletter mailing discussing the importance of well-child visits, vaccinations, developmental milestones and healthy eating and the Well-Child Health Rewards was mailed to 0–12 months old Medi-Cal members.
Post Bright Steps Well-Baby Follow-Up Calls	9/8/2020	Ongoing	160 Parent or Guardian were Outreached	Outreach calls to mothers who participated in Bright Steps Program to follow up on their newborn(s) to complete well-child assessment.
Social Media Posting	8/19/2020	8/19/2020	All, public	Social media post about: Don't delay your child's checkup and immunizations (Instagram, Facebook, Twitter)

2020 Well-Child Visits in the First 15 Months Initiatives: Medi-Cal

1. Intervention: Well-Child Visits 1–3 and 4–6 Member Health Reward Program (1/1/2020-12/31/2020)

A. Description: This member health reward program consisted of identifying CalOptima Medi-Cal members ages 0–15 months due for Well-Child Visits 1–3 and 4–6. The health reward was approved if eligible members completed three or six well-child visits before turning 6 months or by the 15-month birthday, respectively. A form was completed by the provider and faxed in to CalOptima within 60 days of the third or sixth date of service (DOS). The health reward program launched on January 1, 2020, and ran through December 31, 2020. Member submissions that were approved received a $50 gift card via mail. The reward participation rate was tracked utilizing the PHM Incentive database.

B. Findings

W15 Table 3: Total W15 Member Health Reward Participation Rates

Well-Child Health Reward Program	Forms Received	HEDIS Qualified	HEDIS Denominator	Health Reward Participation Rate
1–3 Visits	1,796	284	8,669	3.28%
4–6 Visits	867	515	8,669	5.94%

Data source from PHM Incentive database and final HEDIS 2020 rates

W15 Table 4: Members Participation in W15 1–3 Health Reward by Written Language

Member Written Language	Count of Member Submissions for W15 1–3 Health Reward	% of Total Submissions
English	182	64.08%
Farsi	2	0.70%
Spanish	91	32.04%
Vietnamese	9	3.17%
Grand Total	**284**	

W15 Table 5 Members Participation in W15 4–6 Health Reward by Written Language

Member Written Language	Count of Member Submissions for W15 4–6 Health Reward	% of Total Submissions
Arabic	1	0.19%
English	295	57.28%
Farsi	3	0.58%
Korean	3	0.58%
Spanish	172	33.40%
Vietnamese	41	7.96%
Grand Total	**515**	

C. Analysis

1. There was a total of 2,663 W15 1–3 and W15 4–6 member reward forms received. Of those, 765 unique members fell in the W15 denominator.
2. Only 34 members participated in both W15 1–3 and W15 4–6 Member Health Reward Program who fell into the W15 denominator. Of those only 24 are compliant for W15.
3. Total member reward expenditures = (1674+793) x $50 = $123,350.
4. Members participated in the W15 1–3 Health Reward 1.07 times more than the W15 4–6 Health Reward Program.
5. As identified in Table 2, the impact on HEDIS for this reward participation rate is low, 3.28% and 5.94% for Well-Child Visits 1–3 and 4–6, respectively. Health Reward participation rate is calculated by 'HEDIS Qualified' divided by 'HEDIS Denominator'.
6. As identified in Table 3 and 4, the reward participation by member's written language. Majority of members preferred written language is English (64.08% and 57.28%) and Spanish (32.04% and 33.40%) for W15 1–3 and W15 4–6 reward respectively.

D. Barriers

1. Only those members turning 15 months old in the measurement year technically fell into the HEDIS measure. Therefore, members who were too young may have completed six visits but are not counted toward W15 denominator until the year after.
2. Since the submissions were not validated against claims and encounter data, the third and/or sixth DOS was not validated. Reward forms were taken at face value.
3. Anecdotal qualitative data showed that in clarification inquiries with various provider offices, certain members were unable to complete their sixth W15 visit before their 15-month birthday, because providers were routinely scheduling members after the member turned 15 months.
4. The COVID-19 pandemic impacted preventative well-care visits. Provider offices were not scheduling well-child visits at the peak of the pandemic, further exacerbated by office closures in Spring 2020. When offices reopened scheduling was split and reduced to safeguard patients and staff. Providers are hesitant to perform well-care visits via telehealth since infant cannot speak for themselves.

E. Opportunities for Improvement

1. For future iterations, revise reward program to require all 6 visits versus breaking the visits into two separate rewards. Despite there being more W15 1–3 forms submitted (by 1.07 times) than W15 4–6, it did not drive compliance.
2. Provide clearer instructions of the measure requirements of when the sixth visit is to be completed.
3. Since the well-child measure is based on a series of visits, should aim to work closely with providers to make an impact rather than outreaching to members.

2. Intervention: Well-Child Visits 1–3 and 4–6 Provider Incentive Program (1/1/2020–12/31/2020)

A. Description

Incentive program was made available to all providers who served CalOptima Medi-Cal members ages 0–15 months old. This incentive aligns with the member incentive as it requires the provider to attest to the visits and fax the form within 60 days to CalOptima. For Well-Child Visits 1–3 and 4–6 incentive, they must complete three or six well-child visits before turning 6 months or by the 15-month birthday, respectively. The incentive program launched January 1, 2020 and ran through December 31, 2020. Submissions were validated by claims data. Providers were given a $50 incentive per each approved submission. The following evaluation is data is from PHM Incentives database and final HEDIS 2020 rates.

B. Findings

1. Total of 2,663 submissions were entered into the database.
2. 2,020 out of 2,663 submissions were processed for provider incentive payment.
3. 643 submissions were not processed for Quarter 4 or retrospective payment.
4. Limitations: if a provider submitted an incentive form late, but for a DOS for another an earlier quarter it may have not been processed. Forms were processed by quarter in which the 3rd or 6th DOS fell in.
5. 85 unique providers or offices by Tax Identification Number participated in the well-child provider incentive program.

W15 Table 6: Summary of Well-Child Provider Incentive 2020

Incentive Program	Total Submissions	Total Approved	Total Denied	Not Processed	Total Incentive
Well-Child 1–3 Visit	1,796	1,151	234	411	$57,550
Well-Child 4–6 Visit	867	468	167	232	$23,400
Totals	2,663	1,619	401	643	$80,950

W15 Table 6, approved submissions were validated by claims and encounter data. Total denied is defined as record was processed and assessed for payment yet did not meet the criteria to be incentivized. Not processed indicates records submitted but not processed for provider payment. Note, members, if approved, were awarded a $50 gift card.

C. Analysis

1. Of the 1,619 approved submissions, 410 members were compliant for W15 by the end of the measure period.
2. 1,619 submissions were approved for a provider incentive. However, only 557 members whose form was received fell into the denominator (410 were compliant for W15).

D. Barriers

1. Provider participation exceeded expectations. Budget was not adequate to complete provider incentive payments for Quarter 4, 2020.
2. 643 submissions were not processed for provider payment due to budgetary constraints. Approximately 494 of these records would have been approved for payment ($24,700).
3. It is probable the sixth DOS submitted are accurate and claims and encounters were received but was rejected since it did not meet all the W15 HEDIS specifications to be a numerator hit.

E. Opportunities for Improvement

1. For future provider incentive programs, improvement of communication and promotion of incentives to include language about program limitations and that offering can be discontinued at any time without prior notification by CalOptima is necessary.
2. Consider outreaching to provider offices with a large volume of W15 members that are low performing to collaborate on an improvement project.
3. Work closely with health networks to identify which offices may need help understanding HEDIS metrics.
4. Modify the provider incentive program to be available to a selected a few offices who have potential of making a big impact on the well-child rate and do a tiered payment system versus payment per member to alleviate budgetary constraints.

3. Intervention: CalOptima Days at CHOC Health Alliance Sites (3/4/2020–3/5/2020)

A. Description

There was a concerted effort to increase the number of W15 visits starting in April 2019. CalOptima's collaboration with CHOC Health Alliance to host wellness events at CHOC Orange Clinic and Clinica CHOC Para Ninos were held in March 2020. The clinics focused on outreaching and scheduling members due for W15, W34 or AWC. The incentive was based on a payment tier with a base pay for holding an event for $500 and maximum incentive of $2,500, yielding $3,000 total.

B. Findings

1. CHOC Orange Clinic had two event days, 114 appointments were scheduled, 103 attendees and 80 confirmed CalOptima Medi-Cal members.
2. Clinica CHOC Para Ninos had two event days, 82 appointments were scheduled, 64 attendees and 45 confirmed CalOptima Medi-Cal members.

W15 Table 7: CHOC Health Alliance CalOptima Day Attendance

Clinic	Appt Scheduled	Total Attendance	Attendance Rate	Confirmed Eligible Members	Incentive Amount
CHOC Orange Clinic	114	103	90.35%	80	$3,000
Clinica CHOC Para Ninos	82	64	78.05%	45	$3,000

C. Analysis

1. A total of $9,000 was incentivized to CHOC Health Alliance for hosting the CalOptima Day events and 125 eligible CalOptima Medi-Cal members were seen.
2. CHOC Health Alliance experienced a high attendance rate 78.05%–90.35%.
3. Only 36 members fell in the W15 denominator and six members' visit yielded a numerator hit.

D. Barriers

1. Coordinating events with participating provider clinics.
2. Challenges outreaching to members to attend the clinics with only the W15 population to contact.
3. Difficulty obtaining the event schedule list (participant list) from the sites post event.

E. Opportunities for Improvement

1. Establishing clear expectations in engaging in such events may eliminate communication and delays in execution.
2. Complete a robust analysis of clinic's pediatric population to identify a larger outreach population for scheduling for future events. This may include multiple measures and age groups.

4. Intervention: Health Guide 0–2 Newsletter and Well-Child Incentive Mailing (7/24/2020)

A. Description: Health Guide Newsletter includes health education content specifically for the 0–2 years old age range. The Well-Child Visits 1–3 and/or 4–6 incentive forms were included in the mailings for eligible members. Mailings were sent on July 24, 2020, targeting 8,690 CalOptima Medi-Cal members.

B. Findings

1. 2,944 out of the 8,690 members who were mailed the newsletter and incentive form fell in the W15 denominator.

C. Analysis

1. 563 members completed their sixth well-child visit DOS after receiving the mailing.
2. 35 members in this targeted mailing submitted the W15 4–6 incentive form and were compliant for W15.

D. Barriers

1. No barriers.

E. Opportunities for Improvement

1. Expand Health Guide Newsletter distribution through digital options.
2. Distribute Health Guides as supplemental education source for members and providers.

5. Intervention: Post Bright Steps Well-Baby Follow-Up Call Initiative (9/9/2020–Ongoing)

A. Description

A collaborative effort with health education team was made to outreach to members who completed their Postpartum Assessment by participating in BSP. In leveraging BSP participants, health educators were able to connect with the parent of newborn members and follow-up on their well-care visit status. Calls began September 9, 2020, and this is a continued effort.

B. Findings

1. 191 Post Bright Steps Well Baby Follow-Up call scripts were created between 9/9/20–12/31/20.
2. 160 calls were made to unique Medi-Cal members who participated in the BSP.
3. 112 call scripts were completed and successful. Call success is defined as the health educator was able to reach a live person and conduct the call script. Note: some members were outreached more than once if they were identified as a high priority member or had more than one birth recently (e.g., twins).
4. No members who participated in the Post Bright Steps Well-Baby Follow-Up Call Initiative fell in the W15 denominator for MY 2020.

C. Analysis

1. The outbound call initiative began in September 2020 to newborn members. A majority of members fell in the W30 First 15 Months denominator for MY2021 instead of impacting MY2020.

D. Barriers

1. Pediatric well-child visits measure date of births span over a longer time period than the actual measurement year. For W30 First 15 Months, the member must turn 15 months in the measurement year. To evaluate outreach data will be available a year later.
2. Outreach is limited since it only reaches those whose parent participated in the BSP and continued to be a CalOptima Medi-Cal member on date of outreach.

E. Opportunities for Improvement

1. If data shows positive impact on child's health, consider adding an additional outreach when member is 12 months old to connect BSP aims with child wellness to 1) reaffirm child is on track for well-child visits and vaccinations, and 2) discuss family planning with mother.

2. Collaborate with Maternal Health Team who oversees BSP to complete a robust data analysis including member demographics between BSP participation and general CalOptima membership (pregnant women) to see if their child has better health outcomes. Additionally, to leverage this information to build promotional campaigns and target subcommunities where this resource (BSP) can make a positive health impact.

Additional Well-Child Visits in the First 15 Months Activities in 2020:

1. Well-Child Visits 1–3 and 4–5 Incentive forms were posted to CalOptima's Health Rewards Program landing page (3/1/20–12/31/20).
2. Medi-Cal 2020 Spring Newsletter Mailing (3/19/2020). Newsletter included the following, (1) Stay Well, Play Well advertisement, (2) Well-Child Visits, Getting Well-Child Visits Are A Key Part of Your Child's Health, and (3) Infant and Child Car Seat Safety article. The member newsletter was mailed to 441,196 head of household Medi-Cal members.
3. Provider Fax Blast: Well-Child Visits During COVID-19 Pandemic (5/20/2020). An article was included in Provider Update. The fax went to all contracted providers.
4. July 2020 Community Connections Newsletter included the promotion of all Health Guide Newsletters (0–2 years, 3–6 years, 7–12 years, 13–17 years and 18–21 years old). Communication went out to all newsletter subscribers on 7/15/2020. Community Connections has more than 2,700 readers, representing local community-based organizations, non-profits, charities, local agencies, providers and entities.
5. Provider Fax Blast: 2020 CalOptima Member and Provider Incentive Programs (7/20/2020). An article was included in Provider Update Newsletter. The fax went to all contracted providers.
6. *Stay Current On Well-Care Visits, Screenings and Immunizations* social media was posted to Facebook (engagement rate 15/195 = 7.9%), Instagram (engagement rate 6/190 = 3.1%), and Twitter (engagement data N/A) (8/25/20).

2021 Well-Child Visits in the First 15 Months Initiatives: Medi-Cal

1. Well-Child Visits, 0–30 Months text message campaign, planned for Q4 2021.
2. Medi-Cal 2021 Summer Newsletter Mailing (7/06/2021). Newsletter included *During the COVID-19 Pandemic Is It Safe for Well-Care Visits* article. The member newsletter was mailed to 514,256 head of household Medi-Cal members.

F. Opportunities for Improvement:

1. Conduct a formal evaluation of how data gaps can be closed, since W15 measure is revised to W30 and will strictly be an administrative measure.
2. Promote well-child visits through BSP prenatal and postpartum calls and through Post Bright Steps Well Baby Follow Up Call Initiative.
3. Leverage BSP educational member booklet which includes well-child visits and vaccination schedule to help parents keep on track with their child's health (e.g., vaccine passport they can put on their refrigerator).
4. Since the COVID-19 pandemic impacted health care in 2020 and the W30 population spans over calendar years, impact on the rate may be delayed. Need to continue to closely monitor population for any significant changes.

5. Continue to collaborate and grow partnerships with community-based organizations (e.g., AAP) to develop and/or align with campaigns to further promote the importance of well-care visits and vaccinations.
6. Table 8 below examines the ethnicity breakdown of subpopulations within the W30 First 15 Months measure. This new approach to data pulls will allow the opportunity to address social determinants of health and understand inequities in health care. There is a large Black population of membership, but their W30 First 15 Months rate is lower than other highly populated groups. Future efforts should include identifying subpopulations and their barriers to better focus efforts where needed.
7. In addition to completing outreach in member's threshold language, outreach campaigns should be tailored to subpopulations in various modalities (e.g., text message, radio advertisement, newspaper advertisement, mailing, social media) and culturally appropriate.

W15 Table 8: HEDIS 2020 W30 First 15 Months Rate by Member Ethnicity, 10 Highest Volume Groups

Ethnicity	W30 First 15 Months Numerator Rate	Numerator Count	Denominator Count	Percentage of Total Population	Impact on HEDIS Rate
Hispanic	43.82%	2,092	4,774	55.07%	24.13%
No response, client declined to state	41.43%	563	1,359	15.68%	6.49%
White	39.10%	339	867	10.00%	3.91%
Other	41.43%	273	659	7.60%	3.15%
Vietnamese	52.81%	301	570	6.58%	3.47%
Black	36.28%	41	113	1.30%	0.47%
Korean	39.13%	27	69	0.80%	0.31%
Filipino	35.38%	23	65	0.75%	0.27%
Chinese	29.09%	16	55	0.63%	0.18%
Asian or Pacific Islander	56.86%	29	51	0.59%	0.33%

Child and Adolescent Well-Care Visits (WCV)

The AWC HEDIS and MCAS measure was revised to Child and Adolescent Well-Care Visits (WCV) in October 2020. WCV measure reports three age stratifications and total rate: 3–11 years, 12–17 years, 18–21 years and total. Well-care visits were a top priority in 2020. The focus was on increasing compliance for annual well-care visits for adolescents. Since the measure was revised, there is no benchmark for MY 2020 to be trended. For the purposes of evaluation, data was pulled using AWC measure specifications unless noted otherwise.

Performance Against Goal:

There was no goal defined for MY2020. There are no benchmarks for comparison as WCV is treated as a first-year measure. AWC measure met MPL for MY2019. Table 1 identifies the WCV final HEDIS rate for MY2020. Table 2 is an overview of how adolescent well-care visits performed from 2018–20. WCV HEDIS measure was pulled for MY2020.

AWC Table 1: Child and Adolescent Well-Care Visits (WCV) Final HEDIS 2020 Rate

Child and Adolescent Well-Care Visits (WCV)	Rate
Child and Adolescent Well-Care Visits (3–11 years)	56.58%
Child and Adolescent Well-Care Visits (12–17 years)	54.04%
Child and Adolescent Well-Care Visits (18–21 years)	28.91%
Child and Adolescent Well-Care Visits (Total)	50.58%

AWC Figure 1: Final HEDIS Administrative Rates for Well-Care Visits, 2018–20

AWC Figure 1, identifies the administrative rate for annual well-care visits for 2018–20. Note, MY2018 and 2019 are based on AWC measure specifications (12–21 years old) and MY2020 is based on WCV specifications (3–21 years old). This data cannot be trended.

AWC Figure 2: Number of Members Compliant for AWC for MY 2020

AWC Figure 2 represents all new compliant members by month between January 2020 and December 2020 ($n_{outreached}$=62,943) for MY2020. Based on AWC MY2020 HEDIS specifications, these members fell in the AWC denominator (N=146,384). The AWC rate is 45.46% for members ages 12–21 years old. Note, Kaiser members are excluded from this data set since they are not outreached for initiatives. Numerator reflected here is lower than final administrative rate numerator (n_{actual}=66,553).

AWC Table 2: Adolescent Well-Care Visit Initiatives in 2020

Start Date	End Date	Initiative	Outreach Population	Description
1/1/2020	12/31/2020	Pay 4 Value program	N/A	Pay 4 Value program
1/01/2020	12/31/2020	Well-Care Visits 12–17 Member Incentive Program	10,525 approved; 594 denied	Health rewards program for Medi-Cal members 12–17 years old, who need to complete their annual well-care visit. ($25 gift card or movie tickets)
3/1/2020	12/31/2020	Well-Care Visits 12–17 Member Incentive Program Promotion	All, Public	Annual Well-Care Visits 12–17 program promoted on CalOptima's Health Rewards Program landing page
3/19/2020	N/A	Spring 2020 Medi-Cal Newsletter	HOH: 441,196	Medi-Cal Newsletter promoted adolescent wellness, including articles on: (1) Stay Well, Play Well ad, (2) Well-Child Visits, getting well-child visits are a key part of your child's health, (3) Infant and Child Car Seat Safety
5/22/2020	N/A	Health Guide 18–21 Newsletter Mailing	35,799 Medi-Cal Members	Health Guide Mailing to 18–21 years old population. Articles included: well-care visits, texting and drunk driving, sexually transmitted diseases preventions, managing stress
5/28/2020	N/A	Health Guide 13–17 Newsletter + AWC Incentive Mailing	74,651 Medi-Cal Members	Health Guide Mailing to 13–17 years old population. Articles included: well-care visits, immunizations, sexual health, bullying, behavioral health, healthy weight
7/15/2020	N/A	July 2020 Community Connections Newsletter	More than 2,700 readers	Community Connections Newsletter promoting the availability of Health Guide 13–17 and 18–21 Newsletter as resource to the community.
8/25/2020	N/A	Social Media Posting	All, Public	Stay Current on well-care visits, screenings, and immunizations (Instagram, Facebook, Twitter)

2020 Adolescent Well-Care Visit (AWC) Initiatives: Medi-Cal

1. Intervention: Annual Well-Care Visits Ages 12–17 Member Health Reward Program (1/1/20–12/31/20)

A. Description

Medi-Cal CalOptima members ages 12–17 years old are eligible for the Annual Well-Care Visit for Ages 12–17-member health reward if they complete a well-care visit this calendar year. The form must be completed and mailed or faxed to CalOptima within 8 weeks of completing the visit. Members approved received either three movie theater tickets or a $25 gift card.

B. Findings

AWC Table 3: Total AWC Member Health Reward Participation and HEDIS

AWC Health Reward Program	Forms Received	HEDIS Qualified	HEDIS Denominator	Health Reward Participation Rate
Annual Well-Care 12–17	11,119	10,290	146,384	7.03%

AWC Table 4: Members Participation in Well-Care Visit Ages 12–17 Member Health Reward by Written Language

Member Written Language	Count of Member Submissions for Well-Care Visit 12–17 Incentive	% of Total Submissions
Arabic	31	0.30%
Chinese	10	0.10%
English	3,014	29.29%
Farsi	38	0.37%
Korean	224	2.18%
Spanish	6,192	60.17%
Vietnamese	781	7.59%
Grand Total	10,290	

C. Analysis

1. 11,119 submissions were received, and 10,525 members were approved for the reward.
2. Of these approvals 9,808 fell into the AWC denominator and 9,424 were compliant for AWC.
3. Total member reward expenditure was approximately $263,125.
4. As identified in Table 2, the impact on HEDIS for this reward participation rate is low, 7.03%. Health Reward participation rate is calculated by 'HEDIS Qualified' divided by 'HEDIS Denominator'.
5. As identified in Table 3, the reward participation by member's written language. Majority of members preferred written language is Spanish (60.17%) and English (29.29%).

D. Barriers

1. Since the submissions are not verified through claims and encounters data, the reward form was taken at face value.
2. AWC denominator is large. Despite focusing on the 12–17 age group, the volume made it difficult to process all the forms received by mail and fax.
3. The verbiage for this reward is similar to the Well-Child Visit 1–3 and 4–6 reward which caused confusion. Providers thought this was included in the provider incentive program.
4. COVID-19 pandemic impacted preventative well-visits. Provider offices were not scheduling well-child visits at the peak of the pandemic, with office closures in Spring 2020. When offices reopened, scheduling was split to safeguard patients and staff. Well-care visits for adolescent age group were not prioritized.
5. Additionally, since students transitioned to at-home schooling/online learning due to the pandemic, vaccination mandates weren't enforced which typically aligns with well-care visits.

E. Opportunities for Improvement

1. The strategy to engage the adolescent population needs to be scalable to accommodate the large population. This incentive specifically targeted the 12–17 age group and had a higher response rate compared to the well-child visits reward for members 0–15 months. However, processing the rewards internally was not practical or sustainable.
2. Impacting such a large denominator with health rewards is likely not effective if managed internally. Other means of engaging this member population should focus on social media and creative engagement over health rewards. Since movie tickets and gift cards seem to be desirable for this age demographic, doing a raffle or event day giveaway to drive annual well-care visits may be impactful. This will help offset the reward form processing burden and minimize the impact on budgeted funds for quality initiatives.

2. Intervention

CalOptima Days at CHOC Health Alliance Sites (3/4/2020–3/5/2020)

A. Description: There was a concerted effort to increase the number of W15 visits starting in April 2019. CalOptima's collaboration with CHOC Health Alliance to host wellness events at CHOC Orange Clinic and Clinica CHOC Para Ninos site was held in March 2020. The clinics focused on outreaching and scheduling members who were due for W15, W34, or AWC. The incentive was based on a payment tier with a base pay for holding event of $500 and maximum incentive of $2,500; yielding $3,000 total. *Note: this is the same initiative as discussed earlier in the W30 section.*

B. Findings

1. CHOC Orange Clinic had two event days, 114 appointments scheduled, 103 attended and 80 confirmed CalOptima Medi-Cal members.
2. Clinica CHOC Para Ninos had two event days, 82 appointments scheduled, 64 attended and 45 confirmed CalOptima Medi-Cal members.

AWC Table 5: CHOC Health Alliance CalOptima Day Attendance

Clinic	Appt Scheduled	Total Attendance	Attendance Rate	Confirmed Eligible Members	Incentive Amount
CHOC Orange Clinic	114	103	90.35%	80	$3,000
Clinica CHOC Para Ninos	82	64	78.05%	45	$3,000

C. Analysis

1. Total of $9,000 was incentivized to CHOC Health Alliance for hosting the CalOptima Day events and 125 eligible CalOptima Medi-Cal members were seen.
2. CHOC Health Alliance had a high attendance rate 78.05%–90.35%.
3. 36 members fell in the AWC denominator and all yielded a numerator hit.

D. Barriers

1. Initial delays due to communication and understanding discrepancies between CalOptima and participating entities were exacerbated by staffing changes.
2. Obtaining confirmed attendance list from sites for evaluation posed some difficulty. While clinic partners took on the task of performing outreach and mailing reminder letters, the coordination of delegating this task to one coordinator for each site was difficult.

E. Opportunities for Improvement

1. Due to the heavy resource demands, the time it takes for organization, coordination and execution, and the small impact on actual measure rates, CalOptima Days should not be continued without modifications.
2. Consider working with community partners to host health fairs where the outreach efforts are general and the documentation exchange will be limited to final completed attendance list verses outreach call list, mailers, schedule list to verify eligibility, and confirmed attendance list.
3. Future collaborative efforts should be preceded with confirmation of confirmed participation of champions at hosting site to avoid delays or confusion.

3. Intervention:
Health Guide 13–17 Newsletter and Annual Well-Care Visits Ages 12–17 Member Health Reward Mailing (5/28/20)

A. Description

The Health Guide 13–17 Years Newsletter and Annual Well-Care Visit for Ages 12–17 reward flyer was mailed to 74,651 Medi-Cal members in English, Spanish and Vietnamese in May 2020. Articles included: well-care visits, immunizations, sexual health, bullying, behavioral health, and information about healthy weight.

B. Findings

72,347 members who received the mailing fell in the AWC denominator.

C. Analysis

1. 61,527 had a well-care visit after receiving the mailing, but this compliance cannot be correlated with member targeted mailing.
2. While it is difficult to correlate the direct impact of mailings alone as an effective intervention towards compliance, multiple touches are believed to be effective in tandem with other member engagement strategies.

D. Barriers

No barriers experienced.

E. Opportunities for Improvement

1. Work directly with provider offices to identify which members scheduled for and attended their well-care visit because the reward is the motivating factor.
2. Anecdotally, some provider offices mentioned the reward as being an effective tool to get members to attend their well-care visit, especially as fear of going to the doctor's office grew during the COVID-19 pandemic. However, budget limitations dictated the conclusion of the AWC health reward program.

Additional Adolescent Well-Care Visit (AWC) Activities in 2020:

1. Well-Care Visits Ages 12–17 Member Health Reward Program was promoted on the CalOptima Member Health Rewards Program landing page from March to December 2020.
2. *Health Guide 18–21 Years Newsletter* (5/22/20). Targeted mailing outreached to 35,799 Medi-Cal members in English, Spanish and Vietnamese. Content included articles on well-care visits, texting and drunk driving, sexually transmitted diseases, managing stress, weight management and dating violence.
3. *Medi-Cal 2020 Spring Medi-Cal Newsletter Mailing* (3/19/2020). Newsletter included (1) Stay Well, Play Well advertisement, (2) Well-Child Visits, Getting Well-Child Visits Are a Key Part of Your Child's Health, and (3) Infant and Child Car Seat Safety article. Newsletter was mailed to 441,196 head of household Medi-Cal members.
4. July 2020 Community Connections Newsletter included the promotion of all Health Guide Newsletters (0–2 years, 3–6 years, 7–12 years, 13–17 years and 18–21 years old). Communication went out to all newsletter subscribers on 7/15/2020. Community Connections has more than 2,700 readers, representing local community-based organizations, non-profits, charities, local agencies, providers and entities.
5. Information to stay current on well-care visits, screenings and immunizations were posted to social media including Facebook (engagement rate 15/195 = 7.9%), Instagram (engagement rate 6/190 = 3.1%) and Twitter (engagement data N/A) (8/25/20).

2021 Adolescent Well-Care Visit (AWC) Initiatives: Medi-Cal

1. Back-To-School Vaccination Events held in collaboration with community partners: Anaheim Union High School (7/26/21), Northgate Market in Anaheim (7/31/21), Westminster Family Resource Center (8/18–8/19/20), and Boys & Girls Clubs of Garden Grove (9/11/21) provided resources to families which included but is not limited to: well-care screenings, vaccinations, dental screenings, fresh produce and supplies for back-to-school.
2. Health Guide 3–6 Newsletter and How to Protect Your Family from Lead Poisoning fact sheet mailing (4/29/21). Targeted mailing was sent to 47,901 Medi-Cal members ages 3–6 years old.
3. Back-To-School Vaccination Promotion advertisements were posted to social media periodically from June – August 2021. Animated advertisements included: 1) Don't Miss Your Shot, 2) Don't Wait Vaccinate, and 3) Let's Get Back Together Safely. These back-to-school advertisements were developed in English, Spanish and Vietnamese.
4. Young Adult Well-Care Visits for 18–21 year-olds animated videos were promoted on social media platforms (English: 6/30/20; Spanish and Vietnamese: 7/15/21).
5. Medi-Cal 2021 Summer Newsletter included the article: *During the COVID-19 Pandemic Is It Safe for Well-Care Visits*.

6. National Immunization Awareness Month (NIAM) observance on social media (August 2021) aligned with Centers for Disease Control and Prevention immunization efforts.
7. *Routine Immunizations and Well-Child Visits for Pediatrics*, Health Care Chat video went live on social media platforms on 8/27/21 discussing the importance of routine vaccinations. This was a new method of health education promotion via social media. These videos were in English, Spanish and Vietnamese and featured subject matter experts such as health educators and a pharmacist to elevate the message to as any members as possible.
8. Medi-Cal 2021 Summer Newsletter Mailing (7/06/2021). Newsletter included articles: *(1) During the COVID-19 Pandemic Is It Safe for Well-Care Visits*, (2) *Do You Know the Benefits of Family Meals?, (3) Be A.W.A.R.E. in the Sun* and the Let's Get Back Together Safely in Person advertisement. The member newsletter was mailed to 514,256 head of household Medi-Cal members.
9. Well-Child Visits, 3–17 years, text message campaign, planned for Q4 2021.

Opportunities for Improvement:

1. Since the AWC measure was revised to WCV, which captures the entire pediatric and adolescent population, ages 3–21 years old, a formal evaluation of this population should be conducted to identify data gaps and opportunities to work with high volume health networks or identified provider offices to improve their rate. This is necessary as the revised measure is captured administratively only.
2. Since the COVID-19 pandemic impacted health care in 2020, we need to closely monitor the WCV rate for a significant decrease and refocus interventions, if necessary.
3. Continue to foster working relationships with community-based organizations to collaborate hosting health fair events to reach members hesitant or unable to obtain care in the traditional provider office.
4. In examining the ethnicity breakdown of the WCV population (Table 6), ages 3–21 years old, White members make up 11.46% of the population, however their WCV rate is 38.11% which is much lower than Hispanic (52.85%) and Vietnamese (60.08%) members. This shows the need to include member demographic information in future data pulls to better plan initiatives to make a higher impact to subpopulations who are not getting care as much as other subpopulations. This approach will minimize the outreach population, which will decrease budgetary constraints and allow resources to focus on the subpopulation.
5. Assure future promotional campaigns leverage multiple outreach modalities to properly target members in subpopulations as culturally appropriate, e.g., if a subpopulation and ZIP code tend to use the bus, then complete a bus stop advertisement or if a certain subpopulation tends to get their information from the radio, then radio advertisements would be more appropriate.

AWC Table 6: HEDIS 2020 WCV Rate by Member Ethnicity, 10 Highest Volume Groups

Ethnicity Code (group)	WCV Numerator Rate	Numerator Count	Denominator Count	Percentage of Total Population	Impact on HEDIS Rate
Hispanic	52.85%	92,488	175,008	64.52%	34.10%
White	38.11%	11,843	31,078	11.46%	4.37%

Vietnamese	60.08%	13,524	22,511	8.30%	4.99%
No response, client declined to state	47.97%	7,513	15,663	5.77%	2.77%
Other	41.29%	3,224	7,808	2.88%	1.19%
Korean	55.79%	2,579	4,623	1.70%	0.95%
Black	35.68%	1,573	4,409	1.63%	0.58%
Filipino	45.09%	1,180	2,617	0.96%	0.44%
Chinese	42.91%	999	2,328	0.86%	0.37%
Asian or Pacific Islander	42.74%	765	1,790	0.66%	0.28%

Lead Screening in Children (LSC)

A. Program Description

LSC is a measure that is not held to a minimum performance level. However, the revised guidance outlined in the DHCS APL 20-016, and the effects of the COVID-19 pandemic present an opportunity for CalOptima to prioritize preventive care measures such as LSC.

CalOptima has engaged in efforts to ensure compliance with the DHCS All Plan Letter 20-016 and address blood lead screenings through various efforts paired with health network and provider education that emphasize the importance of timely blood lead screenings. To direct improvement efforts, CalOptima has set an objective to increase blood lead screening rates from 67.73% to 73.11% by December 31, 2023.

2021 Blood Lead Screening Initiatives:

Member Initiatives

1. Spring 2021 Medi-Cal Newsletter: Be Aware of Lead Poisoning article
2. Be Aware of Lead Poster – Distributed to Provider offices for display
3. Health Guide 3–6 Newsletter and How to Protect Your Family from Lead Poisoning fact sheet mailing (4/29/21). Targeted mailing outreached to 47,901 Medi-Cal members ages 3–6 years old.

Health Network/Provider Initiatives

1. Quarterly Blood Lead Screening (BLS) reports with member detail for those that do not meet the lead screenings testing intervals outlined in APL 20-016.
2. September 2021 update on quarterly BLS report at Health Network Quality Forum.
3. BLS updates through monthly Health Network quality meetings, Health Network Weekly Communication announcements and Provider Fax Blast.
4. Blood Lead Supplemental Report with DHCS data to support health networks with the reconciliation of members that complete blood lead screenings.

B. Interventions

1. Facebook, Twitter and Instagram posts during National Lead Poisoning Prevention Week.
2. Targeted mobile texting campaign.

3. Targeted social media campaign in geographic areas of low compliance related to the HEDIS measure for Lead Screening in Children
4. Spring 2022 Medi-Cal Newsletter: Call to Action

C. Analysis

We are developing a tool to provide analysis of the impact from the quarterly Blood Lead Screening report, which is targeted to be completed in 2022.

D. Barriers

1. A recent recall on LeadCare II, LeadCare Plus and LeadCare Ultra Blood Lead Tests may potentially influence MY2021 blood lead screening rates. The August 2021 prospective rates indicate a 7% decrease when compared with the August 2020 rate. This recall has the potential to result in a shortage of blood lead testing supplies or add barriers to members if this requires health networks to send members to complete lab testing. Findings indicate that members are not having these screenings completed after being provided with a lab slip.
2. The COVID-19 pandemic may have contributed to gaps in care, requiring focused efforts to improve preventive care services such as blood lead screening rates.
3. Reduced laboratory testing may be due to limited point of care blood lead testing opportunities.

E. Opportunities for Improvement

1. Blood Lead Screening in Children is not held to the MPL, but as deficiencies in blood lead screenings become increasingly prominent, there are additional opportunities that can be implemented to close HEDIS rates.
2. Offering blood lead screenings at community events in geographic locations with low utilization.
3. Expand the collection of lab data and results. Work with health networks to send point of care lab data through CalOptima's electronic data submission process.
4. Health networks can leverage Prop 56 provider-based payments to provide point of care blood lead screenings in provider offices and reduce the need for patient follow-up for these laboratory tests completed outside of the office visit.
5. Implement IVR robocall campaigns.

Section 3: Quality of Service

Member Experience

CalOptima annually monitors member satisfaction and identifies areas for improvement for all lines of business. CalOptima assesses member satisfaction by identifying the appropriate population and collecting valid data from the affected population about various areas of their health care experience. Opportunities for improvement are identified from this information and specific evidence-based interventions are implemented. The goal is to improve the overall member experience by better meeting our members' needs.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

CalOptima monitors member experience using the CAHPS survey and results, particularly the achievement score at various levels including plan and health network. The achievement score is the calculation of positive responses, typically identified as “Usually” or “Always” or rated top scores of “9 or 10.”

In winter 2020, the United States was struck by the COVID-19 pandemic. At that time, most of the United States had been under a lockdown (shelter-in-place) order. During this lockdown, routine and elective appointments and procedures had often been cancelled or pushed out to an unknown future date when restrictions are lifted. During surges in the virus, some hospital emergency rooms and ICUs reached capacity and had to turn people away. Field hospitals were set up in some areas to deal with the overcrowding and lack of PPE made it difficult to members to be seen. When possible, many medical appointments were converted to telehealth visits by phone or video. There have also been nationwide shortages of tests and vaccines for the virus, resulting in frustrations and delays for people seeking them.

While it is impossible to predict the effects of the pandemic on the survey results, composites such as Getting Needed Care and Getting Care Quickly; ratings of overall care, personal doctor, and health plan; as well as the response rate may all be affected. Due to this unique set of circumstances, the survey results in this report, and any comparisons to trend data, should be viewed with caution.

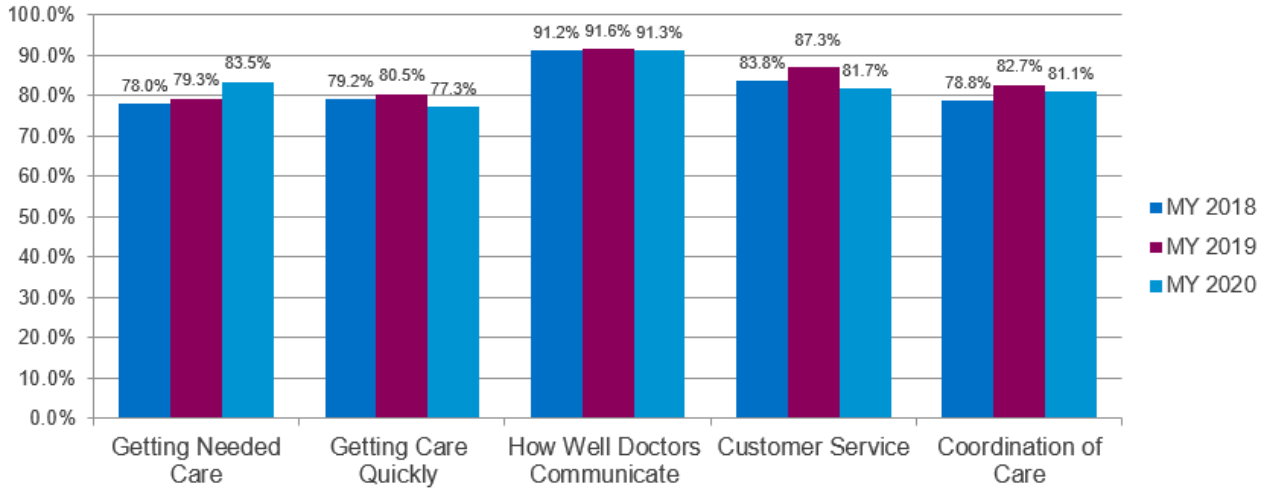
While the COVID-19 pandemic may have contributed, CalOptima’s response rate steadily decreased in the past few years. A lower response rate has led to CalOptima’s inability to report a valid CAHPS rate to NCQA for some measures due to a small denominator (N<100). As a result, CalOptima will be oversampling the population in the next survey cycle.

To better align with NCQA’s Health Plan Ratings methodology, CalOptima has begun benchmarking the plan’s CAHPS performance against the 10th, 33.33rd, 66.67th and 90th measure benchmarks and percentiles for Medi-Cal. For OneCare, the Medicare Star Rating cut points will be used to benchmark CAHPS performance.

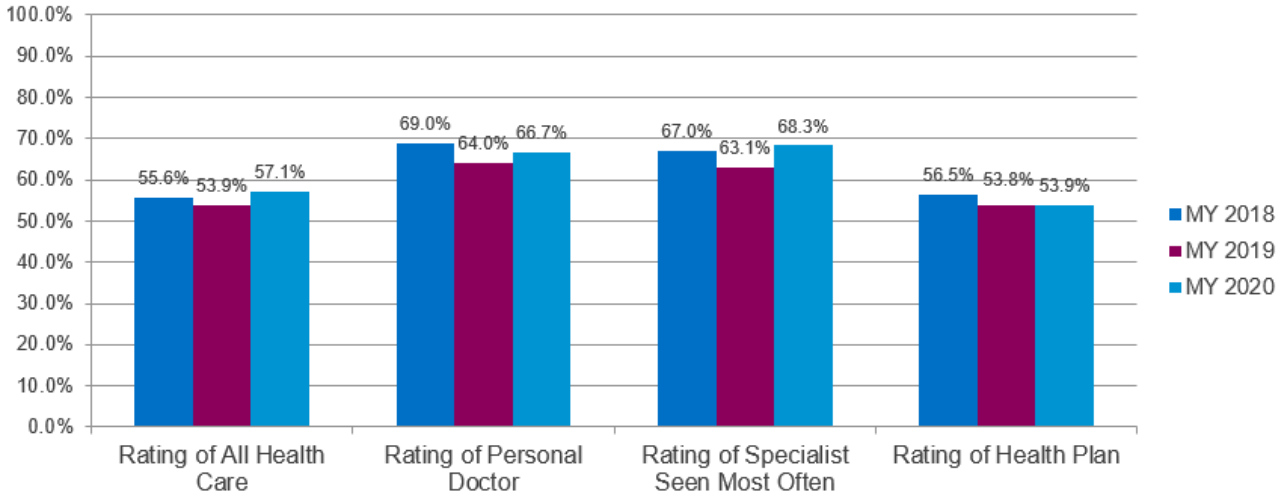
CAHPS Trend Analysis

Medi-Cal Adult CAHPS Survey Results

Goal: To meet the 66th percentile when compared with National Medicaid Benchmarks.



National Quality Compass	CalOptima MY 2020	QC 10th Percentile	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile
Getting Needed Care	83.5%	77.01%	81.58%	85.48%	88.35%
Getting Care Quickly	77.3%	75.36%	81.00%	84.91%	87.07%
How Well Doctors Communicate	91.3%	90.65%	92.42%	94.20%	95.74%
Customer Service	81.7%	86.06%	88.57%	90.69%	92.37%
Coordination of Care	81.1%	79.21%	83.49%	87.59%	90.23%

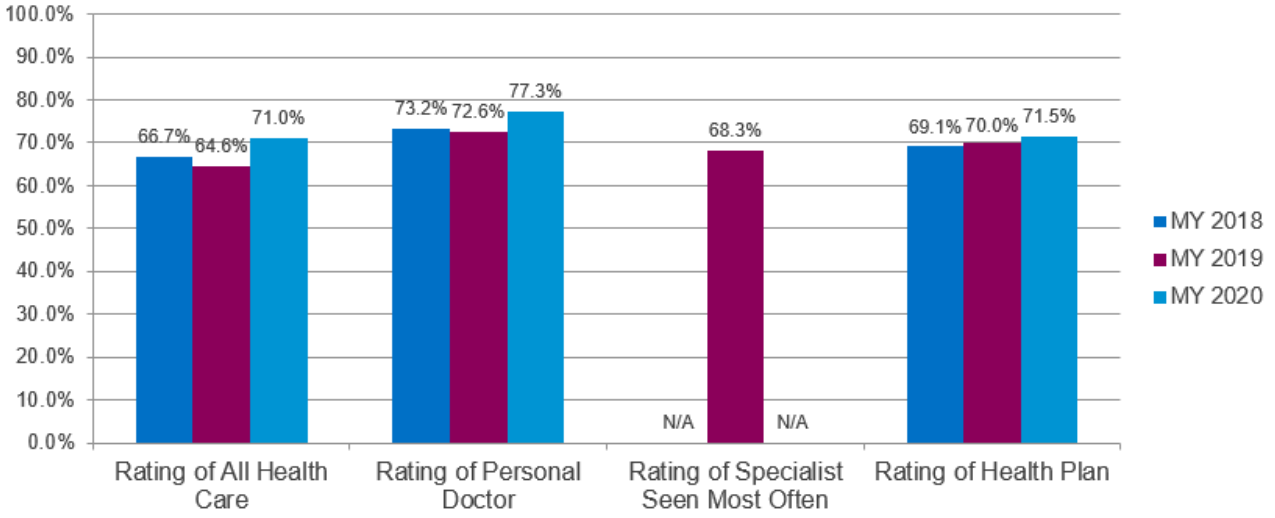


National Quality Compass	CalOptima MY 2020	QC 10th Percentile	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile
Rating of All Health Care	57.1%	51.32%	55.34%	59.55%	64.49%
Rating of Personal Doctor	66.7%	62.75%	67.68%	71.74%	75.68%
Rating of Specialist Seen Most Often	68.3%	62.75%	67.42%	72.48%	75.55%
Rating of Health Plan	53.9%	54.04%	59.40%	65.63%	70.18%

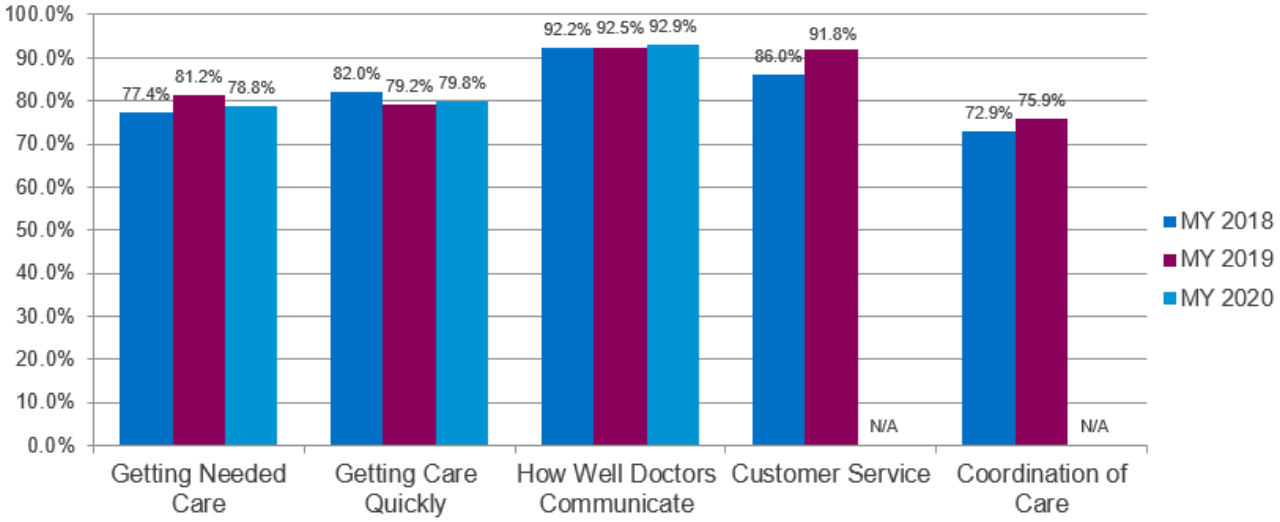
Red denotes performance below the 10th percentile

Medi-Cal Child CAHPS Survey Results

Goal: To meet the 66th percentile when compared with National Medicaid Benchmarks.



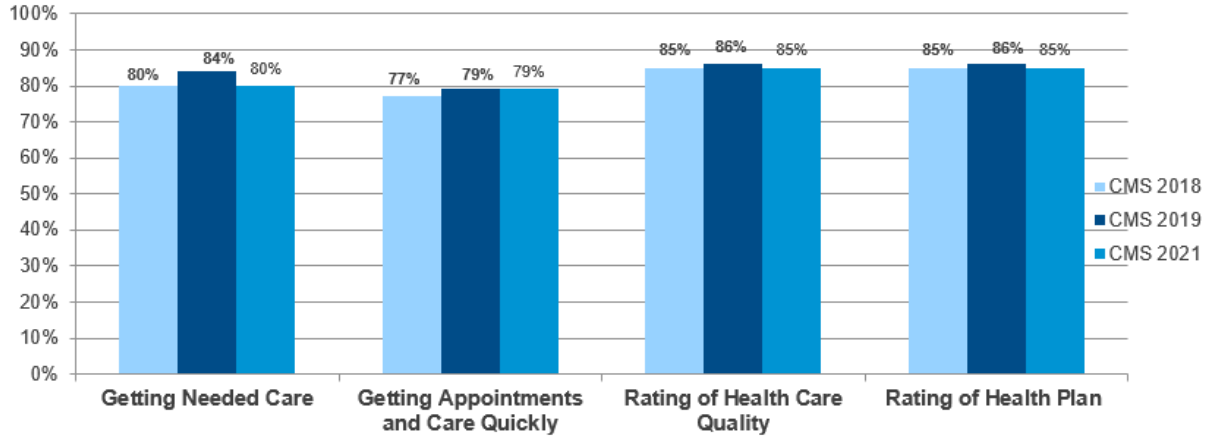
National Quality Compass	CalOptima MY 2020	QC 10th Percentile	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile
Rating of All Health Care	71.0%	66.07%	70.27%	73.99%	77.65%
Rating of Personal Doctor	77.3%	73.14%	77.19%	80.67%	83.33%
Rating of Specialist Seen Most Often	NA	67.98%	73.58%	74.38%	76.8%
Rating of Health Plan	71.5%	63.64%	70.57%	74.55%	77.93%



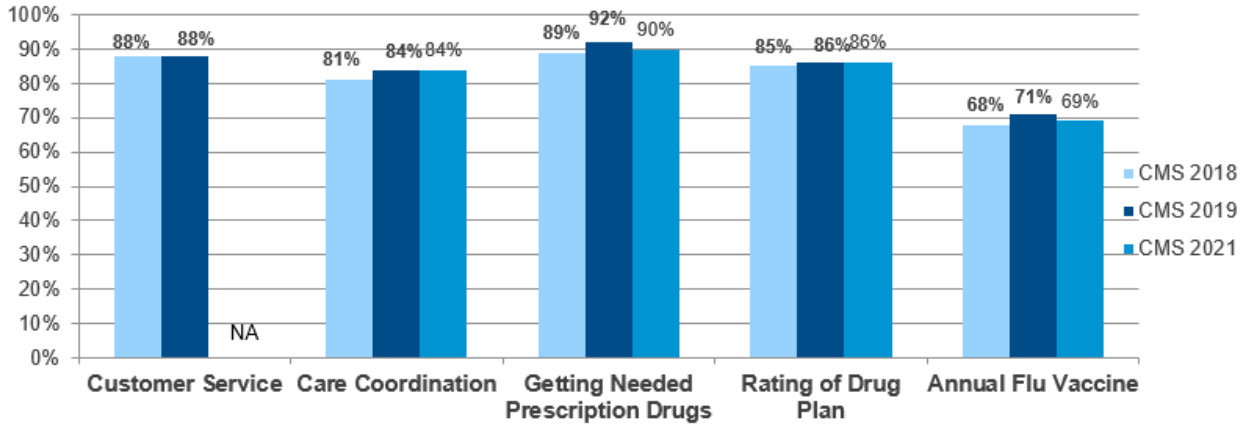
National Quality Compass	CalOptima MY 2020	QC 10th Percentile	QC 33rd Percentile	QC 66th Percentile	QC 90th Percentile
Getting Needed Care	78.81%	80.72%	84.47%	88.33%	91.14%
Getting Care Quickly	79.79%	84.96%	89.59%	92.89%	95.03%
How Well Doctors Communicate	92.89%	92.50%	94.66%	96.40%	97.60%
Customer Service	NA	85.14%	87.25%	90.34%	92.90%
Coordination of Care	NA	79.66%	85.34%	88.24%	90.65%

OneCare CAHPS Survey Results

Goal: To meet the CMS 3 Star Rating



Measure	Mean Score	Statistical Significance	Star Rating for 2021 CAHPS Score	Star Rating for 2020 CAHPS Score	Star Rating for 2019 CAHPS Score
Getting Needed Care	80	No difference	2	4	2
Getting Appointments and Care Quickly	79	No difference	3	4	3
Rating of Health Care Quality	85	No difference	2	3	3
Rating of Health Plan	85	Below Average	2	3	3



Measure	Mean Score	Statistical Significance	2021 Star Rating	Star Rating for 2020 CAHPS Score	Star Rating for 2019 CAHPS Score
Customer Service	N/A	N/A	N/A	2	2
Care Coordination	84	No difference	2	2	1
Getting Needed Prescription Drugs	90	No difference	3	4	3
Rating of Drug Plan	86	No difference	3	4	4
Annual Flu Vaccine	69	Below Average	2	3	2

OCC CAHPS Survey Results

Goal: To meet the CMS National MMP Average

CAHPS Measures	OCC CMS 2018 Results	OCC CMS 2019 Results	OCC CMS 2021 Results	CMS National MMP Results	Statistical Significance **
Getting Needed Care	3.33	3.27	3.37 (+)	3.43	Below Avg.
Getting Appointments and Care Quickly	3.29	3.20	3.14 (-)	3.30	Below Avg.
Rating of Health Care Quality	8.40	8.20	8.6 (+)	8.7	Below Avg.
Rating of Health Plan	8.50	8.50	8.50 (~)	8.8	Below Avg
Customer Service	N/A	3.58	3.62 (+)	3.68	Below Avg.
Care Coordination	3.52	3.47	3.52 (+)	3.57	Below Avg.
Getting Needed Prescription Drugs	NA	3.57	3.65 (+)	3.71	Below Avg.
Rating of Drug plan	8.40	8.30	8.50 (+)	8.8	Below Avg.

Case mix adjusted mean on a 1-4 scale. +/-=score increase/decrease from 2019.
~=no change in score from 2019.

CalOptima reviewed all the MY2020 CAHPS rates in detail and compared them with the benchmarks and found that CAHPS measures remain below the 66th percentile for Medi-Cal, below a CMS 4-Star Rating for OneCare and considered “Below Average” for OneCare Connect. With the exception of 3 OneCare CAHPS measures meeting a CMS 3-Star Rating, CalOptima did not meet the goals set for CAHPS.

CalOptima continues to identify that access-related measures consistently perform below goal. The “Getting Needed Care and Getting Care Quickly” measures did not meet goal and scores from the Medi-Cal Child Survey even sit below the 10th percentile. For OneCare Connect the “Getting Appointments and Care Quickly” rate has shown a decrease from the previous year. The score for the “Coordination of Care” measure for the Medi-Cal Adult Survey only met the 10th percentile and a 2-Star Rating for the OneCare Survey. As a result, CalOptima will continue to focus on these measures in 2022.

Behavioral Health Member Experience Surveys

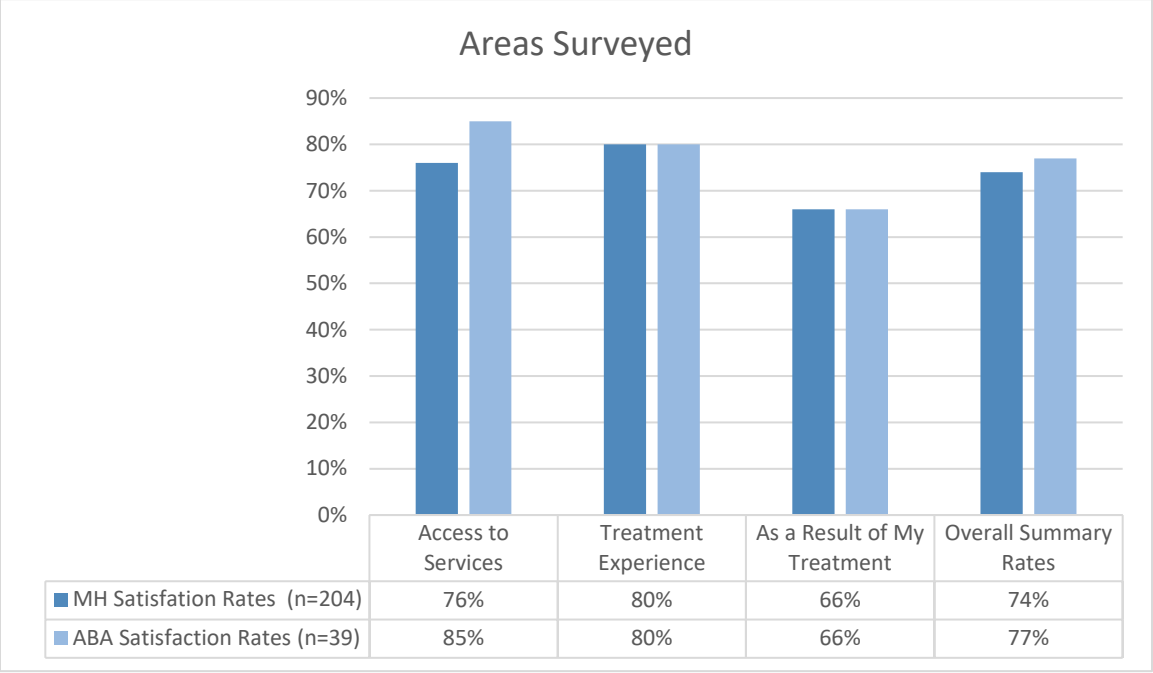
CalOptima conducts a comprehensive Behavioral Health survey and analysis annually to assess member satisfaction specific to Behavioral Health services and care received. CalOptima worked with an outside vendor to field the 2021 Behavioral Health Member Experience Surveys to measure member satisfaction on BH services received in 2020. Two separate surveys were administered: the Behavioral Health Member Satisfaction: Applied Behavior Analysis (ABA) Services Survey and the

Behavioral Health Member Satisfaction: Mental Health (MH) Services Survey. The MH version of the survey assesses for both psychotherapy and medication services, whereas the ABA version is solely for ABA services. The consistent areas surveyed annually are Access to Services, Treatment Experience and As a Result of my Treatment. Additional questions on telehealth services, duration of treatment and overall experience were included based on feedback received from the Behavioral Health Quality Improvement (BHQI) Workgroup, Member Experience Committee and Quality Improvement Committee (QIC).

A two-wave mailout survey methodology using a random sample size of 1,800 members was used to carry out the survey. Members of all ages and genders were surveyed. The survey was available to all members in their preferred language. Questions were scored on a five-point Likert scale that allowed the members to express how much they agree or disagree with a particular statement and included an option of Not Applicable (NA). The response rate for the MH services survey was 14% for a total of 204 completed surveys and 17% for a total of 39 completed surveys for ABA services.

CalOptima has established an overall satisfaction goal of 85%. Satisfaction rates for telehealth experience shown medication services fell below the intended goal (MH survey 80%; ABA 71%). In addition, satisfaction rates were significantly lower when asked if given the option to continue to receive services with their provider using telehealth (MH survey 48%; ABA 24%). Results for lower satisfaction rates for ABA services may be due to services typically conducted in the home. For MH services, lower rates may be a result of lack of privacy, not having an area where members feel comfortable disclosing personal information.

Goal: To meet Internal Benchmark of 85%



	Access to Services	Treatment Experience	As a Result of My Treatment	Overall Summary Rates
MH Satisfation Rates (n=204)	76%	80%	66%	74%
ABA Satisfaction Rates (n=39)	85%	80%	66%	77%

2021 Overall Summary Rates		Goal	Gap to Goal
Mental Health Survey	74%	85%	-11%
ABA Survey	77%	85%	-8%

The Overall Member Experience Survey rates for areas surveyed consistently year-to-year (i.e., Access to Services, Treatment Experience and As a Result of My Treatment) did not meet the intended goal of 85%. The gap to goal remained the same for the MH survey results for 2020 and 2021 at 11%. However, the gap to goal for ABA survey results decreased from 11% in 2020 to 8% in 2021. As a Result of My Treatment received the lowest satisfaction rate of the areas surveyed, as seen in prior years. To address potential misunderstanding of questions in this area, a new question was added this year directly asking members how they feel in comparison to starting treatment with their provider. The direct question produced significantly higher results (MH 80% and ABA 68% responded feeling Much/Slightly Better). Another question added this year was duration of treatment to assess for correlations with satisfaction rates. 42% of members responding to the MH survey reported feeling Much/Slightly Better compared with how they were feeling before seeing their provider were in treatment for over 12 months. 46% reported feeling Much/Slightly Better compared to how I was feeling before seeing their ABA provider were in treatment for more than 12 months as well. Review of results elicited feedback to increase sample size to improve response rates to better represent members receiving services and to share responses with Provider Relations to receive provider perspectives on how to improve member satisfaction scores and the overall member experience of care.

Grievances and Appeals

CalOptima monitors member experience using the grievance and appeals data trended by quarter for 2021, where data for this evaluation only includes data from Q1 and Q2. For Medi-Cal, the top two categories with the most grievances are Quality of Service (62%) and Access (19%) making up a total 81% of all grievances the first half of 2021. While there was a small decrease in the percentage of Quality of Service grievances from the previous year, there was a 7 percentage point increase in access-related grievances, which may be likely be attributed to the COVID-19 national health emergency. For CMS grievances, Medical Necessity makes up 53% and 72% of all grievances for OneCare and OneCare Connect, respectively. When looking more closely at the data, the top grievances sub-categories are appointment availability, telephone accessibility, transportation/non-medical and delay in service, which includes delay in referral/authorization. As a result, CalOptima will focus on these measures in 2022.

Access to Care

CalOptima monitors availability and accessibility on an annual basis. The evidence is clear that timely access to health care services results in better health outcomes, reduced health disparities and lower spending and better overall member satisfaction with health care.

Timely Access Survey

For this year, CalOptima fielded a survey with a mystery shopper and direct survey methodology to collect appointment and telephone wait times and compare them to standards from DHCS and CMS. A compliance rate is calculated by standard for each provider type.

In early 2020, the world was struck by the COVID-19 pandemic. In light of the COVID-19 pandemic, CalOptima placed a temporary hold on conducting the Timely Access Survey. A hold was necessary as call centers were closed due to statewide shelter-in-place mandates. In addition, CalOptima also wanted to ease the burden and allow network providers to focus operations on COVID-19. This decision to place a hold on the survey was aligned with DHCS' discussion to hold their timely access survey of the plans. However, in November 2020, CalOptima restarted fielding the Timely Access Survey and the survey was fielded from November 2020 to June 2021.

For the 2020 Timely Access Survey, the methodology was revised to incorporate a direct call methodology on top of the mystery shopper call methodology to increase overall response rate, particularly for the urgent appointments and behavioral health providers. A sampling methodology was also implemented for this survey cycle.

As part of this survey, a sample size of 3,629 primary care providers, high-volume and high-impact specialists, BH providers and ancillary providers were pulled for outreach and data collection.

Goal:

1. To meet internal goal of 80% for each individual measure and practitioner types.
2. To increase the PCP and Specialist for routine and specialist compliance rates by 10 percentage points.

Timely Access Survey Analysis

Of the survey population across all programs, where the vendor was able to obtain an appointment for comparison against the standards, the data shows that the rates have improvement from the previous survey cycle. The following appointment availability standards newly met the internal goal of 80% in the 2020 Timely Access Survey: OB/GYN Prenatal, Routine Psychiatry and Routine Ancillary. The appointment types for routine and urgent care visits for primary care, specialty care and non-physician behavioral health provider (NPBH) continue to be an opportunity for improvement. While there was a significant increase in rates for both PCP and specialist for urgent appointments (over 40 percentage points) from the previous survey cycle meeting the goal, PCP and specialist routine only had a 9 percentage point increase and did not meet the goal. These measures did not meet the internal goal of 80%. Consistent with previous year, rates tend to be lower for urgent and specialty appointments and appointments. In regard to telephone access, CalOptima met the internal goal for telephone triage within 30 minutes and flexibility in rescheduling members with disabilities, but did not met the internal 80% goal for providers having a live person answer the phone in 30 seconds and instructions to callers in a recording if there is an emergency. Based on the review of timely access study results, appointment and telephone access continue to be an area of focus. When evaluating timely access for each of CalOptima's delegated health networks, the health networks similarly did not meet the internal goal of 80% for the same standards.

Network Adequacy — Time or Distance Analysis

CalOptima monitors network adequacy on a quarterly basis by running reports to evaluate whether the plan meets the time and distance standards established by CMS and DHCS. In 2021, DHCS issued an updated All-Plan Letter on Network Certification and provided more guidance on meeting the standards and on how to run the reports. Plans are now only required to meet time or distance standards where each ZIP code must have members meeting 100% access. Plans also need to account for anticipated membership using the 100 points of light methodology pulling from the 2010 census. For all programs, the plan has met the time or distance standards. When evaluating network adequacy for each of CalOptima's delegated health networks, the health networks did not meet all the time or distance standards. They had challenges providing geographic coverage for specialists, particularly in south Orange County. As required by DHCS, CalOptima is required to certify all delegated health networks by July 2022 for Medi-Cal. Health networks with ZIP code/provider type combinations not meeting time or distance standards must submit a provider of that specialty and in that ZIP code area, through the Alternate Access Template, to meet the gap. CalOptima intends to have each delegated network fill the time/distance gap and be certified by July 2022.

Comparison to Complaints/Appeals

When the CAHPS results were compared to access grievances, CalOptima found that access grievances make up about 20% of all grievances in the first half of 2021 for Medi-Cal. Compared with the previous year, the percentage of access-related grievances have increased from last year. For OneCare and OneCare Connect, Medical Necessity makes up 53% and 72% of all grievances for OneCare and OneCare Connect, respectively. The top three sub-categories of access grievances are appointment availability, telephone accessibility and specialty care. Of the access-related grievances, appointment availability and telephone accessibility continue to be a pain point for members with approximately 35% and 24% of all access-related grievances, respectively, for Medi-Cal.

Member Experience Activities Completed in 2021

The Member Experience Subcommittee identified access, member engagement and virtual care strategies as the areas of focus for 2021.

Virtual Care Initiatives

On May 7, 2020, CalOptima obtained Board approval for overall Virtual Care Strategy and Roadmap and the Virtual Strategies Workgroup continued to implement these strategies throughout 2021.

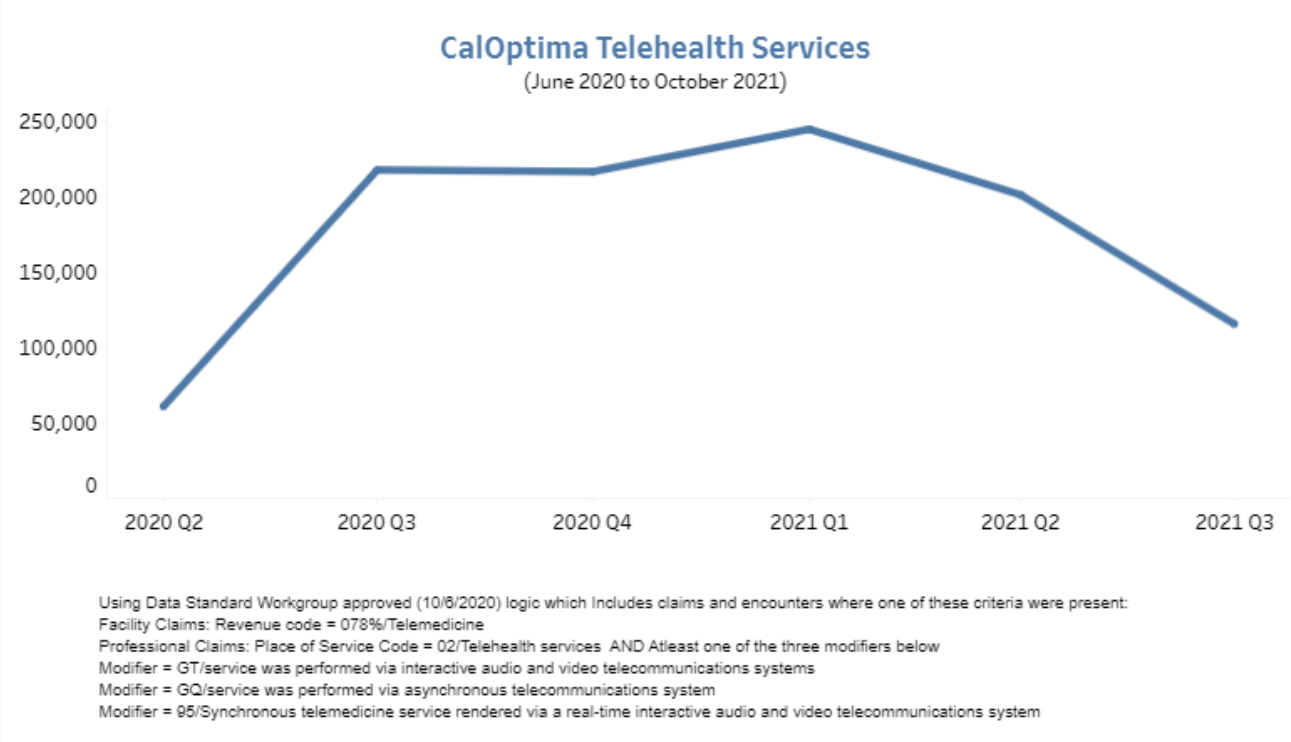
1. Member Texting: CalOptima secured Board approval for three years of funding and contracted with mPulse on 7/28/20 to provide one-way and two-way interactive texting campaigns to members. In March, CalOptima obtained DHCS approval and the initial campaign on COVID-19 Vaccination was launched on March 22, 2021, to more than 300,000 households and the tool has been useful in getting information out to members quickly. Since then, CalOptima has launched a member texting campaign on COVID-19 education and clinics, well child programs and other member education. While opt-out rates are increasing as additional campaigns are executed, the Telephone Consumer Protection Act (TCPA) project continues to obtain member consent and approximately 137,540 member consents were obtained as of 6/25/21.
2. PACE Telehealth Solution: CalOptima secured Board approval for funding to implement a technology platform using VSee to support PACE staff (clinicians) virtual visits with participants at home or other remote locations that work in conjunction with

Facetime/Google Duo during COVID-19 and support long-term need to engage participants at home. Pilot launched in October 2020 and rolled out to all PACE clinical teams by early December. As of July 2021, the telehealth engagement is 65% and there are more than 1,200 telehealth encounters.

3. eConsult: An eConsult system allows PCPs and specialists to securely share health information and discuss patient care that may replace the requirement for authorizations. A RFP had been issued in the end of 2020, vendor selection has taken place, and CalOptima intends to finalize contract negotiations and prepare for Board presentation to obtain approval and execute the contract.
4. Behavioral Health (BH) Virtual Visits: CalOptima contracted with Bright Heart to provide BH virtual visits to our members. Bright Heart providers have been credentialed and visits began in August 2020. BH providers have been utilizing referrals for BH services, and member liaisons have been utilizing referrals for medication management services. As of May 2021, there were 1,184 Bright Heart Telehealth Services to date.
5. Virtual Visit: CalOptima intends to provide 24/7 direct access to physician virtual visits via website link or nurse advice line referral. CalOptima obtained Board approval for funding and CalOptima plans to re-issue an RFP in Q3 2021.

The goal was to successfully launch all five virtual care initiatives in 2021. Three initiatives (Member Texting, PACE Telehealth Solutions and Behavioral Health Virtual Visits) were launched in late 2020 or 2021. eConsults and Virtual Visits are still in progress.

Telehealth Utilization Trend Analysis



CalOptima began implementation of the virtual care strategies in August 2020, beginning with the Bright Hearts Program. Along with efforts to promote telehealth services, there was an increase in telehealth utilization from Q2 2020 to Q1 2021, which would reflect the height of the COVID-19

national pandemic where provider offices were closed to in-person visits and converted to telehealth visits as an alternative. In Q1 2021, as provider offices began to open and again offer in-person visits, there was a steady decrease in telehealth utilization, with 244,22 visits in Q1 2021 and only 115,757 visits for Q3 2021. The goal was to increase utilization to 30% (visit count/#members) and CalOptima did not meet that in Q3 2021 with only 13.6%. There was also a decrease in the member telehealth usage rate from 8.8% to 5.2% and the goal of 10% was not met.

At this time, this metric may not be the best indicator of success of the virtual care strategy as many of the programs have yet to launch. In addition, a decrease in utilization may not be an indication of less access or satisfaction since members now have more options and modalities when seeking care.

Member Engagement

1. In 2021, the following efforts were made to promote the self-service options on the Member Portal:
    a. New recorded announcements on the CalOptima's customer service telephone tree educating members on member portal services.
    b. Notice was mailed to members on January 2021 about the TCPA and the member portal.
    c. Customer Service staff educating members about Health Rewards Incentives for COVID-19 vaccinations and the member portal.
2. In 2021, the following member outreach campaigns were implemented:
    a. Informing members of specific PCP terminating from the CalOptima and assisting members with locating a new PCP.
    b. Informing members who are deeming and educating members on how to resolve their Medi-Cal eligibility issue.
    c. Informing members who have a share of cost and educating members on contacting social services to assist with share of cost status and/or questions.
    d. Following up with new enrollees after 45 days of being enrolled with the plan to check in on how everything is working and offer assistance if necessary.
    e. Outreaching to members to wish them a Happy Birthday.

Expanding the Provider Network

CalOptima has focused on recruiting hard-to-access specialties in our CalOptima Community Network. As of end of Q3 2021, 59 executed agreements, 23 in active negotiation, and six in credentialing for the following specialties: Dermatology, Gastroenterology, Nephrology and Orthopedic Surgery. The goal is to recruit 25% of 135 hard-to-access leads (34 providers). CalOptima met that goal by executing 59 agreements.

Overall Assessment of Member Experience and Access to Care

Based on the review of CAHPS, Timely Access study, Time/Distance Analysis and complaints data, the general theme that stands out is that appointment access, delay in care and telephone access is an area of concern. The data shows that of all the appointment types, urgent care, non-urgent care visits are areas where there are opportunities for improvement for almost all provider types, primary care and specialty care. It also shows that members are not always reaching providers when they call to make an appointment. This has a significant impact on how members respond on the member CAHPS survey for questions related to getting care quickly and getting needed care. In 2022, CalOptima will continue focusing on the key initiatives that were implemented in 2021 and develop

additional initiatives to improve timely access to care. The section below describes the barriers that continue to exist that maybe impacting timely access to care.

Existing Barriers
Based on the member experience data, CalOptima has identified the following areas as critical measures, making them the highest priority in terms of making improvements.

A group of subject matter experts from across the organization completed a detailed barrier analysis:

Access and Availability
1. Lack of extended office hours for appointments can be a significant barrier.
2. PCPs have too many members in their panel.
3. There may be an adequate number of practitioners in CalOptima's panel but not all providers have open panels or are available to see CalOptima new patients.
    a. CalOptima is a delegated model and members are only able to see a provider in their health network.
    b. A particular PCP and specialist group will not see members that are not in their system.
4. Certain geographic areas in Orange County, particularly south Orange County, do not have an adequate number of specialists for a particular type of specialty (i.e., pediatric subspecialties, oncologists, rheumatologists, etc.).
5. Not enough specialists are willing to contract with CalOptima.
    a. Low reimbursement rates in comparison with other types of health insurance.

Provider Data Quality
1. Members not always able to get through to their provider to make an appointment.
    a. Member calls reached the wrong number, a number where the provider is not recognized or no longer at that location, or no answer at all.
2. Members are referred to and approvals are sent to specialists who cannot see the patient.
    a. Specialists/subspecialties/area focus is not clear, or information is not captured.
3. Open/closed panel is not up to date.
    a. No real-time process to collect correct information about which specialists have open panels and available appointments to see patients.
4. System issue: FACETS shows no longer accepting patients, but Guiding Care shows as participating without any restrictions.

Prior Authorization Process
1. Timelines of submission of PCP and specialist in an issue. Provider office staff wait to submit the authorization request.
2. Providers do not always send all the information needed to make a decision at the time of the initial submission. Resubmission is sometimes required and may cause delay in obtaining services.
3. Since UCI provides a tertiary level of care, all referrals need to be reviewed and cannot go through an auto authorization process, which may make members feel like it takes a long time.

Opportunities for Member Experience in 2022
The Member Experience Subcommittee identified access to care as the areas of focus for 2021.

In order to accomplish this goal, CalOptima is developing several interventions that include, but are not limited, to the following:

1. Request action from health networks with low CAHPS scores and health networks not meeting timely access standards, in the form of a Plan-Do-Study-Act (PDSA), in order to improve their overall member experience. Health networks will be asked to review their CAHPS and Timely Access results and identify plans to improve areas with low performance. Upon CalOptima's approval of the plan, health networks shall implement and then evaluate the plan to determine its success and generalizability.
2. Continue to implement the virtual care initiatives in the Virtual Care Strategy and Roadmap, including implementation of a virtual visit system and an eConsult system to serve as a peer-to-peer communication messaging platform between PCPs and specialists, which will improve patient access to specialty care and overall quality of care.
3. Continue to monitor PCPs to determine if their panel size is too large to provide care for our members. Ensure quarterly provider overcapacity notification letters are sent in a timely manner. Close panels for providers that are not meeting the capacity.
4. Network adequacy monitoring by health network. As DHCS requires all plans to certify their delegated networks on network adequacy access performance by July 1, 2022, CalOptima has already begun monitoring adequacy of network at the health network level. Beginning 2021, health networks began receiving their quarterly time/distance accessibility reports and in July 2021 health networks were asked to provide CalOptima with a list of providers to meet their time/distance gaps by completing the Alternate Access Template. Reports in Q4 2021 will include mandatory provider types and provider to member ratios.
5. Provider outreach and education via a notification letter to providers not meeting the timely access standards. An escalation process has been developed to track continue instances of non-compliance that may lead to further action (i.e. corrective action plan, freezing panels, sanctions, etc.).
6. Provider data validation to ensure that members have the correct contact information in the provider directory. Provider outreach to providers deemed as unable to reach as part of the Timely Access Survey.

Section 4: Safety of Clinical care

Post-Acute Infection Prevention Quality Initiative (PIPQI)

A. Description

PIPQI is a CalOptima quality initiative program aimed to reduce antibiotic-resistant bacteria in nursing homes. Participating nursing facilities utilize Chlorhexidine Gluconate (CHG) soap for all baths and showers and Iodophor nasal swabs five days per week every other week. Currently, 26 nursing facilities participate in PIPQI.

B. Interventions

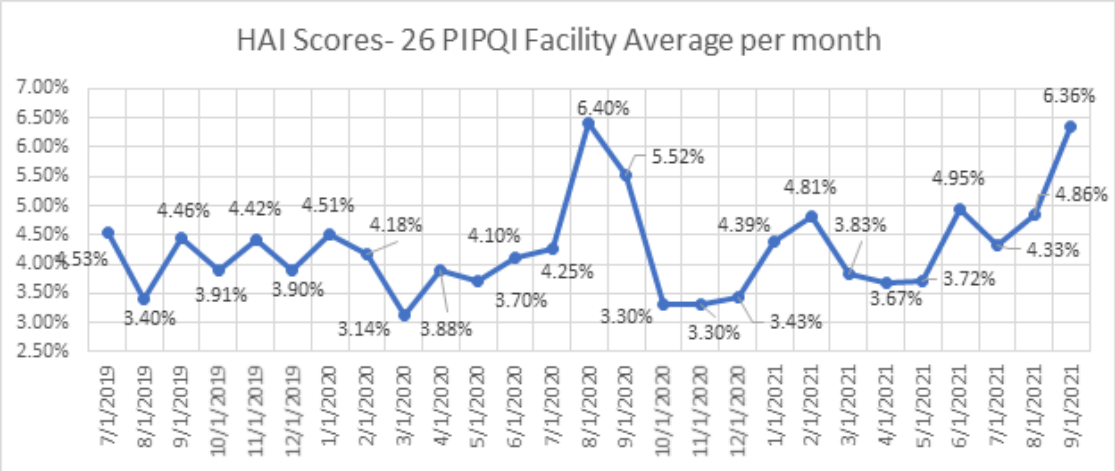
1. The PIPQI team began gearing the trainings toward helping the facilities use the product purchasing data to gauge how compliant their staff and residents are with following the PIPQI Protocols.
2. The PIPQI team has been on-site in the facilities since March 2021, offering hands-on training and education to the staff.

3. The PIPQI team has offered to support the individual facilities by hosting trainings for new staff and being available during skills days.
4. PIPQI Brand recognition is low in the community because many facilities still view this project as an extension of the UCI SHEILD program. The CalOptima PIPQI team is working toward improving the branding on the training materials given to the nursing facilities.

C. Findings

Prior to the implementation of PIPQI, the University of California, Irvine (UCI) conducted a program called SHEILD following the same infection prevention principles. The PIPQI team uses one training video, created by the UCI SHEILD Team, to review with all participating nursing facilities monthly since March of 2020. Quality performance measures were being monitored in 2021 including Healthcare Associated Infections (HAI) Score trends, quantitative analysis of products purchased compared to the number of licensed beds and the relationship between proper product utilization and hospital admission rates for MDRO's as a primary or secondary diagnosis. PIPQI hopes to expand to additional facilities in 2022.

HAI scores are submitted each month by the Nursing Facility staff members to the CalOptima PIPQI Nurses. Using this data, the CalOptima Nurses track and trend HAI events in each nursing facility and provide feedback to the facilities on their individual trends. The chart below shows the averages for all facilities throughout the course of the PIPQI Program. The highest peak was in August of 2020, and we are starting to again see an upward trend going into the fall of 2021. Lower scores indicate fewer infections in the nursing homes and the staff works with facilities to decrease or maintain their individual HAI scores.



In addition to collecting HAI Scores, the CalOptima PIPQI team collects invoices showing proof of product purchasing. In 2021, we began to look at the quantitative data in more detail to track trends from individual nursing facilities to assist them with ensuring they have adequate quantities available for their residents. A data set was created in January 2021 that determined a product quantity for each facility based on the 75% of the licensed beds being filled. Once that was completed, we compared the amount projected for the facilities to the

actual invoices given to the PIPQI staff. Below are representations of the Chlorhexidine Gluconate (CHG) and the Iodophor.

CHG Invoice Data Collection (260 possible invoices)

	No Purchase Proof	118
	Purchased less than 50%	66
	Purchased 51-79%	24
	Purchased 80-120%	31
	Purchased greater than 120%	21

Iodophor Invoice Data Collection (260 possible invoices)

	No Purchase Proof	171
	Purchased less than 50%	20
	Purchased 51-79%	18
	Purchased 80-120%	16
	Purchased greater than 120%	35

D. Barriers

The baseline data is showing there are still a few gaps in product purchasing and the data being made accessible to the CalOptima Employees.

1. The facilities did not submit 45% of the CHG Invoices and 66% of the Iodophor invoices despite the in-person, telephonic and e-mail reminders.
2. There has been a high staff turnover rate in the nursing facilities including central supply and housekeeping employees due to the effects of the pandemic.
3. The census' in the nursing facilities have been fluctuating and there are times when they are at less than 75% capacity, however this is a rare occurrence an only contributes to a small margin of data.
4. Of the invoices submitted, there are only a small margin that are purchasing at or above the projected quantities. Since these quantities are based on each resident following the protocols as directed, (4oz bath/ shower every other day and 10 Iodophor Swabs/ month), we are seeing some facilities show compliance with or above average utilization of the products.
5. COVID-19 presents the following barriers:
    a. Nursing facilities are short staffed and overworked leaving little time to participate in PIPQI monitoring protocol.

b. High turnover rates in facilities creates a need for constant PIPQI training.
c. Due to COVID-19, CalOptima nurses were not allowed to conduct on-site visits for monitoring or training of facility staff from March 2020 until March 2021.
d. The CHG Swab testing approved in the April 2020 COBAR was placed on hold for the duration of the Public Health Emergency, with the Incentive Funds being repurposed to help the facilities cover staffing costs and additional Personal Protective Equipment (PPE) purchasing.

E. Opportunities for Improvement

Some of the most prominent barriers to the PIPQI program are the lack of brand recognition in the community as well as the facilities under purchasing the two products. To mitigate those in the future and move the program forward, we have created a few areas in which we are focusing our attention.

The first will be working with the facilities to ensure they are purchasing proper quantities of the two products. Often, there is someone at the facility who either works in central supply or housekeeping that is responsible for the coordination of these product purchasing. These staff members may or may not have received training from their organization about how much to order of the products. We have implemented trainings for those staff members to help give them guidelines on how much product they should anticipate needing to purchase. We have created par levels based on projected census levels. By the Central Supply staff understanding how much product they need, they can help guide us on supply chain issues and how quickly their staff is going through the products as well as helping to track the needed invoice data.

Orange County COVID Nursing Home Prevention Program

A. Description

Beginning May 2020, CalOptima partnered with the Orange County Health Care Agency and the University of California, Irvine (UCI) to provide COVID-19 support to OC nursing homes to improve prevention readiness and restrict, to the extent possible, the impact of the anticipated COVID-19 surge to Orange County Nursing Homes. As of August 2021, the following interventions have been completed and finding identified:

B. Interventions:

1. UCI developed a toolkit and implemented training for the OC nursing home staff.
2. OC Nursing Home COVID-19 Prevention Team has provided consultative services provided to OC nursing homes:
    a. 12 nursing homes received an intensive training program with weekly feedback of staff safety metrics;
    b. 12 nursing homes receive training on surveillance on PCR testing of residents and staff, which included training to obtain nasopharyngeal samples. PCR testing of residents and staff was used to inform the trajectory for the spread and immunity of COVID-19.

c. 150 hours of consultation to 31 additional OC nursing homes for COVID-19 prevention.

3. A confidential helpline for COVID-19 questions and inquiries was launched in June 2020, which addressed 157 inquiries regarding questions about COVID-19 prevention, vaccines, and safety.
4. An online toolkit was developed which contained 3 modules, 51 documents and 20 videos. To date, there have been over 3,000 views.
5. Informational Wall-Clings were printed, which included 10 different posters. The posters addressed the symptoms of COVID-19, breakroom safety, and hand hygiene/mask safety. More than 1,200 copies were distributed to the nursing homes.
6. Webinars were hosted 6 times with invitations to all Orange County nursing homes. Each webinar had approximately 60 attendees.
7. Encouraged COVID-19 vaccine by increasing the knowledge and dispelling the myths about the vaccine, and tracking COVID-19 vaccination among the residents and staff by providing in person training with infectious disease experts and provide information in multiple languages.

C. Findings

The consultative services include video montage examples of correct and incorrect behavior, including mask wearing, touching of the face without cleaning hands, failure to socially distance with a focus on when masks are removed (e.g. eating), and hand hygiene. Video reviewers also completed an observation form to track safety metrics over time. Overall, the training and video feedback was been positively received across sites.

There were two vaccine webinars hosted on 12/9/20 and 3/9/21 to provide information and address questions about COVID-19 vaccines. Between the two webinars, we drew over 150 attendees from over 40 nursing homes.

To enable tracking of vaccine uptake by type of healthcare personnel, we created a roster-based tracker. We are using this form to collect point prevalence vaccination coverage among nursing home staff. We assessed point prevalence values at 17 nursing homes with vaccination among staff ranging from 36-100%.

We created vaccine FAQ documents in English and Spanish and continue to update these documents as more updated information becomes available. Finally, we engaged with the CalOptima communications team to provide hot topics and suggested language about COVID vaccines and prevention, to be used in text messaging, flyers, and newsletters, and enable co-branded messaging on the UCI Health website.

Quality of Care Grievances

A. Description:

In 2020, CalOptima received a Corrective Action Plan (CAP) from DHCS. The findings stated that, at a minimum, all Quality of Care (QOC) grievances were to be submitted to a medical director for review and action during the grievance process.

B. Intervention:

In November 2020, QI and GARS implemented a new model for responding to QOC grievances. In this model, the Grievance Resolution Specialist (RS) identifies the QOC grievance and forwards it to the QI RN who performs an Initial Clinical Review to identify any urgent clinical issues that require immediate intervention. At the same time, the RS requests a response from the provider for whom the grievance is regarding. When the response is received, the RS notifies the QI RN who summarizes the case for the medical director. The medical director completes a clinical recommendation which is copied into the Grievance Resolution Letter by the RS and sent to the member within calendar 30 days.

C. Findings:

1. The process change was accepted by DHCS in the CAP response and will be reviewed at the DHCS audit in 2022.
2. The process resulted in a dramatic decline of PQI cases, from an average of 112 per month in 2020 to 16 per month in 2021. Over 95% of the cases referred by GARS in past years were ultimately determined to be Quality of Service, not Quality of Care. The reduction of non-QOC cases has allowed the QI nurses and medical directors to focus on true Potential Quality Issues.

D. Barriers:

Strictly adhering to the referral list may have resulted in a failure to refer to quality of care grievances.

E. Opportunities for Improvement:

Examine complaints related to Access to Care for Quality of Care issues to better identify these types of grievances.

Section 5: 2020–2021 ImproveMENT PROJECTS

The following are a summary of all Quality Improvement Projects (QIP), Chronic Care Improvement Programs (CCIP), Performance Improvement Projects (PIP) and PDSA projects which began or continued through 2020–2021 by each improvement project type.

Quality Improvement Projects (QIPs) – OneCare Connect Population and NCQA Patient Safety Standard – Medi-Cal

1. Improving Statins Use for Patients with Diabetes (SPD) 2019–2022

The improving statin adherence for patients with diabetes mailing intervention targets all three (3) lines of business; Medi-Cal (MC), OneCare (OC) and OneCare Connect (OCC). The Medi-Cal results will be reported to NQQA to satisfy the Patient Safety standard. The OneCare Connect results will be reported to CMS as part of a quality improvement project (QIP). There is no QIP requirement for the OneCare population. However, CalOptima chose to include this small population as part of the SPD intervention.

Goal
To increase statin use among members with diabetes by 5%.

Target Population
All CalOptima members who are diagnosed with diabetes mellitus.

Interventions
A member-focused multi-modal promotion campaign was implemented to reduce cardiovascular risk among CalOptima members diagnosed with diabetes. An SPD member mailing was sent in tandem with an existing provider focused program to promote statin use among members diagnosed with diabetes and to encourage members to have a discussion with their health care providers about whether a statin is right for them.

Activities
Quarterly mailings have been put into place to encourage members to consider the potential benefits of preventing cardiovascular complications.

Mailing Summary: Data collection continues for all three LOB (lines of businesses): Medi-Cal, OneCare and OneCare Connect. Will continue to track and monitor throughout 2021.

SPD Member Quarterly Mailings						
	Q1 2021			Q2 2021		
LOB	Member Count	Members Eligible Sent	Members Received Intervention	Member Count	Members Eligible Sent	Members Received Intervention
OneCare	83	27	17	81	71	18
OCC	657	290	197	562	464	84
Medi-Cal	5347	2183	1348	4780	3947	402
Total	6087	2500	1562	5423	4482	504

Performance Improvement Projects (PIPs)

1. Improving Well-Care Visits for Children in Their First 30 Months of Life (W30) for CalOptima Medi-Cal Members (March 1, 2020-December 31, 2022)

Goal
To increase the percentage of well-care visits among Medi-Cal members turning 15 months old for Provider Office A, from 39.47% to 44.96% by 12/31/2022. This examines factors such as: provider engagement, data exchange opportunities, provider resources, provider awareness, and appointment availability to see how they directly impact well-care visits.

Target Population
Children assigned to Provider Office A who turn 15 months old during the measurement year.

Intervention
Establish data sharing procedures between the Managed Care Organization (MCO) and the provider office to identify members due for outreach. CalOptima trends rates on a monthly basis and will conduct data exchanges with the provider office quarterly.

2. Improving Breast Cancer Screening (BCS) rates for Korean and Chinese CalOptima Medi-Cal Members (March 1, 2020-December 31, 2022**)**

Goal
By 12/31/2022, increase the percentage of breast cancer screening among Korean and Chinese Medi-Cal member ages 50-74 from 53.62% to 57.63%.

Target Population
Korean and Chinese CalOptima Medi-Cal members 52-74 years of age as of December 31 of the measurement year. and meet continuous enrollment/allowable gap/anchor date who are eligible to complete a mammogram to screen for breast cancer.

Intervention
CalOptima will conduct a multi-layered member outreach campaign to Korean and Chinese CalOptima Medi-Cal members 52-74 years of age who are eligible to complete a mammogram to screen for breast cancer.

3. **Medi-Cal PIP: Improving Access to Acute/Preventive Care Services to Medi-Cal Members Experiencing Homelessness in Orange County.**

   Goal
   By June 30, 2021, increase the rate of acute and or preventive care services among Medi-Cal members 18 years and older identified as experiencing homelessness in Orange County from 41.8% to 43.2%.

   Interventions
   Implementing Homeless Clinical Access Program (HCAP) to increase access to acute/preventative care services through mobile clinics for CalOptima members 18 years and older experiencing homelessness.

   DHCS directed CalOptima to close out the PIP projects early due to COVID-19. CalOptima completed up to Module 3 submissions. No interventions were implemented for this PIP project.

CCIPs: OC and OCC and NCQA Emerging Risk Standard – Medi-Cal

Emerging Risk — Improving HbA1c Control <8% for Members Recently Experiencing Poor Control >8% — 2021

Goal: Improve Comprehensive Diabetes Care (CDC) measure, specifically HbA1c good control (<8) by conducting proactive outreach to OneCare members with diabetes who were previously <8% but have moved to have an HbA1c ≥8% based on the most recent lab results. The goal is to move 5% of OC members identified and who participate back to an HbA1c <8% within one year.

Target Population: OC members at risk for poor control >8% who were previously in good control <8% based on recent labs.

1. These members have been enrolled by December 31st of the measurement year and be within 18–75 years old. Members must also have no more than one gap in enrollment of up to 45 days during the measurement year per HEDIS specifications.
2. Exclusion Criteria:
    a. Ineligible CalOptima members
    b. Members identified for LTC or dementia
    c. Members delegated to Kaiser
    d. Is pregnant
    e. Is currently in palliative care/hospice facility
    f. Was identified as unable to contact by the health coach in the previous outreach list

Interventions: This intervention targets OC members with diabetes with HbA1c results trending upward from <8% to >8%. OC members that had an HbA1c result <8% but now have an HbA1c result ≥8% will be assigned to a health coach for telephonic coaching. Health coaches will be assigned approximately 15 emerging risk members every month and continue coaching the members on areas such as medication adherence, exercise and diet adjustments that will provide them success in decreasing HbA1c values <8%.

Summary of Results: Data collection for the intervention started in 2021. See table below:

Emerging Risk Health Coach Telephonic Outreach (OC)

Year	QTR	LOB	Starting Denominator	Members Assigned to a HC	Emerging Risk Members Successfully Outreached	Emerging Risk Members Unsuccessfully Outreached
2021	Q1	OC	5	5	3	0
2021	Q2	OC	5	5	4	1

In Q1 2021, there were 5 OC members that were assigned to a health coach and 3 were successfully outreached telephonically. For Q2 2021, there were 5 OC members that were assigned to a health coach and 4 were successfully outreached telephonically. Will continue to track and monitor throughout 2021.

1. OC CCIP — Emerging Risk — Improving A1C Control <8% for Members Recently Experiencing Poor Control >8% — 2021

Goal: Improve Comprehensive Diabetes Care (CDC) measure, specifically HbA1c good control (<8) by conducting proactive outreach to OCC members with diabetes who were previously <8% but have moved to have an HbA1c ≥8% based on the most recent lab results. The goal is to move 5% of OCC members identified and who participate back to an HbA1c <8% within one year.

Target Population: OneCare Connect members at risk for poor control >8% who were previously in good control <8% based on recent labs.

1. These members have been enrolled by December 31st of the measurement year and be within 18-75 years old. Members must also have no more than one gap in enrollment of up to 45 days during the measurement year per HEDIS specifications.

Interventions: This intervention targets OCC members with diabetes with HbA1c results trending upward from <8% to >8%. OCC Members that had an HbA1c result <8% but now have an HbA1c result ≥8% will be assigned to a health coach for telephonic coaching. Health coaches will be assigned approximately 15 emerging risk members every month and continue coaching the member on areas such as medication adherence, exercise and diet adjustments that will provide them success in decreasing A1C values <8%.

Summary of Results: Data collection for the intervention started 2021. See table below:

Emerging Risk Health Coach Telephonic Outreach (OCC)

Year	QTR	LOB	Starting Denominator	Members Assigned to a HC	Emerging Risk Members Successfully Outreached	Emerging Risk Members Unsuccessfully Outreached
2021	Q1	OCC	94	20	10	3
2021	Q2	OCC	108	55	34	3

In Q1 2021, 20 OCC members were assigned to a health coach and 10 were successfully outreached telephonically. In Q2 2021, 55 members were assigned to a health coach and 34 were successfully outreached telephonically. Will continue to track and monitor throughout 2021.

2. OCC CCIP — Emerging Risk – Improving A1C Control <8% for Members Recently Experiencing Poor Control >8% — 2021

Goal

Improve Comprehensive Diabetes Care (CDC) measure, specifically HbA1c good control (<8) by conducting proactive outreach to OCC members with diabetes who were previously <8% but have moved to have an HbA1c ≥8% based on the most recent lab results. The goal is to move 5% of OCC members identified and who participate back to an HbA1c <8% within one year.

Target Population

OCC members at risk for poor control >8% who were previously in good control <8% based on recent labs.

1. These members were enrolled by December 31st of the measurement year and be within 18–75 years old. Members must also have no more than one gap in enrollment of up to 45 days during the measurement year per HEDIS specifications.

Interventions

This intervention targets OCC members with diabetes with HbA1c results trending upward from <8% to >8%. OCC Members that had an HbA1c result <8% but now have an HbA1c result ≥8% will be assigned to a health coach for telephonic coaching. Health coaches will be assigned approximately 15 emerging risk members every month and continue coaching the member on

areas such as medication adherence, exercise and diet adjustments that will provide them success in decreasing HbA1c values <8%.

Summary of Results
Data collection for the intervention started 2021. See table below:
Emerging Risk Health Coach Telephonic Outreach (OCC)

Year	Qtr	LOB	Starting Denominator	Members Assigned to a HC	Emerging Risk Members Successfully Outreached	Emerging Risk Members Unsuccessfully Outreached
2021	Q1	OCC	94	20	10	3
2021	Q2	OCC	108	55	34	3

In Q1 2021, 20 OCC members were assigned to a health coach and 10 were successfully outreached telephonically. In Q2 2021, 55 members were assigned to a health coach and 34 were successfully outreached telephonically. Will continue to track and monitor throughout 2021.

3. Medi-Cal NCQA Standard — Emerging Risk — Improving A1C Control <8% for Members Recently Experiencing Poor Control >8% — 2021

Goal
Improve Comprehensive Diabetes Care (CDC) measure, specifically HbA1c good control (<8) by conducting proactive outreach to Medi-Cal (MC) members with diabetes who were previously <8% but have moved to have an HbA1c ≥8% based on the most recent lab results. The goal is to move 5% of MC members identified and who participate back to an HbA1c <8% within one year.

Target Population
MC members at risk for poor control >8% who were previously in good control <8% based on recent labs.

1. These members have been enrolled by December 31st of the measurement year and be within 18–75 years old. Members must also have no more than one gap in enrollment of up to 45 days during the measurement year per HEDIS specifications.

Interventions
This intervention targets MC members with diabetes with HbA1c results trending upward from <8% to >8%. MC members that had an HbA1c result <8% but now have an HbA1c result ≥8% will be assigned to a health coach for telephonic coaching. Health coaches will be assigned approximately 15 emerging risk members every month and continue coaching the member on areas such as medication adherence, exercise and diet adjustments that will provide them success in decreasing HbA1c values <8%.

Summary of Results
Data collection for the intervention started 2021. See table below:

Emerging Risk Health Coach Telephonic Outreach (Medi-Cal)

Year	Qtr	LOB	Starting Denominator	Members Assigned to a HC	Emerging Risk Members Successfully Outreached (#5 Yes)	Emerging Risk Members Unsuccessfully Outreached (#5 No)
2021	Q1	Medi-Cal	817	75	47	2
2021	Q2	Medi-Cal	712	148	99	11

In Q1 2021, 75 MC members were assigned to a health coach and 47 were successfully outreached telephonically. In Q2 2021, 148 members were assigned to a health coach and 99 were successfully outreached telephonically. Will continue to track and monitor throughout 2021.

Plan, Do, Study, Act (PDSA)

1. **PDSA – <u>Cervical Cancer Screening Plan, Do, Study, Act</u>**

2021 Cervical Cancer Screening Medi-Cal PDSA Goal:

Measure	2020 PDSA Goal
Cervical Cancer Screening: The percentage of women 21–64 years of age who were screened for cervical cancer	**To increase the number of Medi-Cal members 21-64 years of age who were screened for cervical cancer.**

Background

Every year, the California Department of Healthcare Services (DHCS) establishes minimum performance levels (MPLs) for the Managed Care Accountability Set (MCAS). Plans with measures below the MPL are required to conduct Plan-Do-Study-Act (PDSA). The PDSA methodology is a rapid cycle/continuous Quality Improvement (QI) process designed to perform small tests of change, which allow more flexibility to make adjustments throughout the improvements process. For reporting year (RY) 2020, DHCS required plans to conduct a Plan-Do-Study Act (PDSA) rapid cycle project on a single performance measure of the plan's choice that focused on a preventative care, chronic disease management, or behavioral health MCAS measure impacted by COVID-19.

CalOptima PDSA cycle addressed cervical cancer screening (CCS) among the Medi-Cal members 21-64 years of age. CalOptima anticipated lower screening rates due to the COVID-19 pandemic and therefore focused efforts in trying to sustain and even possibly improve the cervical cancer rates from the previous year. CalOptima had observed a reduction in people accessing health care services, including cancer screenings, due to fear of contracting the COVID-19 virus.

CalOptima collaborated with a health network to identify a provider office with a high volume of Medi-Cal CalOptima members 21-64 years of age that was performing lower in the CCS measure. The PDSA tested member outreach to increase CCS rates among eligible health network members at the targeted provider office site.

Provider Office A's MY2021 rate for the cervical cancer screening (CCS) measure was established as of February 2021 (Table 1). Provider Office A has approximately 27% (N=2762) of the assigned health network CalOptima Medi-Cal members ages 21-64 for CCS measure. The total target population for the PDSA was 1,486. This baseline data was used to compare Provider Office A's CCS measure rate at the end of cycle 1 and cycle 2 after the member outreach intervention.

Table 1: Health Network Provider Office Cervical Cancer Rates for MY2021

Provider Office	MY 2021 Preliminary Rate	Current Den	Current Num	Target Population
Provider Office A	46.2%	2762	1276	1486

Planning

The health network Performance Program Department generated a target list of members due for CCS for the provider office that had been identified. The health network Practice Support Specialist provided the targeted list of members due for CCS to provider the office staff at the beginning of each month. The provider office staff used the targeted list to conduct telephonic outreach to members to schedule CCS appointments. The provider office provided the health network Practice Support Specialist with an outreach tracking log. The tracking log captured the number of members outreached, number of CCS exam appointments made, number of CCS exam no-shows and the number of CCS exams completed. The health network Performance Program sent the tracking log to CalOptima for updates on the CCS completion progress. At the end of Cycle 1 and Cycle 2, the provider office staff was be offered an incentive based on their engagement in the initiative. The engagement is measured by, 1) the provider office sharing a monthly tracking log and outreach goal of 90% of the members in their target list and, 2) the provider office scheduling or completing 10% of the CCS exams from members outreached in cycle 1.

Cycle 1

The SMART AIM for cycle 1 was to outreach to at least 90% (1,337/1486) of members on the target list by May 2021.

Intervention

In February, the health network Support Specialist securely emailed the tracking log to the office Manager of Provider Office A Manager. There was a delay in the initiation of member outreach from February to March. Beginning March, the Provider Office A staff conducted member outreach by sending reminder letters to members from the tracking log. Of the 1478 members, 45 members were removed since they had completed cervical cancer screenings prior to start of this intervention. With the removal of the 45 members, the new denominator was 1433 who were included in the intervention period from March through May 2021.

On a monthly basis the Provider Office A manager securely emailed the updated tracking log to health network Support Specialist and provided any feedback that was relevant to the intervention. The Health Network Support Specialist securely emailed tracking log to CalOptima QA Analyst as well as feedback.

Results

Table 2: Health Network Provider Office Cervical Cancer Screening Outreach by month					
Month	Initial Target List	Prior Completion	New Target List	Count of letters mailed by 5/31/2021	Outreach Rate
March	1478	45	1433	168	11.72%
April	1478	-	1433	95	6.63%
May	1478	-	1433	1123	78.37%
Total	-	-	1433	1386*	96.72%

By May 2021 the Provider Office A staff was able to mail cervical cancer reminder letters to 1,386 members due for cervical cancer screening of 1,433 on the target list with an outreach rate of 96.2%. There was a delay in initiating member outreach from February to March because Provider Office A became a COVID-19 Vaccination site taking away staff resources to initiate member outreach.

Based on the results of the intervention, CalOptima had chosen to adapt the intervention. The intervention completed in cycle 1 focused on Provider Office A staff outreaching to members who were due for cervical cancer screening. Provider Office A still focused on outreaching to members to schedule cervical cancer screenings, but CalOptima plans to add a provider office staff incentive that focused on the number of scheduled or completed cervical cancer screenings.

Cycle 2

The SMART AIM for cycle 2 was to schedule or complete 10% (n=139) of CalOptima eligible Medi-Cal members for cervical cancer screenings that were outreached in cycle 1 (N=1386) by July 16, 2021.

Intervention

In June, the health network Support Specialist securely emailed the updated tracking log to Provider Office A Manager. Provider Office A staff conducted follow-up phone calls to members that were sent reminder letters in cycle 1. Provider Office A staff tracked follow-up phone call outcomes on tracking log as well as members that were scheduled or completed CCS. There were 1386 members that were sent the reminder letters in cycle 1 and would be able to receive a follow-up phone call.

On a monthly basis the Provider Office A manager securely emailed the updated tracking log to the Provider Support Specialist and added any feedback that was relevant to the intervention. The provider Support Specialist then securely emailed the tracking log to CalOptima QA Analyst.

Results

Table 3: Health Network Provider Office A Cervical Screening Follow-Up Phone Call Outcomes	
Follow-up Phone Call Outcome	Count
Completed	47
Pt sees different provider	3
Other (Add Notes): Excluded from measure	2
Left Voicemail	150
Other (Add notes): Moved out of state	1

No Answer	11
No Follow-Up Call	1029
No Phone # on file for pt	6
Pt requests referral to specialist	1
Pt refused	18
Requested a Call Back	33
Pt Scheduled	65
Pt termed	3
Wrong # for pt on file	17
Total	**1386**

The total number of members that received a follow-up phone call were 357 out of 1386 members who were mailed a reminder letter in cycle 1. For this intervention 47 members completed cervical a cancer screening and 65 were scheduled for a cervical cancer screening for a total of 112. The results for this intervention indicated that 8.08% (112/1386) of members that were sent a reminder letter in cycle 1 either scheduled or completed a cervical cancer screening in cycle 2. Therefore, the SMART objective goal was not reached.

Provider Office A staff only had the opportunity to attempt one follow-up phone call to members that were mailed reminder letters for cervical a cancer screening in cycle 1. Due to the short duration of cycle 2, there were 1,029 members that did not receive a follow-up phone call.

Based on the results of the intervention, CalOptima chose to adopt the intervention. CalOptima and the health network will identify other provider offices that have high volume of Medi-Cal CalOptima members due for cervical cancer screening (CCS) and low performing for the CCS measure. The Health Network Performance Program Department will generate a target list of members due for CCS for other provider offices that will be identified.

2021-2022 COVID-19 QIP Proposal- Pending Approval

Each measure in QIP proposal will be evaluating the impact of COVID-19 upon the measure.

Strategy 1: Behavioral Health

1. **Strategy:**
    a. Increase the number of diabetes screenings for members on antipsychotic medication.
    b. Identify members still in need of diabetes screening for the year and notify prescribing provider of (a) members in need of diabetes screening (b) best practice guidelines (c) primary care physician (PCP) name and contact information for each member (to promote coordination of care).
    c. Conduct outreach to prescribing provider via phone, then fax to include (a) list of members in need of diabetes screening for providers to contact members via phone; (b) best practice guidelines reminder; and (c) primary care physician (PCP) name and contact information for each member (to promote coordination of care by requesting prescribers to contact the PCP with lab results).
    d. Plan to monitor monthly prospective rates to evaluate progress.

2. **Targeted MCAS measure:** Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)
3. **Targeted Population:** All
4. **Rationale:** SSD did not meet the MPL for MY 2020. Due to the impact of the pandemic (e.g., stay-at-home orders), individuals may have been less likely to attend routine or follow-up appointments and take care of certain recommendations by their providers (i.e., lab work requests). Identified 1,234 members still in need of screenings this year.

Strategy 2: Women's Health

1. **Strategy:** Increase the number of Medi-Cal members 21-64 years of age who were screened for cervical cancer.
    a. The intervention will test member outreach via letter reminders and/or phone call reminders to increase CCS rates among eligible HN CalOptima ages 21-64 members at the targeted provider office sites. Member outreach modality will be chosen by each provider office site based on staff resources.
    b. CalOptima and HN have identified provider offices that have high volume of CalOptima Medi-Cal members due for cervical cancer screening (CCS) and low performing for the CCS measure.
    c. Identified 4 HN provider offices with a combined CCS denominator of 5,111 members. The target outreach population for this intervention is 2,619. This represents the HN CalOptima members ages 21-64 who are due to complete cervical cancer screening.
2. **Targeted MCAS measure:** Cervical Cancer Screening (CCS)
3. **Targeted Population:** Multiple; Medi-Cal members ages 21-64 years who need a cervical cancer screening
4. **Rationale:** CalOptima and HN have identified provider offices that have high volume of CalOptima Medi-Cal members due for cervical cancer screening (CCS) and low performing for the CCS measure.
5. **Next steps:** Reach out to the identified provider offices if interested in participating in member outreach intervention to increase cervical cancer screening. CalOptima will be providing a provider office staff incentive based on process measure and outcome measure.

Strategy 3: Child and Adolescent Health

1. **Strategy:** Increase the immunization rates of Medi-Cal members turning 2 years of age who are due for vaccinations.
    a. CalOptima has identified provider offices that have high volume of CalOptima Medi-Cal members due for childhood vaccinations and low performing for the CIS-Combo 10 measure. Vaccinations include: DTP, FLU, HEP, HEPA, HIB, MMR, PCV, PV, ROTA, VZV
    b. The intervention will include provider office outreaching to noncompliant members via phone to help increase compliance. Using target list provided by CalOptima, the provider office is expected to outreach to members, educate members on the importance of vaccinations, schedule appointment(s), and complete visits/vaccinations. These efforts will be measured and equate to the provider office staff incentive. The provider office staff incentive tier payment

system will be based on operational and performance metrics as established by CalOptima.

1. **Targeted MCAS measure:** Childhood Immunization Status (CIS Combo 10)
2. **Targeted Population:** Multiple; all members ages 0-2 years old who are assigned to partnering provider office.
3. **Rationale:** Immunizations continue to be high priority especially with the impact of COVID-19 pandemic delaying office visits due to hesitancy and scheduling. CalOptima has identified provider offices that have high volume of CalOptima Medi-Cal members due for childhood vaccinations and low performing for the CIS-Combo 10 measure. Vaccinations include: DTP, FLU, HEP, HEPA, HIB, MMR, PCV, PV, ROTA, VZV.
4. **Next steps:** Outreach to identified provider office to solicit interest in participating in member outreach intervention to increase childhood immunizations. CalOptima will provide an office staff incentive based on process measure and outcome measure.
    a. After outreaching to offices to partner, South Coast Pediatrics (SCP) agreed to collaborate on this QIP. SCP has 663 Medi-Cal members who fall in the CIS-Combo 10 denominator for MY 2021. The target outreach population is: 611 members. There current CIS-Combo 10 rate is 7.84% based on claims and encounters processed through August 2021. The NCQA 50th Percentile Benchmark (MPL) for CIS-10 is 38.20%.

2021 Oversight of QIPE/PPME Dashboard for OC and OCC

OC

1. HRA initial and annual outreach completed to date for 2021 between 98%–100%
2. HN Model of Care oversight 100% for all quarters to date.

OCC

1. HRA initial and annual outreach completed to date for 2021 between 98%–100%
2. CA 1.5 high risk members with an ICP completed Q1 63%, Q2 63%, Q3 65%
3. CA 1.5 low risk members with an ICP completed Q1 49%, Q2 50%, Q3 51%
    a. There is expected improvement for both high and low risk completion rates based on recent clarifications from DHCS.
4. CA 1.6 Members with ICP with documented discussion of care goals. Q1 92%, Q2 93%, Q3 89%

ICP completed in 90 days: CalOptima has maintained high rate for ICP completion within 90 days of eligibility as seen in our 3.2 MMP reporting. Quarter 1 reporting demonstrated a rate of 86 %; Quarter 2 reporting reflected rate of 87%; and, Q3 results show 89% completion. This success is based on processes that were implemented in 2020. ICP completion in 90 days is a withhold measure. 2021, DY 7 has benchmark of 85% completion rate for 3.2 MMP reporting. CalOptima is on track to achieve this benchmark.

Overall Effectiveness and Opportunities

In conclusion, CalOptima's 2021 QI Program Evaluation findings inform the 2022 QI Work Plan. Key issues and improvement opportunities are monitored routinely to ensure that adequate input is received and implemented on a regular basis.

The mission of CalOptima is, "To provide members with access to quality health care services delivered in a cost-effective and compassionate manner." CalOptima's Quality Management Program leads us toward this goal while focusing on quality initiatives that can be most impactful.

~~2021~~2022

QUALITY IMPROVEMENT PROGRAM

~~2021~~2022 QUALITY IMPROVEMENT PROGRAM SIGNATURE PAGE

Quality Improvement Committee Chair:

Richard ~~Emily Fonda~~Pitts, D.O., Ph.D. _____ Date
~~Interim~~ Chief Medical Officer

Board of Directors' Quality Assurance Committee Chair:

~~Mary Giammona~~Trieu Tran, M.D. _____ Date

Board of Directors Chair:

Supervisor Andrew Do _____Date

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WE ARE CALOPTIMA

Caring for the people of Orange County has been CalOptima's privilege since 1995. ~~Our 25th anniversary serving our members was in 2020.~~ We believe that our Medicaid (Medi-Cal) and Medicare members deserve the highest quality care and service throughout the health care continuum. CalOptima works in collaboration with providers, community stakeholders and government agencies to achieve our mission and vision while upholding our values.

Our Mission

To provide members with access to quality health care services delivered in a cost-effective and compassionate manner

The mission of CalOptima is the foundation of everything we do. It permeates every level of the organization. Our mission is focused on our members, and our members are the sole reason CalOptima exists.

Our Vision

To be a model public agency and community health plan that provides an integrated and well-coordinated system of care to ensure optimal health outcomes for all our members.

Our Values — CalOptima CARES

Collaboration

We seek regular input and act upon it. We believe outcomes are better through teamwork and effective communication with our members, providers, community health centers and community stakeholders.

Accountability

We were created by the community, for the community and are accountable to the community. Meetings open to the public are: Board of Directors, Board Finance and Audit Committee, Board Quality Assurance Committee, Investment Advisory Committee, Member Advisory Committee, OneCare Connect Member Advisory Committee, Provider Advisory Committee and Whole-Child Model Family Advisory Committee.

Respect

We respect and care about our members. We listen attentively, assess our members' health care needs, identify issues and options, access resources and resolve problems.

- We treat members with dignity in our words and actions.
- We respect the privacy rights of our members.
- We speak to our members in their languages.

- We respect the cultural traditions of our members.
- We respect and care about our partners.
- We develop supportive working relationships with providers, community health centers and community stakeholders.

Excellence

We base our decisions and actions on evidence, data analysis and industry-recognized standards so our providers and community stakeholders deliver quality programs and services that meet our members' health needs. We embrace innovation and welcome differences of opinion and individual initiative. We take risks and seek new and practical solutions to meet health needs or solve challenges for our members.

Stewardship

We recognize that public funds are limited, so we use our time, ~~talent~~talent and funding wisely and maintain historically low administrative costs. We continually strive for efficiency.

We are "Better. Together."

We cannot achieve our mission and our vision alone. We must work together with providers, community health centers, county agencies, state and federal agencies, and other community stakeholders. Together, we develop innovative solutions and meet our diverse members' health care needs. We are "Better. Together."

Our Strategic Plan

In late 2019, CalOptima's Board and executive team worked together to develop our next three-year Strategic Plan. After engaging a wide variety of stakeholders and collecting feedback, the strategic plan was approved in December 2019. Members are the essential focus of the 2020–2022 Strategic Plan, and our Priorities and Objectives are designed to enhance the programs and services provided to members by CalOptima.

The five Strategic Priorities and Objectives are:

- Innovate and Be Proactive
- Expand CalOptima's Member-Centric Focus
- Strengthen Community Partnerships
- Increase Value and Improve Care Delivery
- Enhance Operational Excellence and Efficiency

WHAT IS CALOPTIMA?

Our Unique Dual Role

CalOptima is unusual in that it is both a public agency and a community health plan.

As both, CalOptima must:

- Provide quality health care to ensure optimal health outcomes for our members
- Support member and provider engagement and satisfaction
- Be good stewards of public funds by making the best use of our resources and expertise
- Ensure transparency in our governance procedures, including providing opportunities for stakeholder input
- Be accountable for the decisions we make

WHAT WE OFFER

Medi-Cal

In California, Medicaid is known as Medi-Cal. CalOptima marked 25 years of service to Orange County's Medi-Cal population in 2020.

Medi-Cal covers low-income adults, families with children, seniors, people with disabilities, children in foster care (as well as former foster youth up to age 26), pregnant women and low-income people with specific diseases, such as tuberculosis, breast cancer or HIV/AIDS. A Medi-Cal member must reside in Orange County to be enrolled in CalOptima Medi-Cal.

Scope of Services

Under our Medi-Cal program, CalOptima provides a comprehensive scope of acute and preventive care services for Orange County's Medi-Cal and dual eligible population, including eligible conditions under California Children's Services (CCS) managed by CalOptima through the Whole-Child Model (WCM) Program that went into effect in 2019.

Certain services are not covered by CalOptima but may be provided by a different agency, including those indicated below:

- Specialty mental health services are administered by the Orange County Health Care Agency (HCA)
- Substance use disorder services are administered by HCA
- Dental services are provided through ~~California's Denti-Cal~~the Medi-Cal Dental Program

Members With Special Health Care Needs

To ensure that clinical services as described above are accessible and available to members with special health care needs — such as seniors, people with disabilities and people with chronic conditions — CalOptima has developed specialized case management services. These case management services are designed to ensure coordination and continuity of care and are described in the Utilization Management (UM) Program and the Population Health Management (PHM) Strategy.

Additionally, CalOptima works with community programs to ensure that members with special health care needs (or with high risk or complex medical and developmental conditions) receive additional services that enhance their Medi-Cal benefits. These partnerships are established as

special services through specific Memoranda of Understanding (MOU) with certain community agencies, including HCA and the Regional Center of Orange County (RCOC).

Medi-Cal Managed Long-Term Services and Supports

Since July 1, 2015, DHCS integrated Long-Term Services and Supports (LTSS) benefits for CalOptima Medi-Cal members. CalOptima ensures LTSS services are available to members who have health care needs and meet the program eligibility criteria and guidelines.

These integrated LTSS benefits include three programs:

- Community-Based Adult Services (CBAS)
- Nursing Facility (NF) Services for Long-Term Care (LTC)
- Multipurpose Senior Services Program (MSSP)

OneCare (HMO SNP)

Our OneCare (OC) members have Medicare and Medi-Cal benefits covered in one single plan, making it easier for our members to get the health care they need. Since 2005, CalOptima has been offering OC to low-income seniors and people with disabilities who qualify for both Medicare and Medi-Cal. OC has extensive experience serving the complex needs of the frail, disabled, dual eligible members in Orange County. With the start of OneCare Connect (OCC) in 2015, only individuals not eligible for OCC can enroll in OneCare.

OneCare provides a comprehensive scope of services for dual eligible members enrolled in Medi-Cal and Medicare Parts A and B. OneCare has an innovative Model of Care, which is the structure for supporting consistent provision of quality care. Each member has a Personal Care Coordinator (PCC) whose role is to help the member navigate the health care system and receive integrated medical, behavioral and supportive services. Also, the PCCs work with our members and their doctors to create individualized health care plans that fit each member's needs. Addressing individual needs results in a better, more efficient and higher quality health care experience for the member.

To be a member of OC, a person must live in Orange County and not be eligible for OCC. Enrollment in OC is voluntary and by member choice.

Scope of Services

In addition to the comprehensive scope of acute care, preventive care and behavioral health services covered under Medi-Cal and Medicare, CalOptima OC members are eligible for enhanced services, such as ~~transportation to medical services and~~ gym memberships.

OneCare Connect

The OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) launched in 2015 for people who qualify for both Medicare and Medi-Cal. OneCare Connect (OCC) is part of Cal MediConnect, a demonstration program operating in seven counties throughout California. The demonstration aims to transform the health care delivery system for people eligible for both Medicare and Medi-Cal.

These members frequently have several chronic health conditions and multiple providers, yet their separate insurance plans often create confusion and fragmented care. By combining all benefits into one plan, OCC delivers coordinated care. Care coordination eliminates duplicated services and shifts services from more expensive institutions to home- and community-based settings.

At no extra cost, OCC adds benefits such as vision care, gym benefits and an out-of-the-country urgent/emergency care benefit. Additionally, OCC integrates CBAS, MSSP and LTC into the plan benefits. OCC includes personalized support — all to ensure each member receives the services they need when they need them.

OneCare Connect achieves these advancements via CalOptima's innovative Model of Care. Each member has a Personal Care Coordinator (PCC) whose role is to help the member navigate the health care system and receive integrated medical, behavioral and supportive services. Also, the PCCs work with our members and their doctors to create individualized health care plans that fit each member's needs. Addressing individual needs results in a better, more efficient and higher quality health care experience for the member.

To join OCC, a member must live in Orange County, have both Medicare Parts A and B and Medi-Cal, and be 21 years of age or older. Members cannot be receiving services from a regional center or be enrolled in certain waiver programs. Other exceptions also apply.

The Cal MediConnect demonstration program is ending in 2022, and CalOptima is planning to transition OCC members to OC, effective January 1, 2023.

Scope of Services

OCC simplifies and improves health care for low-income seniors and people with disabilities, while ensuring timely access to the comprehensive scope of acute care, preventive care and behavioral health services covered under Medi-Cal and Medicare. At no extra cost, OCC adds enhanced benefits such as vision care, gym benefits and over-the-counter benefits ~~and transportation~~. OCC also includes personalized services through the PCCs to ensure each member receives the services they need when they need them.

~~**In 2022, transition plans will be in process for OCC programs to sunset by 12/31/2022, and transition all members to the OneCare programs.**~~

~~Program of All-Inclusive Care for the Elderly (PACE)~~

~~In 2013, CalOptima launched the only PACE program in Orange County. PACE is a community-based Medicare and Medi-Cal program that provides coordinated and integrated health care services to frail seniors to help them continue living independently in the community.~~

~~To be a PACE participant, members must be at least 55 years old, live in Orange County, be determined to be eligible for nursing facility services by the State of California, and be able to live safely at home or in a community setting with proper support.~~

~~**Scope of Services**~~

~~PACE provides all the acute and long-term care services covered by Medicare and Medi-Cal through an Interdisciplinary Team (IDT). The IDT is made up of physicians, nurses, social workers, dietitians, physical therapists, occupational therapists, home care staff, activity staff, and transportation staff who are committed to planning, coordinating and delivering the most fitting and personalized health care to participants. PACE participants must receive all needed services – other than emergency care – from CalOptima PACE providers and are personally responsible for any unauthorized or out-of-network services.~~

PROGRAM INITIATIVES

Mitigate Impact and Improve Health Equity: COVID-19 Pandemic

The COVID-19 pandemic created a public health emergency (PHE) that has changed the landscape of delivering quality health care to our members. The ~~2021~~2022 QI Program goals and initiatives are designed to address the COVID-19 PHE and include initiatives to mitigate the impact of the pandemic. Examples include the Orange County COVID-19 Nursing Home Prevention Program, the LTC Facility Transfer Plan due to COVID-19 pandemic, the Health Equity strategy, as well as the COVID-19 Vaccination and Communication strategy.

Health care disparities play a major role in quality outcomes. Historic and academic publications have shown that health care disparities in race and ethnicity have existed for decades. The COVID-19 pandemic shined a bright light on the health disparities and inequity. The California Department of Public Health COVID-19 analysis by race and ethnicity in ~~October 2020~~September 2021 revealed that Latinx account for 45.9% of coronavirus deaths, in a state where they make up 38.9% of the population; and Blacks account for 6.7% of the deaths, but make up only 6% of the population. Since health care disparities play a major role in quality outcomes, CalOptima identified opportunities to improve health equity as part of the QI Work Plan. ~~Additionally, the COVID-19 pandemic adversely impacted the mental health of many members, especially children. Hence, several trauma-informed interventions are included in the 2021~~2022 ~~QI Work Plan to address the toxic stress and Adverse Childhood Experiences (ACEs) related to the COVID-19 pandemic.~~

Department of Health Care Services (DHCS) Comprehensive Quality Strategy (CQS)

The 2022 Draft CQS lays out DHCS' quality and health equity strategy to support a 10-year vision for Medi-Cal, whereby people served by Medi-Cal should have longer, healthier and happier lives. The goals and guiding principles summarized below are built upon the Population Health Management (PHM) framework that is the foundation of California Advancing and Innovating Medi-Cal (CalAIM) and stress DHCS' commitment to health equity, member involvement and accountability in all program initiatives.

Quality Strategy Goals

- Engaging members as owners of their own care
- Keeping families and communities healthy via prevention
- Providing early interventions for rising risk and member-centered chronic disease management
- Providing whole-person care for high-risk populations, addressing drivers of health

Quality Strategy Guiding Principles

- Eliminating health disparities through anti-racism and community-based partnerships
- Data-driven improvements that address the whole person
- Transparency, accountability and member involvement

Health Equity Framework is a depiction of how DHCS intends to approach the elimination of health disparities. The following domains represent DHCS' multipronged vision to building analytic, workforce and programmatic capacity, at all levels, to eliminate health disparities.

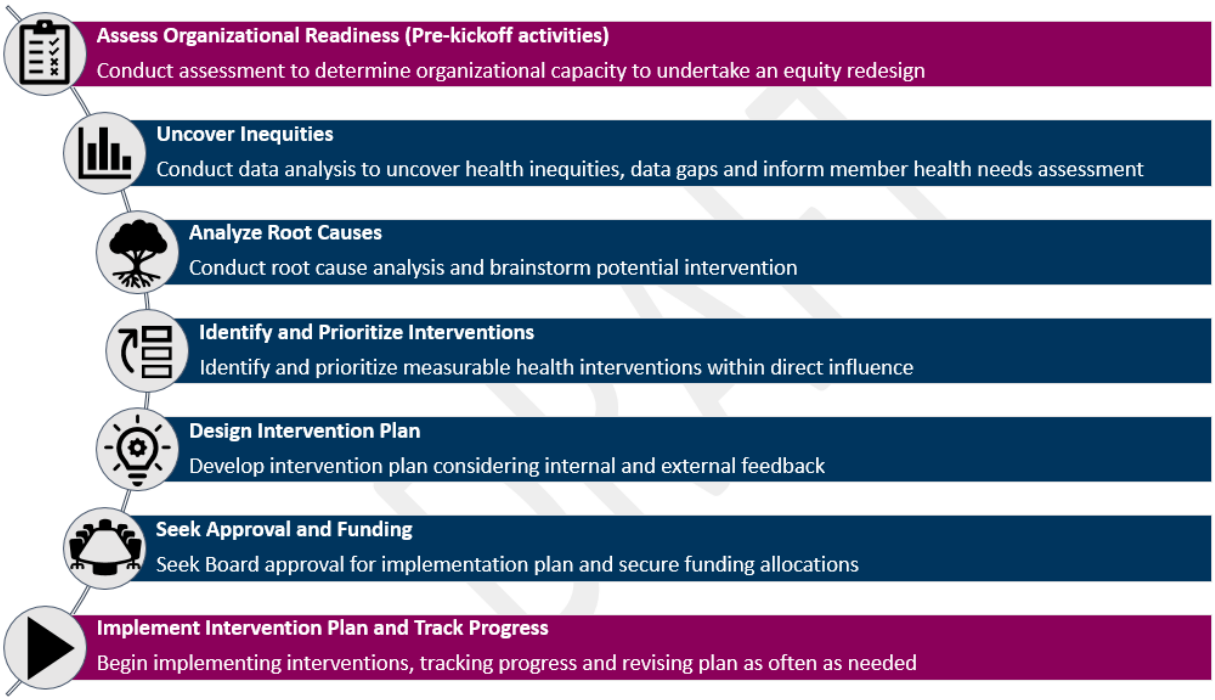
- Data collection and stratification
- Workforce diversity and cultural responsiveness
- Reducing health care disparities

Health Equity Framework

Health equity is achieved when an individual has the opportunity to "attain his or her full health potential" and no one is "disadvantaged from achieving this potential because of social position or other socially determined circumstances" (Centers for Disease Control and Prevention).

Social Determinants of Health (SDOH) are the conditions that exist in the places where people are born, live, learn, work, play, worship and age that affect health outcomes (Henry J. Kaiser Family Foundation).

In response to CalOptima's strategic plan, staff began the process to identify and address health equity and SDOH for vulnerable populations throughout Orange County. The framework includes several milestones from uncovering inequities, looking at root causes and designing a comprehensive intervention plan to planning and tracking progress. It begins with a comprehensive Readiness Assessment to determine organizational capacity to undertake a health equity redesign. As the framework is developed, there will be opportunities to obtain feedback from internal and external stakeholders and include their input in the intervention and design process.



California Advancing and Innovating Medi-Cal (CalAIM)

~~Whole Person Care~~

~~Whole Person Care (WPC) is a five-year pilot established by DHCS as part of California's Medi-Cal 2017-2019 Strategic Plan. In Orange County, the pilot is being led by the HCA. It focuses on improving health care outcomes for members who frequently visit the emergency department and are either homeless or have a serious mental illness. The WPC information-sharing platform was launched in November 2018. WPC is scheduled to terminate on December 31, 2020; however, the Department of Health Care Services (DHCS) has requested that the Centers for Medicare & Medicaid Services (CMS) extend the pilot for an additional year.~~

~~Whole Child Model~~

~~California Children's Services (CCS) is a statewide program for children with certain serious medical conditions. CCS provides medical care, case management, physical/occupational therapy and financial assistance. As of July 1, 2019, through SB 586, the state required CCS services to become a CalOptima Medi-Cal managed care plan benefit. The goal of this transition was to improve health care coordination by providing all needed care (most CCS and non-CCS services) under one entity rather than providing CCS services separately. The Whole Child Model (WCM) successfully transitioned to CalOptima in 2019 and will continue indefinitely. Under this program in Orange County, the medical eligibility determination processes, the Medical Therapy Program and CCS service authorizations for non-CalOptima enrollees will remain with HCA.~~

~~Health Homes Program~~

~~The Affordable Care Act gives states the option to establish health homes to improve care coordination for beneficiaries with chronic conditions. California has elected to implement the~~

"Health Homes for Patients with Complex Needs Program" (often referred to as Health Homes Program or HHP), which includes person-centered coordination of physical health, behavioral health, CBAS and LTSS.

CalOptima implemented HHP in two phases: January 1, 2020, for members with chronic physical conditions or substance use disorders (SUD); and July 1, 2020, for members with serious mental illness (SMI) or serious emotional disturbance (SED). During implementation, HHP targeted the highest risk 3–5% of the Medi-Cal members with multiple chronic conditions who present the best opportunity for improved health outcomes. To be eligible, members must have:

1. Specific combinations of physical chronic conditions and/or SUD or specific SMI conditions and
2. Meet specified acuity/complexity criteria

Members eligible for HHP must consent to participate and receive HHP services. CalOptima is responsible for HHP network development. Community-Based Care Management Entities (CB-CME) will be the primary HHP providers. In addition to CalOptima's Community Network, all health networks (HN) will serve in this role. CB-CMEs are responsible for coordinating care with members' existing providers and other agencies to deliver the following six core service areas:

1. Comprehensive care management
2. Care coordination
3. Comprehensive transitional care
4. Health promotion
5. Individual and family support services
6. Referral to community and social support services

CalOptima will provide housing-related and accompaniment services to further support HHP members. CalOptima has partnered with the HCA to provide members in the WPC program, who are also eligible for the HHP, to continue with their current WPC providers for their housing-related services.

Homeless Health Initiative (HHI)

In Orange County, as across the state, the homeless population has increased significantly over the past few years. To address this problem, Orange County has focused on creating a system of care that uses a multi-faceted approach to respond to the needs of County residents experiencing homelessness. The system of care includes five components: behavioral health; health care; housing support services; community corrections; and public social services. The county's WPC program is an integral part of this work as it is structured to focus on Medi-Cal beneficiaries struggling with homelessness.

CalOptima has responded to this crisis by committing $100 million to fund homeless health programs in the County. Homeless health initiatives supported by CalOptima include:

- Recuperative Care — As part of the Whole Person Care program, recuperative care services provide post-acute care for up to 90 days for homeless CalOptima members. HCA and CalOptima split the cost of recuperative care on a 50/50 basis. CalOptima's ongoing

~~participation is limited to funds available through an intergovernmental transfer grant to HCA in connection with the Whole Person Care program, and the CalOptima Board of Directors has authorized the extension of the grant agreement beyond the currently scheduled December 31, 2020, pilot end date.~~

- ~~Medical Respite Care — As an extension to the recuperative care program, CalOptima provided a grant to HCA to provide additional respite care beyond the 90 days of recuperative care under the Whole Person Care program. These grant funds have been exhausted.~~

- ~~Clinical Field Teams — In collaboration with Federally Qualified Health Centers (FQHC), HCA's Outreach and Engagement team, and CalOptima's Homeless Response Team, this pilot program provides immediate acute treatment/urgent care to homeless CalOptima members. In response to the COVID-19 pandemic, these services are available via telehealth, in addition to in person.~~

  ~~Homeless Clinical Access Program — This Homeless Clinical Access Program (HCAP) focuses on increasing access to care for individuals experiencing homelessness by providing incentives to community health centers to establish regular hours at Orange County shelters and hot spots via mobile clinics. The expanded access to primary and preventive care services and care coordination helps connect the member back to the primary care delivery system. Community health centers work with nearby shelters and hot spots that meet the program requirements and receive an incentive based on the scheduled time and members served through mobile or on-site fixed clinics. The goal of HCAP is to provide quality care for our members. By partnering with community health centers, we are able to have pop-up mobile clinics for our members experiencing homelessness. Through this program, CalOptima provides preventive screenings, chronic care, care coordination and follow up.~~

- ~~Hospital Discharge Process for Members Experiencing Homelessness — Support is provided to assist hospitals with the increased cost associated with discharge planning under state requirements.~~

  California Advancing and Innovating Medi-Cal (CalAIM) is a multiyear initiative, spanning from 2022 to 2027, by DHCS to improve the quality of life and health outcomes of the ~~our~~Medi-Cal population by implementing broad delivery system, ~~as well as~~ program and payment reforms ~~across Medi-Cal~~.

  CalAIM has three primary goals:

  1. Identify and manage member risk and need through whole-person care approaches and addressing SDOH.
  2. Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility.
  3. Improve quality outcomes, reduce health disparities and drive delivery system transformation and innovation through value-based initiatives, modernization of systems and payment reform.

Enhanced Care Management and Community Supports

Beginning on January 1, 2022, CalOptima ~~will~~ implemented two CalAIM components: Enhanced Care Management (ECM) and Community Supports. Enhanced Care Management ~~ECM~~ provides a whole-person approach to care that addresses the clinical and non-clinical circumstances of high-need Medi-Cal members. Community Supports are medically appropriate, flexible, wrap-around services ~~which~~that addresses the member's complex medical and social needs. Community Supports ~~provide a~~are alternatives to covered services, which are provided to reduce or avoid admissions to ~~substitute to, or to avoid, other covered services, such as~~ a hospital or skilled nursing facility admission, emergency department visits and ~~of a~~ discharge delays.

CalOptima's implementation of ECM and Community Supports ~~will~~ build upon the Health Homes Program (HHP) and Whole-Person Care (WPC) Pilot infrastructures by preserving existing member relationships with HHP and WPC service providers. CalOptima's HHP Community-Based Care Management Entities will transition to become ECM Providers. This means that CalOptima and ~~its~~ our delegated health networks (HNs) ~~(HNs)~~ will provide ECM services as ECM providers to eligible populations. ~~Enhanced Care Management~~~~ECM~~These providers will be responsible for coordinating care with members' existing providers and other agencies to deliver the following seven core service components:

1. Outreach and engagement
2. Comprehensive assessment and care management plan
3. Enhanced coordination of care
4. Health promotion
5. Comprehensive transitional care
6. Member and family supports
7. Coordination of and referral to community and social support services

Beginning January 1, 2022, ECM went~~goes~~ live for the following populations of focus:

- Members experiencing homelessness (adults and children)
- High utilizer adults
- Adults with Serious Mental Illness (SMI)/Substance Use Disorder (SUD)

Additionally, members participating in WPC and/or HHP ~~will~~ automatically transitioned into ECM.

~~Health Homes Program and Whole Person Care~~~~HHP~~HHP and WPC service providers will continue to provide services under Community Supports as CalOptima works to expand ~~its~~the network of Community Supports providers that have the expertise and capacity to provide the specific types of services~~, as needed~~. Members eligible for Community Services must consent to participate and receive services. Community Support services include the following:

1. Housing transition navigation services
2. Housing deposits
3. Housing tenancy and sustaining services
4. Short-term post-hospitalization housing
5. Recuperative care (medical respite)
6. Respite services
7. Day habilitation programs
8. Nursing facility transition/diversion to assisted living facilities
9. Community transition services/nursing facility transition to a home
10. Personal care and homemaker services
11. Environmental accessibility adaptations (home modifications)

12. Medically tailored meals/medically supportive foods
13. Sobering centers
14. Asthma remediation

Beginning January 1, 2022, CalOptima ~~will~~ offers the following four~~, distinct~~ Community Supports services:

1. Housing transition navigation services
2. Housing deposits
3. Housing tenancy and sustaining services
4. Recuperative care (medical respite)

CalOptima will continue to assess the needs the of members and collaborate with community stakeholders to add new Community Supports.

2021 ~~20~~22 ~~CCN~~CalOptima Community Network (CCN) Pilot Program

Diabetes Mellitus Program to Improve Health Care Quality for Medi-Cal Members With Poorly Controlled Diabetics

To address high rates of poorly controlled diabetics identified in the CCN network, the following pilot program was proposed and approved by the CalOptima Board of Directors.

1. Pharmacist Involvement and Intervention:
   CalOptima pharmacists' role will be extended to include individual member outreach and provider consultations. CalOptima believes that our internal pharmacists can promote and support behavior changes needed for diabetic members with a multidisciplinary team approach, including collaboration with primary care providers (PCPs) and health coaches/registered dietitians/case managers.
2. Health Coach/Registered Dietitian Management Intervention:
   CalOptima health coaches will provide CCN-focused interventions such as assessment/care planning, motivational interviewing, member education materials and referral to other community resources based on needs. Health coaches/registered dietitians ~~would~~will also participate in Interdisciplinary Care Team (ICT) meetings, as applicable, and connect members to case management if other acute needs are identified during an intervention.
3. Non-Monetary Member Incentives:
   CalOptima would like to support member engagement and compliance by providing members with health rewards (non-monetary incentives). The non-monetary incentives will be provided as gift cards subject to DHCS approval in the near future.
4. Provider Incentives:
   In order to have successful provider ~~buy-in~~support, CalOptima proposes providing incentives for their dedicated participation in this multidisciplinary ~~DM~~diabetes program. Providers are eligible for incentives when they ~~participate in the program to~~ manage a member with known or potentially poorly controlled diabetes and meet the eligibility criteria for participation year.

Pharmacy Administration Changes

Effective January 1, 2022 ~~April 1, 2021~~, DHCS carved out the outpatient pharmacy benefit for Medi-Cal beneficiaries from managed care plans and moved it to a state fee-for-service program, known as Medi-Cal Rx. Outpatient pharmacy claims processing/prior authorizations, formulary administration and pharmacy-related grievances will be the responsibility of Medi-Cal Rx. CalOptima-retained responsibilities will include physician-administered drug claims processing/prior authorizations, pharmacy care coordination, clinical aspects of pharmacy adherence, disease and medication management, and participation on the Medi-Cal Global Drug Utilization Review (DUR) Board. This change is for Medi-Cal only and does not affect OC, OCC or PACE.

~~Virtual Care Strategy~~

With Whom We Work

Contracted Health Networks/Contracted Network Providers

Providers have ~~several~~ options for participating in CalOptima's programs to provide health care to ~~Orange County's Medi-Cal~~CalOptima members. Providers can ~~participate~~ contract through CalOptima Direct, CalOptima Direct-Administrative and/or CalOptima Community Network (CCN) and/or contract with a CalOptima HN. CalOptima members can choose CCN or one of 12 HNs representing more than ~~8,5~~9,400 practitioners.

CalOptima Direct (COD)

CalOptima Direct has two elements: CalOptima Direct-Administrative and CCN.

- CalOptima Direct-Administrative (COD-A)

  CalOptima Direct-Administrative is a self-directed program administered by CalOptima to serve Medi-Cal members in special situations~~, who are not HN eligible~~, including dual-~~eligibles~~eligibles (those with both Medicare and Medi-Cal who elect not to participate in ~~CalOptima's OneCare Connect or OneCare programs~~OC or OCC), share-of-cost members, newly eligible members transitioning to a ~~health network or CNN~~HN and members residing outside of Orange County.

- CalOptima Community Network (CCN)

  ~~The CalOptima Community Network provides~~CCN doctors with an alternate path to contract directly with CalOptima to serve our members. CCN is administered directly by CalOptima and available for HN-eligible members to select, supplementing the existing HN delivery model and creating additional capacity for access.

CalOptima Contracted Health Networks

CalOptima has contracts with delegated HNs through a variety of ~~HN financial~~ risk models to provide care to members. The following contract risk models are currently in places~~. Since 2008, CalOptima's HNs consist of~~:

- Health Maintenance Organization (HMO)

- Physician/Hospital Consortia (PHC)
- Shared-Risk ~~Risk~~ ~~Medical~~ Groups (SRG)

Through our~~the~~ delegated ~~se~~ HNs, CalOptima members have access to more than~~nearly~~ 1,~~600~~ 500 ~~primary care providers (~~PCPs~~)~~, more than ~~86,800~~ ~~6~~7,900 specialists, 40 acute and rehabilitative hospitals, ~~35~~ 31 ~~clinics~~ community health centers and nearly 100~~100~~ long-term care facilities.

CalOptima contracts with the following HNs:

Health Network~~/Delegate~~	Medi-Cal	OneCare	OneCare Connect
AltaMed Health Services	SRG	SRG	SRG
~~AMVI/Prospect Medical Group~~		~~SRG~~	
AMVI Care Health Network	PHC	-	PHC
~~Optum Care Network - Arta Western Medical Group~~	~~SRG~~	~~SRG~~	~~SRG~~
AMVI/Prospect ~~Health Network~~Medical Group	-	SRG	-
CHOC Health Alliance	PHC	-	-
~~Family Choice Health Network~~	~~PHC~~		
Family Choice Medical Group	PHC	SRG	~~SRG~~~~PHC~~SRG
HPN-Regal Medical Group	HMO	-	HMO
Kaiser ~~Permanente~~~~Foundation Health Plan~~Permanente	HMO	-	-
Noble Mid-Orange County~~Optum Care Network - Monarch HealthCare~~	SRG~~HMO~~	SRG~~SRG~~	SRG~~HMO~~
~~Monarch Health Plan, Inc.~~	~~HMO~~		~~HMO~~
Optum Care Network - Arta	SRG	SRG	SRG
Optum Care Network - Monarch	HMO	SRG	HMO

Optum Care Network - Talbert	SRG	SRG	SRG
~~Noble Mid-Orange County~~	~~SRG~~	~~SRG~~	~~SRG~~
Prospect ~~Health Plan~~Medical Group	HMO	-	HMO
~~Optum Care Network - Talbert Medical Group~~	~~SRG~~	~~SRG~~	~~SRG~~
United Care Medical Group	SRG	SRG	SRG

Delegate	Medi-Cal	OneCare	OneCare Connect
Vision Service Plan	VS	VS	VS

HMO=Health Maintenance Organization
PHC=Physician-Hospital Consortium
SRG=Shared Risk Group
VS=Vision Service

Upon successful completion of readiness reviews and audits, the HNs may be delegated for clinical and administrative functions, which may include:

- Utilization management
- Basic and complex case ~~Case m~~Management ~~and Complex Case Management~~
- Claims~~(professional and institutional)~~
- Contracting
- Credentialing of practitioners
- Customer service ~~activities~~

MEMBERSHIP DEMOGRAPHICS

CalOptima
A Public Agency
Better. Together.

Fast Facts: February 2022

Mission: To provide members with access to quality health care services delivered in a cost-effective and compassionate manner

Membership Data from December 31, 2021, Financial Information

Total CalOptima Membership
870,489

Program	Members
Medi-Cal*	852,805
OneCare Connect	14,933
OneCare (HMO SNP)	2,330
Program of All-Inclusive Care for the Elderly (PACE)	421

Note: Fiscal Year 2021–22 Membership Data began on July 1, 2021.
* Based on unaudited financial report and includes prior year adjustment

Member Age (All Programs)

9%	0 to 5
27%	6 to 18
33%	19 to 44
19%	45 to 64
12%	65+

Languages Spoken (All Programs)

59%	English
26%	Spanish
10%	Vietnamese
2%	Other
1%	Korean
1%	Farsi
<1%	Chinese
<1%	Arabic

Medi-Cal Aid Categories

41%	Temporary Assistance for Needy Families
35%	Expansion
9%	Optional Targeted Low-Income Children
9%	Seniors
5%	People with Disabilities
<1%	Long-Term Care
<1%	Other

Financial Information FY 2021–22 Budget

Program	Annual Budgeted Revenue	% Total Budgeted Revenue
Medi-Cal	$3,249,878,660	88.89%
OneCare Connect	$339,332,450	9.28%
OneCare	$25,409,771	0.69%
PACE	$40,274,039	1.10%
MSSP**	$1,218,536	0.03%

Note: Fiscal Year 2021–22 Operating Budget began on July 1, 2021.
** Multipurpose Senior Services Program (MSSP)

Total Budgeted Annual Revenue
$3.7 billion

CalOptima spends nearly 96 cents of every dollar on member care.

CalOptima
A Public Agency
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Fast Facts: February 2021

Mission: To provide members with access to quality health care services delivered in a cost-effective and compassionate manner

Membership Data from December 31, 2020 Financial Information

Total CalOptima Membership
808,290

Program	Members
Medi-Cal*	791,349
OneCare Connect	14,938
OneCare (HMO SNP)	1,609
Program of All-Inclusive Care for the Elderly (PACE)	394

Note: Fiscal Year 2020-21 Membership Data began on July 1, 2020.
* Based on unaudited financial report and includes prior year adjustment

Member Age (All Programs)

10%	0 to 5
28%	6 to 18
31%	19 to 44
19%	45 to 64
12%	65+

Languages Spoken (All Programs)

57%	English
27%	Spanish
10%	Vietnamese
2%	Other
1%	Korean
1%	Farsi
<1%	Chinese
<1%	Arabic

Medi-Cal Aid Categories

42%	Temporary Assistance for Needy Families
34%	Expansion
9%	Optional Targeted Low-Income Children
9%	Seniors
6%	People with Disabilities
<1%	Long-Term Care
<1%	Other

QUALITY IMPROVEMENT PROGRAM

CalOptima's Quality Improvement (QI) Program encompasses all clinical care, health and wellness services, and customer service provided to our members, which aligns with our vision to provide an integrated and well-coordinated system of care to ensure optimal health outcomes for all our members.

CalOptima developed programs using evidence-based guidelines that incorporate data and best practices tailored to our populations. Our focus extends across the health care continuum, from primary care, urgent care, acute and subacute care to long-term ~~care~~care~~, to~~ and end-of-life care. Our comprehensive person-centered approach integrates physical and behavioral health, leveraging the care delivery systems and community partners for our members with vulnerabilities, ~~disabilities~~disabilities and chronic illnesses.

CalOptima's QI Program includes processes and procedures designed to ensure that all medically necessary covered services are available and accessible to all members, including those with limited English proficiency or diverse cultural and ethnic backgrounds, regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, gender identity, health status or disability. All covered services are provided in a culturally and linguistically appropriate manner.

~~Since 2010, the "Triple Aim" has been at the heart of the CMS Medicare Advantage and Prescription Drug Plan (Medicare Parts C and D) quality improvement strategy. The Triple Aim focuses on patient-centered improvements to the health care system including improving the care experience and population health and decreasing the cost of care. The Quadruple Aim adds a fourth element focused on provider satisfaction on the theory that providers who find satisfaction in their work will provide better service to patients. CalOptima's quality strategy embraces the Quadruple Aim as a foundation for its quality improvement strategy.~~CalOptima is committed to promoting diversity in practices throughout the organization, including HR best practices for recruiting and hiring. Also, as part of the new hire process as well as annual compliance, employees are trained on cultural competency, bias and inclusion.

QUALITY IMPROVEMENT PROGRAM PURPOSE

The purpose of the CalOptima QI Program is to establish objective methods for systematically evaluating and improving the quality of care provided to CalOptima members through CalOptima CCN and COD-A, as well as our contracted ~~health networks~~HNs. Through the QI Program — and in collaboration with ~~its~~ providers and community partners — CalOptima strives to continuously improve the structure, processes and outcomes of its health care delivery system to serve our members.

The CalOptima QI Program incorporates the continuous QI methodology of Plan-Do-Study-Act (PDSA) that focuses on the specific needs of CalOptima's multiple customers (members, health care providers, community-based organizations and government agencies). The QI Program is organized around a systematic approach to accomplish the following annually:

- Identify and analyze significant opportunities for improvement in care and service to advance CalOptima's strategic mission, goals and objectives.
- Foster the development of improvement actions, along with systematic monitoring and evaluation, to determine whether these actions result in progress toward established benchmarks or goals.
- Focus on QI activities carried out on an ongoing basis to support early identification and timely correction of quality-of-care issues to ensure safe ~~patient~~ care and experiences.
- Maintain agencywide practices that support accreditation by NCQA and meet DHCS/CMS quality and measurement reporting requirements.

In addition, the QI Program's ongoing responsibilities include the following:

- Setting expectations to develop plans to design, measure, assess and improve the quality of the organization's governance, management and support processes.
- Supporting the provision of a consistent level of high-quality care and service for members throughout the contracted provider networks, as well as monitoring utilization practice patterns of practitioners, contracted hospitals, contracted services, ancillary services and specialty providers.
- Providing oversight of quality monitors from the contracted facilities to continuously assess that the care and service provided satisfactorily meet quality goals.
- Ensuring certain contracted facilities report to the public health authority (HCA) outbreaks of conditions and/or diseases ~~to the public health authority (HCA)~~, which may include, but are not limited to, methicillin resistant Staphylococcus aureus (MRSA), scabies, tuberculosis, etc.
- Promoting ~~patient~~ member safety and minimizing risk through the implementation of ~~patient~~ safety programs and early identification of issues that require intervention and/or education and working with appropriate committees, departments, staff, practitioners,

provider medical groups and other related organizational providers (~~OPS~~OPs) to assure that steps are taken to resolve and prevent recurrences.

- Educating the workforce and promoting a continuous quality improvement culture at CalOptima.

In collaboration with the Compliance ~~Internal and External~~ Audit & Oversight departments, the QI Program ensures the following standards or outcomes are carried out and achieved by CalOptima's contracted HNs, including CCN and/or COD network providers serving CalOptima's various populations:

- Support the agency's strategic quality and business goals by utilizing resources appropriately, effectively and efficiently
- Continuously improve clinical care and service quality provided by the health care delivery system in all settings, especially as it pertains to the unique needs of the population
- Timely identify important clinical and service issues facing the Medi-Cal, OC and OCC populations relevant to their demographics, high risks, disease profiles for both acute and chronic illnesses, and preventive care
- Ensure continuity and coordination of care between specialists and primary care practitioners, and between medical and behavioral health practitioners by annually evaluating and acting on identified opportunities
- Ensure accessibility and availability of appropriate clinical care and a network of providers with experience in providing care to the population
- Monitor the qualifications and practice patterns of all individual providers in the network to deliver quality care and service
- Promote the continuous improvement of member and provider satisfaction, including the timely resolution of complaints and grievances
- Ensure the reliability of risk prevention and risk management processes
- Ensure compliance with regulatory agencies and accreditation standards
- Ensure the annual review and acceptance of the UM Program Description and other relevant Population Health Programs and Work Plans
- Promote the effectiveness and efficiency of internal operations
- Ensure the effectiveness and efficiency of operations associated with functions delegated to the contracted HNs

- Ensure the effectiveness of aligning ongoing quality initiatives and performance measurements with CalOptima's strategic direction in support of its mission, vision and values

- Ensure compliance with up-to-date Clinical Practice Guidelines and evidence-based medicine.

The Quality and Clinical Operations departments and Medical Directors, in conjunction with multiple CalOptima departments, support the organization's mission and strategic goals, and oversee the processes to monitor, evaluate and act on the quality of care and services that members receive.

AUTHORITY, BOARD OF DIRECTORS' COMMITTEES AND RESPONSIBILITIES

Board of Directors

The CalOptima Board of Directors has ultimate accountability and responsibility for the quality of care and services provided to CalOptima members. The responsibility to oversee the program is delegated by the Board of Directors to the Board's Quality Assurance Committee — which oversees the functions of the QI Committee described in CalOptima's state and federal contracts — and to CalOptima's Chief Executive Officer (CEO), as described below.

The Board holds the CEO and Chief Medical Officer (CMO) accountable and responsible for the quality of care and services provided to members. The Board promotes the separation of medical services from fiscal and administrative management to ensure that medical decisions will not be unduly influenced by financial considerations. The Board approves and evaluates the QI Program annually.

The QI Program is based on ongoing systematic collection, integration and analysis of clinical and administrative data to identify member needs, risk levels and appropriate interventions to make certain that the program meets the specific needs of the individual member and promotes health equity among specific population segments, while improving overall population health and member experience. The CMO is charged with identifying appropriate interventions and allocating resources necessary to implement the QI Program. Such recommendations shall be aligned with federal and state regulations, contractual obligations and fiscal parameters.

CalOptima is required under California's open meeting law, the Ralph M. Brown Act, Government Code §54950 *et seq.*, to hold public meetings except under specific circumstances described in the Act. CalOptima's Board meetings are open to the public.

Board of Directors' Quality Assurance Committee

The Board of Directors appoints the Quality Assurance Committee (QAC) to conduct annual evaluation, provide strategic direction and make recommendations to the Board regarding the overall QI Program. QAC routinely receives progress reports from the QIC describing improvement actions taken, progress in meeting objectives and quality performance results achieved. The QAC also makes recommendations to the Board for annual approval with modifications and appropriate resources allocations of the QI Program aimed to achieve the Institute for Healthcare Improvement's Quadruple Aim (which expands on CMS' Triple Aim):

1. Enhancing patient experience
2. Improving population health
3. Reducing per capita cost
4. Enhancing provider satisfaction

Member Advisory Committee

The Member Advisory Committee (MAC) ~~is comprised of~~has 15 voting members, with each seat ~~represents~~ representing a constituency served by CalOptima. The MAC ensures that CalOptima

members' values and needs are integrated into the design, implementation, operation and evaluation of the overall QI ~~program~~Program. The MAC provides advice and recommendations on community outreach, cultural and linguistic needs and needs assessment, member survey results, access to health care, and preventive services. The MAC meets on a ~~bimonthly~~ monthly basis and reports directly to the CalOptima Board of Directors. MAC meetings are open to the public.

The MAC membership ~~is composed of~~includes representatives from the following constituencies:

- Adult beneficiaries
- Behavioral/mental health
- Children
- Consumers
- Family support
- Foster children
- HCA
- LTSS
- Medi-Cal beneficiaries
- ~~Medically indigent persons~~ Medical safety net
- ~~Orange County~~County of Orange Social Services Agency (OC SSA)
- Persons with disabilities
- ~~Persons with mental illnesses~~
- Persons with special needs ~~behavioral/mental health~~
- Recipients of CalWORKs
- Seniors

Two of the 15 positions — held by HCA and OC SSA — are permanent. Each of the remaining 13 appointed members serve two-year terms with no term limits.

OneCare Connect Member Advisory Committee

The OCC Member Advisory Committee (OCC MAC) reports directly to the CalOptima Board of Directors. The OCC MAC ~~is comprised of~~has 10 voting members, each seat representing a constituency served by OCC, and four non-voting liaisons representing county agencies collaborating on the ~~implementation of the~~ program.

The OCC MAC membership ~~is comprised of~~includes representatives from the following constituencies:

- OCC beneficiaries or family members of OCC beneficiaries (three seats)
- CBAS provider representative
- Home- and Community-Based Services (HCBS) representative serving persons with disabilities
- HCBS representative serving seniors
- HCBS representative serving members from an ethnic or cultural community
- In-Home Supportive Services (IHSS) provider or union representative
- LTC facility representative

- Member advocate, such as Health Insurance Counseling and Advocacy Program, Legal Aid Society or Public Law Center
- Non-voting liaisons include seats representing the following county agencies:
    - HCA Behavioral Health
    - OC SSA
    - OC Community Resources Agency, Office on Aging
    - OC IHSS Public Authority

The four non-voting liaison seats held by county agencies are standing seats. The 10 appointed voting members serve two-year terms with no term limits. The bimonthly meetings ~~are held at least quarterly and~~ are open to the public.

Provider Advisory Committee

The Provider Advisory Committee (PAC) was established ~~in 1995~~ by the CalOptima Board of Directors to advise the Board on issues impacting the CalOptima provider community. The PAC ~~is comprised of providers who~~members represent the broad provider community that serves CalOptima members. The PAC has 15 members, 14 of whom serve three-year terms with two consecutive term limits, along with a representative of HCA, which maintains a standing seat. PAC meets ~~at least quarterly~~monthly and is open to the public. The 15 seats include:

- Health networks
- Hospitals
- Physicians (three seats)
- Nurse
- Allied health services (two seats)
- Community health centers
- HCA (one standing seat)
- LTSS (LTC facilities and CBAS) (one seat)
- Non-physician medical practitioner
- ~~Traditional~~ Safety net ~~provider~~
- Behavioral/mental health
- Pharmacy

Whole-Child Model Family Advisory Committee

Whole-Child Model Family Advisory Committee (WCM FAC) has been required by the state as part of California Children's Services (CCS) since it became a Medi-Cal managed care plan benefit. The WCM FAC provides advice and recommendations to the Board and staff on issues concerning the WCM program, serves as a liaison between interested parties and the Board, and assists the Board and staff in obtaining public opinion on issues relating to CalOptima's WCM program. The committee can initiate recommendations on issues for study and facilitate community outreach.

The WCM FAC ~~is composed of~~includes the following 11 voting seats:

- Family representatives (seven ~~to nine~~ seats)
    - Authorized representatives, which includes parents, foster parents and caregivers of a CalOptima member who is a current recipient of CCS services; or

- CalOptima members age 18–21 who are current recipients of CCS services; or
- Current CalOptima members over the age of 21 who transitioned from CCS services

- Interests of children representatives (~~: two to four~~four seats)
  - Community-based organizations; or
  - Consumer advocates

Members of the committee serve staggered two-year terms. WCM FAC meets bimonthly~~at least quarterly~~, and meetings are open to the public.

ROLE OF CALOPTIMA OFFICERS FOR QUALITY IMPROVEMENT PROGRAM

Chief Executive Officer (CEO) allocates financial and employee resources to fulfill program objectives. The CEO delegates authority, when appropriate, to the Chief Medical Officer (CMO), the Chief Financial Officer (CFO) and the Chief Operating Officer (COO). The CEO makes certain that the QI Committee (QIC) satisfies all remaining requirements of the QI Program, as specified in the state and federal contracts.

Chief Information Officer (CIO) provides oversight of CalOptima's enterprise-wide technology needs, operations and strategy. The CIO also serves as the Chief Information Security Officer responsible for security and risk management to proactively manage and decrease the agency's risk exposure.

Chief Operating Officer (COO) is responsible for oversight and day-to-day operations of several departments, including Customer Service, Information Technology Services, Program Implementation, Process Excellence, Network Operations, Grievance and Appeals Resolution Services (GARS), Claims Administration, and Coding Initiatives.~~Operations, Network Management, Information Services, Claims Administration, Customer Service, Grievance and Appeals Resolution Services (GARS), Coding Initiatives, Electronic Business and Human Resources.~~

Chief Medical Officer (CMO) oversees strategies, programs, policies and procedures as they relate to CalOptima's quality and safety of clinical care delivered to members. The CMO has overall responsibility of the QI ~~program~~ Program and supports efforts so that the QI Program objectives are coordinated, integrated and accomplished. At least quarterly, the CMO presents reports on QI activities to the Board of Directors' Quality Assurance Committee.

~~**Deputy Chief**~~ **Deputy Chief Medical Officer** (DCMO), along with the CMO, oversees strategies, programs, policies and procedures as they relate to CalOptima's medical care delivery system. The DCMO collaborates with directors and medical directors in the operational oversight of the medical division, including Quality Improvement, ~~Medical Data Management~~Quality Analytics, Utilization Management, Case Management, Population Health Management, Pharmacy Management, ~~Long Term Care~~LTSS and other medical management programs.

Chief of Staff (COS) acts as advisor to the CEO and facilitates cross-collaborative development, implementation and improvement of organizational programs and initiatives. COS ~~Carpenter~~ is

responsible for achieving operational efficiencies to support CalOptima's strategic plan, goals and objectives.

~~**Deputy Chief Medical Officer** (DCMO), along with the CMO, oversees strategies, programs, policies and procedures as they relate to CalOptima's medical care delivery system. The DCMO and CMO oversee Quality Analytics (QA), Quality Improvement (QI), Utilization Management (UM), Case Management (CM), Population Health Management (PHM), Pharmacy Management (PM), Behavioral Health Integration (BHI) and, Long Term Services and Supports (LTSS) and Enterprise Analytics (EA).~~

Medical Director (Quality) is the physician designee who chairs the QIC and is responsible for overseeing QI activities and quality management functions. The medical director provides direction and support to CalOptima's Quality and Population Health Management teams to ensure QI Program objectives are met. The medical director is also the physician designee who ~~the~~ chairs ~~of~~ the Credentialing Peer Review Committee (CPRC).

Medical Director (Behavioral Health) is the designated behavioral health care physician~~practitioner~~ in the QI ~~program~~ Program who serves as a participating member of the QIC, as well as the Utilization Management Committee (UMC) and CPRC. The medical director is also the chair of the Pharmacy & Therapeutics Committee (P&T).

Executive Director, Quality & Population Health Management (ED Q&PHM) is responsible for facilitating the companywide QI Program deployment; driving performance results in Healthcare Effectiveness Data and Information Set (HEDIS), DHCS, CMS Star measures and ratings; and maintaining NCQA accreditation standing as a high performing health plan ~~with NCQA.~~. The ED Q&PHM serves as a member of the executive team, and with the CMO, DCMO and ~~ED~~Executive Director, Clinical Operations, supports efforts to promote adherence to established quality improvement strategies and ~~integrating~~ integrate behavioral health across the ~~health care~~ delivery system and populations served. Reporting to the ED Q&PHM are the directors of Quality Analytics, Quality Improvement and Population Health Management~~Behavioral Health Services (Clinical Operations) and Behavioral Health Integration.~~.

Executive Director, Behavioral Health Integration (ED BH) is responsible for oversight of CalOptima's Behavioral Health (BH) program including utilization of services, quality outcomes and the coordination and true integration of care between physical and BH practitioners across all lines of businesses.

Executive Director, Clinical Operations (ED CO) is responsible for oversight of all operational aspects of key Medical Affairs functions, including UM, Care Coordination, Complex Case Management, LTSS and MSSP services, along with new program implementation related to initiatives in these areas. The ED CO serves as a member of the executive team and, with the CMO, DCMO and ED ~~of~~ Q&PHM, makes certain that Medical Affairs is aligned with CalOptima's strategic and operational priorities.

Executive Director, Program Implementation (ED PI) is responsible for maintaining the organization's strategic plan, development and implementation of new programs, operational process improvement activities and community relations. Reporting to ED PI ~~are~~ is the director of ~~both~~ Process Excellence ~~and Strategic Development~~.

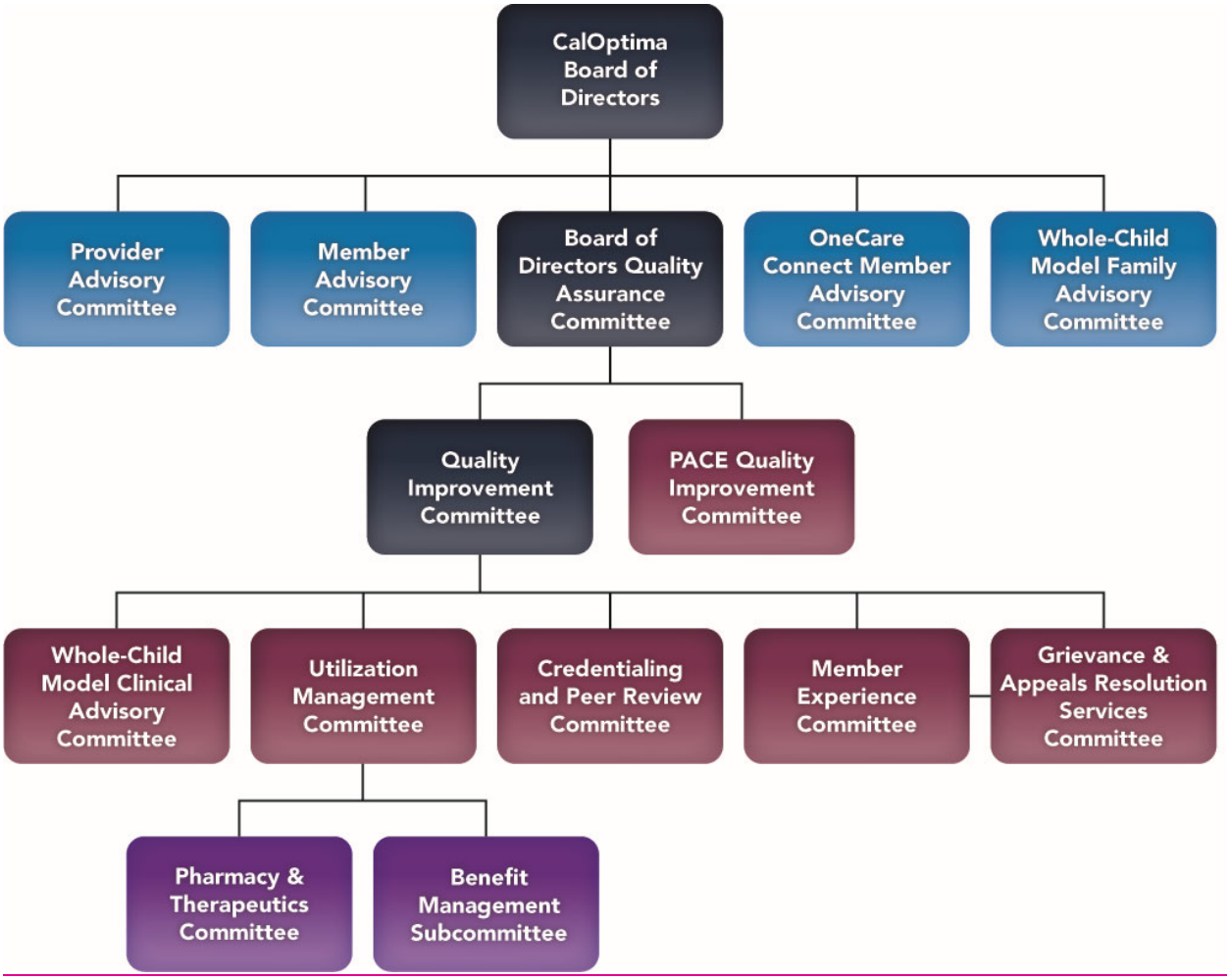
Executive Director, Public Affairs (ED PA) is responsible for CalOptima's Communications, Government Affairs, Community Relations and Strategic Development departments. ED PA is charged with assisting the CEO in carrying out organizational goals, including overseeing the development of the CalOptima Strategic Plan and implementation of communications strategies to highlight CalOptima programs and priorities. Under ED PA's leadership, the Public Affairs team members collaborate on efforts that support the CalOptima mission and reach internal and external audiences, ranging from employees and members to government officials and the media. Reporting to ED PA are the directors of both Communications and Strategic Development.

Executive Director, Compliance (ED C) is responsible for monitoring and driving interventions so that CalOptima and its HNs and other First Tier, Downstream and Related Entities (FDRs) meet the requirements set forth by DHCS, CMS and DMHC. The Compliance staff works in collaboration with the ~~CalOptima~~ Audit & Oversight department~~s (external and internal)~~ to refer any potential ~~sustained~~ noncompliance issues or trends encountered during audits of HNs and other functional areas. The ED C serves as the State Liaison and is responsible for legislative advocacy. Also, the ED C oversees CalOptima's regulatory and compliance functions, including the development and amendment of CalOptima's policies and procedures to ensure adherence to state and federal requirements.

Executive Director, Network Operations (ED NO) leads and directs the integrated operations of the HNs and ~~must~~ coordinates organizational efforts internally and externally with members, providers and community stakeholders. The ED NO is responsible for building an effective and efficient operational unit to serve CalOptima's networks and making sure the delivery of accessible, cost-effective and quality health care services is maintained throughout the service delivery network.

Executive Director, Operations (ED O) is responsible for overseeing and guiding Claims Administration, Customer Service, GARS, Coding Initiatives and Electronic Business.

Committee Organization Structure — Diagram



QUALITY IMPROVEMENT COMMITTEES AND SUBCOMMITTEES

Quality Improvement Committee (QIC)
The QIC is the foundation of the QI ~~program~~ Program and is accountable to the QAC. The QIC assists the CMO in overseeing, maintaining and supporting the QI Program and QI Work Plan activities.

The purpose of the QIC is to assure that all QI activities are performed, integrated and communicated internally and to the contracted delegated ~~health networks~~HNs to achieve the result of improved care and services for members. In collaboration with the Compliance Committee, the QIC oversees the performance of delegated functions by monitoring ~~its~~ delegated ~~health networks~~HNs and their contracted provider and practitioner partners.

The composition of the QIC includes participating practitioners who are external to CalOptima, including a behavioral health practitioner to specifically address integration of behavioral and physical health, appropriate utilization of recognized criteria, development of policies and procedures, case review as needed and identification of opportunities to improve care.

The QIC provides overall direction for the continuous improvement process and evaluates whether activities are consistent with CalOptima's strategic goals and priorities. It supports efforts to ensure that an interdisciplinary and interdepartmental approach is taken, and adequate

resources are committed to the program. It monitors compliance with regulatory and accrediting body standards relating to QI Projects, activities and initiatives. In addition, and most importantly, it makes certain that members are provided optimal quality of care. HEDIS activities and interventions are reviewed, approved, processed, monitored and reported through the QIC.

Responsibilities of the QI Committee include:

- Recommending policy decisions and priority alignment of the QI subcommittees for effective operation and achievement of objectives
- Overseeing the analysis and evaluation of QI activities
- Making certain that there is practitioner participation through attendance and discussion in the planning, design, implementation and review of QI ~~program~~ Program activities
- Identifying and prioritizing needed actions and interventions to improve quality
- Making certain that there is follow up as necessary to determine the effectiveness of quality improvement-related actions and interventions

Practice patterns of providers, practitioners and delegated ~~health networks~~HNs are evaluated, such as UM over/under utilization in collaboration with applied behavioral analysis utilization. Recommendations are made to promote practices that all members receive medical and behavioral health care that meets CalOptima standards.

The QIC oversees and coordinates member outcome-related quality improvement actions. Member outcome-related QI actions consist of well-defined, planned QI ~~Projects~~ projects by which the plan addresses and achieves improvement in major focus areas of clinical and non-clinical services.

The QIC also recommends strategies for dissemination of all study results to CalOptima-contracted providers and practitioners, and delegated ~~health networks~~HNs.

The QI Program adopts the classic Continuous Quality Improvement cycle with four basic steps:

- **Plan** Goals with detailed description of an implementation plan
- **Do** Implementation of the plan
- **Study** Data collection
- **Act** Analyze data and develop conclusions

The composition of the QIC is defined in the QIC Charter and includes, but may not be limited to:

Voting Members

- Four physicians or practitioners, with at least two practicing physicians or practitioners
- County Behavioral Health Representative
- CalOptima ~~CMO~~ Chief Medical Officer (Chair or Designee)

- CalOptima Medical Directors
- CalOptima Behavioral Health Integration~~BH~~ Medical Director (or Designee)
- Executive Director, Quality & Population Health Management
- Executive Director, Clinical Operations
- Executive Director, Network Management
- Executive Director, Operations

The QIC is supported by:

- Director, Quality Improvement
- Director, Quality Analytics
- Director, Population Health Management
- Director, Behavioral Health Integration
- Committee Recorder as assigned

Quorum

A quorum consists of a minimum of six voting members of which at least four are physicians or practitioners. Once a quorum is attained, the meeting may proceed and any vote will be considered official, even if the quorum is not maintained. Participation is defined as attendance in person or participation by telephone.

The QIC shall meet at least eight times per calendar year and report to the Board QAC quarterly.

QIC and all QI subcommittee reports and proceedings are covered under California Welfare & Institution Code § 14087.58(b), Health and Safety Code § 1370, and California Evidence Code §1157. Section 14087.58(b) renders records of QI proceedings, including peer review and quality assessment records, exempt from disclosure under the Public Records Act.

Minutes of the ~~Quality Improvement Committee~~QIC and Subcommittees

Contemporaneous minutes reflect all committee decisions and actions. These minutes are dated and signed by the committee chair to demonstrate that they are representative of the official findings of the committee.

Minutes of the QIC meeting include, but are not limited to:

- Goals and objectives outlined in the QIC Charter
- Active discussion and analysis of quality issues
- Credentialing or re-credentialing issues, as appropriate
- ~~Establishment or approval of clinical practice guidelines~~
- Reports from various committees and subcommittees
- Recommendations, actions and follow-up actions
- Plans to disseminate Quality Management/Improvement information to network providers and practitioners
- Tracking of Work Plan activities

All agendas, minutes, reports and documents presented to the QIC are maintained in a confidential manner. Minutes are maintained in an electronic format and produced only for committee approval.

Credentialing and Peer Review Committee (CPRC)

The CPRC provides guidance and peer input into the CalOptima practitioner and provider selection process and determines corrective actions, as necessary, to ensure that all practitioners and providers who serve CalOptima members meet generally accepted standards for their profession or industry.

The CPRC reviews, investigates and evaluates the credentials of all CalOptima practitioners, which include internal and external physicians who participate on the committee. The committee maintains a continuing review of the qualifications and performance of all practitioners every three years. In addition, the CPRC reviews and monitors sentinel events, quality of care issues and identified trends across the entire continuum of CalOptima's contracted providers, delegated ~~health networks~~HNs and OPs to ensure ~~patient~~ member safety aiming for zero defects. The CPRC, chaired by the CalOptima CMO or physician designee, consists of representation of active physicians from CCN and HNs. Physician participants represent a range of practitioners and specialties from CalOptima's network. CPRC meets a minimum of six times per year and reports through the QIC. The voting member composition and quorum requirements of the CPRC are defined in its charter.

Utilization Management Committee (UMC)

The UMC promotes the optimum utilization of health care services, while protecting and acknowledging member rights and responsibilities, including their right to appeal denials of service. The UMC is multidisciplinary and provides a comprehensive approach to support the UM Program in the management of resource allocation through systematic monitoring of medical necessity and quality, while maximizing the cost effectiveness of the care and services provided to members.

The UMC monitors the utilization of medical, behavioral health and ~~Long Term Services and Support (~~LTSS services for ~~the CalOptima Care Network (~~CCN and through the delegated ~~health networks~~HNs to identify areas of underutilization or overutilization that may adversely impact member care. The UMC oversees Inter-Rater Reliability (IRR) testing to support consistency of application in nationally recognized criteria for making medical necessity determinations, as well as development of evidence-based clinical practice guidelines, and completes an annual review and updates the clinical practice guidelines to make certain they are in accordance with recognized clinical organizations, are evidence-based, and comply with regulatory and other agency standards. These clinical practice guidelines and nationally recognized evidenced-based guidelines are approved annually, at minimum, at the UMC. The UMC meets quarterly and reports through the QIC. The voting member composition (including a behavioral health practitioner*) and the quorum requirements of the UMC are defined in its charter.

* Behavioral Health practitioner is defined as medical director, clinical director or participating practitioner from the organization.

Pharmacy & Therapeutics Committee (P&T) ~~(P&T)~~

The P&T ~~committee~~ is a forum for an evidence-based formulary review process. The P&T ~~committee~~ promotes clinically sound and cost-effective pharmaceutical care for all CalOptima members. ~~, and~~It reviews ~~anticipated~~anticipated and actual drug utilization trends, parameters and results based on specific categories of drugs and formulary initiatives, as well as the overall program. In addition, the P&T ~~committee~~ reviews and evaluates current pharmacy-related issues that are interdisciplinary, involving interface between medicine, pharmacy and other practitioners involved in the delivery of health care to CalOptima's members. The P&T ~~committee~~ includes practicing physicians (including both CalOptima employee physicians and participating provider physicians), and the membership represents a cross-section of clinical specialties and clinical pharmacists in order to adequately represent the needs and interests of all plan members. The P&T ~~committee~~ provides written decisions regarding all formulary development decisions and revisions. The P&T ~~committee~~ meets at least quarterly and reports to the UMC. The voting member composition and quorum requirements of the P&T ~~committee~~ are defined in its charter.

Benefit Management Subcommittee (BMSC)

The purpose of the BMSC is to oversee, coordinate and maintain a consistent benefit system as it relates to CalOptima's responsibilities for administration of ~~all its lines of business~~ benefits, prior authorization and financial responsibility requirements ~~for the administration of benefits~~. The ~~subcommittee~~ BMSC reports to the UMC and ensures that benefit updates are implemented and communicated accordingly to internal CalOptima staff, and are provided to contracted HMOs, PHCs and SRGs. The Regulatory Affairs and Compliance department provides technical support to the subcommittee, which includes, but is not limited to, analyzing regulations and guidance that impacts the benefit sets and CalOptima's authorization rules. The voting member composition and quorum requirements of the BMSC are defined in its charter.

Whole-Child Model Clinical Advisory Committee (WCM CAC)

~~The WCM CAC was formed in 2018 pursuant to DHCS All Plan Letter 18-023.~~ The WCM CAC advises on clinical and behavioral issues relating to CCS conditions, including such matters as treatment authorization guidelines, and ensuring they are integrated into the design, implementation, operation and evaluation of the CalOptima WCM program. The WCM CAC works in collaboration with county CCS, the WCM ~~Family Advisory Committee~~FAC and HN CCS providers. The WCM CAC meets four times a year and reports to the QIC. The voting member composition and quorum requirements of the WCM CAC are defined in its charter.

Member Experience Committee (MEMX)

Improving member experience is a top priority of CalOptima. The MEMX committee was formed to ensure strategic focus on the issues and factors that influence the member's experience with the health care system for Medi-Cal, OC and OCC. NCQA's Health Insurance Plan Ratings measure three dimensions: prevention, treatment and customer satisfaction. The MEMX committee is designed to assess the annual results of CalOptima's Consumer Assessment of Healthcare Providers and Systems (CAHPS)~~CAHPS~~ surveys; monitor the provider network, including access and availability; ~~(CCN and the HNs)~~ review customer service metrics; and evaluate complaints, grievances, appeals, authorizations and referrals for "pain points" in health care that impact our members at the plan and ~~health network~~HN level (including CCN), where appropriate. In ~~2021~~2022, the MEMX committee, which includes the Access and Availability

workgroup, will continue to meet at least quarterly and will be held accountable to implement targeted initiatives to improve member experience and demonstrate significant improvement in the MY ~~2021~~ 2022 and MY ~~2022~~ 2023 CAHPS survey results.

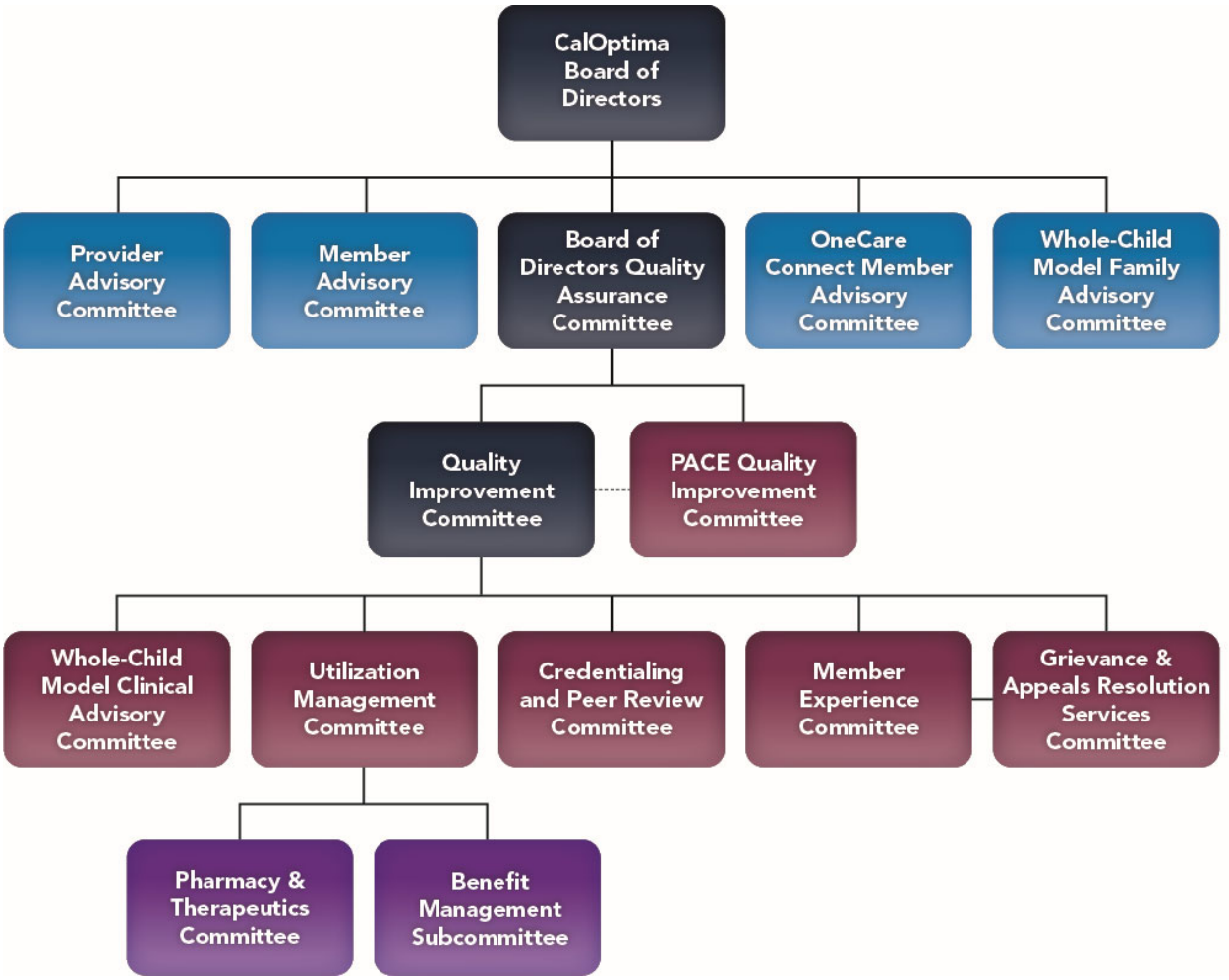
Grievance and Appeals Resolution Services (GARS) Committee ~~(GARS)~~

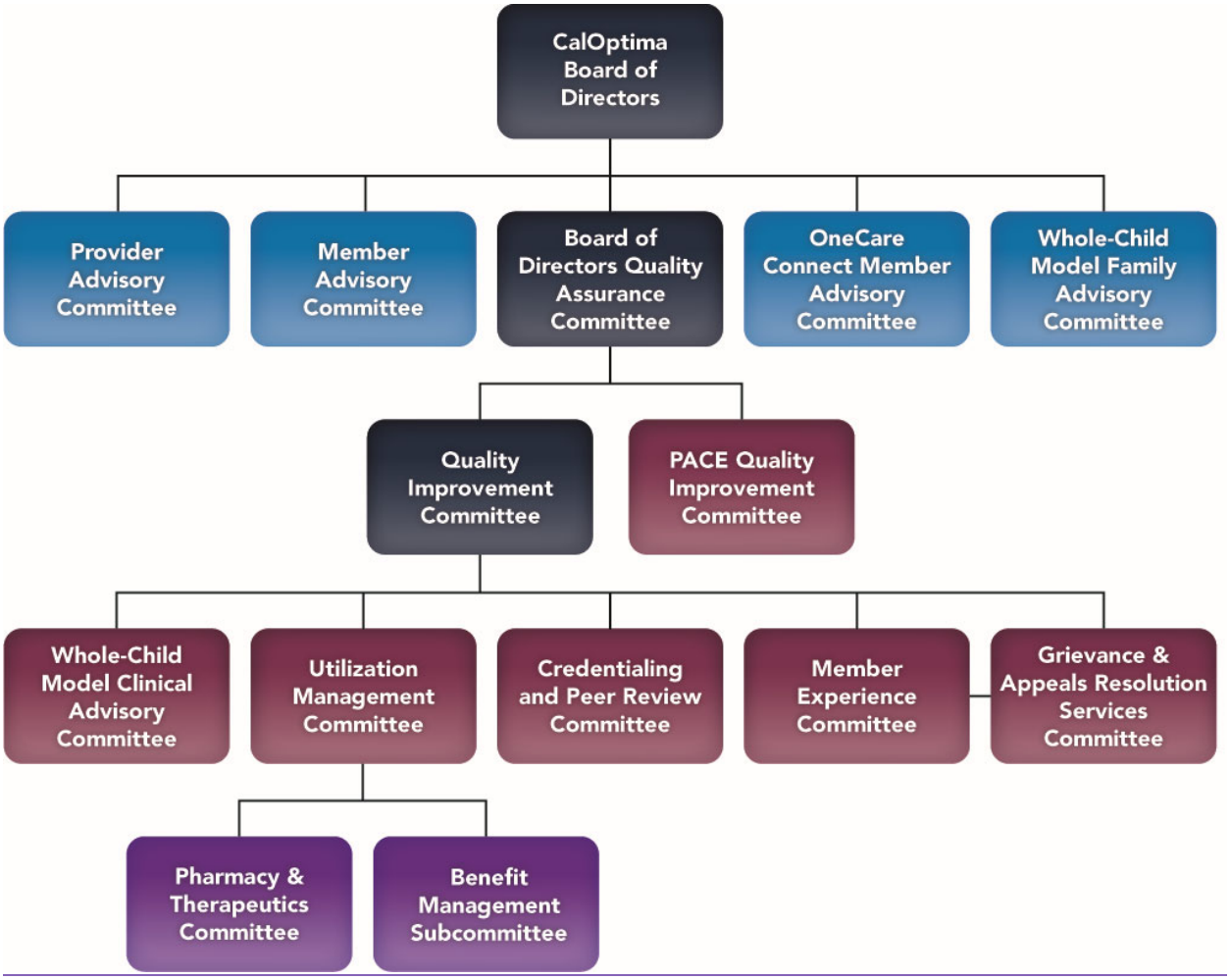
The GARS ~~committee~~ Committee serves to protect the rights of ~~our~~ members, promote the provision of quality health care services and ensure that the policies of CalOptima are consistently applied to resolve member complaints in an equitable and compassionate manner through oversight and monitoring. The GARS ~~committee~~ Committee serves to provide a mechanism to resolve provider complaints and appeals expeditiously for all CalOptima providers. It protects the rights of practitioners and providers by providing a multilevel process that is fair and progressive in nature, leading to the resolution of provider complaints. The GARS ~~committee~~ Committee meets at least quarterly and reports through the QIC. The voting member composition and quorum requirements of the GARS Committee are defined in its charter.

~~Program of All-Inclusive Care for the Elderly Quality Improvement Committee (PQIC)~~

~~The PQIC committee provides oversight for the overall administrative and clinical operations of CalOptima PACE. The PQIC assures compliance to all state and federal regulatory bodies. The PQIC may create new ad hoc committees or task forces to improve specific clinical or administrative processes that have been identified as critical to participants, families or staff. The PQIC meets, at a minimum, quarterly and is chaired by the PACE Medical Director. A summary of the PQIC meetings are submitted to the CalOptima Quality Improvement Committee (QIC), which are then included in the QIC summary submitted to the CalOptima Board of Directors Quality Assurance Committee (QAC). Annually, the PQIC will assess all PACE quality improvement initiatives, review the results of monitoring activities, provide oversight for proposed changes to improve quality of service and review follow up of all changes implemented. Potential areas for improvement will be identified through analysis of the data and through root cause analysis.~~

~~Committee Organization Structure Diagram~~





Confidentiality

CalOptima has policies and procedures to protect and promote proper handling of confidential and privileged medical record information. Upon employment, all CalOptima employees — including contracted professionals who have access to confidential or member information — sign a written statement delineating responsibility for maintaining confidentiality. In addition, all committee members of each entity are required to sign a confidentiality agreement on an annual basis. Invited guests must sign a confidentiality agreement at the time of committee attendance.

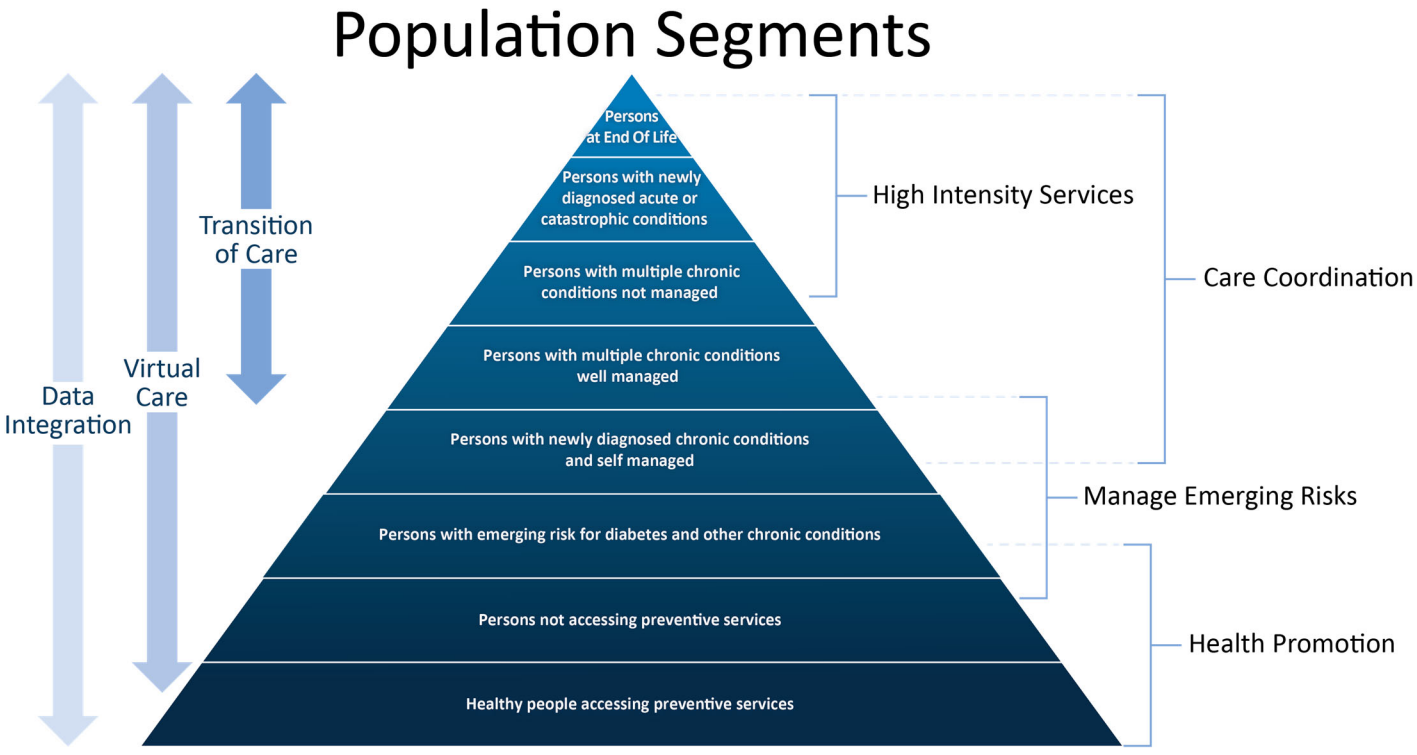
All records and proceedings of the QI Committee and the subcommittees related to member- or practitioner-specific information are confidential and are subject to applicable laws regarding confidentiality of medical and peer review information, including Welfare and Institutions Code section 14087.58, which exempts the records of QI proceedings from the California Public Records Act. All information is maintained in confidential files. The delegated networks hold all information in the strictest confidence. Members of the QI Committee and the subcommittees sign a confidentiality agreement. This agreement requires the committee member to maintain confidentiality of any and all information discussed during the meeting. The CEO, in accordance with applicable laws regarding confidentiality, issues any QI reports required by law or by the state contract.

Conflict of Interest

CalOptima maintains a Conflict of Interest policy that addresses the process to identify and evaluate potential social, economic and professional conflicts of interest and take appropriate actions so that they do not compromise or bias professional judgment and objectivity in quality, credentialing and peer review matters. This policy precludes using proprietary or confidential CalOptima information for personal gain or the gain of others, as well as direct or indirect financial interests in, or relationships with, current or potential providers, suppliers or members, except when it is determined that the financial interest does not create a conflict. The policy includes an attestation that is completed annually by all appointed, volunteer or employed positions serving on the QI/UM committees and subcommittees. Additionally, all employees who make or participate in the making of decisions that may foreseeably have a material effect on economic interests file a Statement of Economic Interests form on an annual basis.

QUALITY IMPROVEMENT STRATEGIC GOALS

The QI Program and structure provides operational support and oversight to a member-centric Population Health Management (PHM) approach, by stratifying the population based on their health needs, conditions and issues, and aligns the appropriate resources to meet these needs. Building upon CalOptima's existing innovative Model of Care (MOC), the ~~2021~~2022 QI Work Plan will focus on building out additional services leveraging telehealth technology to engage the new population segments currently not served, such as the population with emerging risk or experiencing social determinants of health. The Population Segments with an integrated intervention hierarchy, is shown below.



CalOptima's MOC recognizes the importance of mobilizing multiple resources to support our members' health needs. The coordination between our various medical and behavioral health

providers, pharmacists and care settings, plus our internal experts, supports a member-centric approach to care/care coordination. The current high-touch MOC is ~~very~~ effective in managing the health care needs of high-risk members one by one. By enhancing the service capabilities and the transition of care process leveraging telehealth and mobile technology, the current MOC can be scaled to address the health care needs of the population segments identified through systematic member segmentation and stratification using integrated data sets.

~~2021~~2022 QI Goals and Objectives

CalOptima's QI Goals and O~~o~~bjectives are aligned with CalOptima's ~~2021~~2022 ~~2022~~ ~~20~~23 Strategic Goals.

1) Develop and implement a comprehensive Health Equity framework that transforms practices, policies and systems at the member, organizational, and community levels.
~~1) Support our alignment with Department of Health Care Services by…Health Equity~~
~~1)~~ ~~2)~~ Ensure member's safety during COVID-19 pandemic by a~~A~~iming for ~~9~~80% COVID-19 vaccine rate or community immunity~~, as a stretch goal to ensure member's safety during COVID-19 pandemic.~~
2)
3) ~~2)~~ Improve quality of care and member experience by m~~M~~aintaining NCQA Health Plan Rating of 4.0, and at least a ~~3~~Three-Star Rating for Medicare.

~~1.~~ ~~3) a.~~ Engage providers through the provision of new Pay for Value (P4V) program for Medi-Cal and the new OneCare programs through ~~Develop and receive Board of Directors approval for a new P4V program for new OneCare program to~~ incentivize measures related to our STAR rating~~Aim for 70% COVID-19 vaccine rate as a stretch goal to ensure member safety during COVID-19 pandemic.~~

~~2. Improve member's ability to access primary and specialty care for routine appointments by 10 percentage points from 2019 baseline.~~

~~3.~~4) ~~Achieve Accredited NCQA status post 2021 Renewal Survey, and maintain NCQA overall rating at 4.0~~

These top ~~three~~ four priority goals were chosen to be aligned with CalOptima's strategic objectives, ~~related to~~ the pandemic, as well as continued goals related to access to care and NCQA accreditation. The ~~2021~~2022 QI Workplan details the planned activities to meet the COVID-19 vaccine aim, which include ~~an~~ strategies for immunization ~~strategy~~, ~~a~~ targeted communication ~~strategy~~ and a member incentive ~~strategy~~. The planned activities related to members' ability to access care are captured ~~in the Virtual Care strategy, as well~~ as a communication and corrective action strategy for providers not meeting timely access standards (as measured by the annual Timely Access study). ~~Finally, the goal of achieving NCQA Accredited status in 2021 and maintain overall health plan rating is high priority since CalOptima will be~~is pursing re-accreditation in July of 2021. All goals and sub-goals will be measured and monitored in the QI Workplan, reported to QIC quarterly and evaluated annually.

QI Measurable Goals for the Model of Care

The MOC is member-centric by design, and it monitors, evaluates and acts upon the coordinated provisions of seamless access to individualized, quality health care for ~~the OneCare and OneCare Connect programs~~OC and OCC. The MOC meets the needs of special member populations through strategic activities. Measurable goals are established and reported annually.

The MOC goals are:

- Improving access to essential services
- Improving access to preventive health services
- Assuring appropriate utilization of services
- Assuring proper identification of ~~Social Determinants of Health (SDOC)~~SDOH
- Improving coordination of care through an identified point of contact
- Improving seamless transitions of care across health care settings, providers and health services
- Improving integration of medical, behavioral health and pharmacy services
- Improving beneficiary health outcomes

A formal annual performance evaluation is conducted and strategies for continuous improvement for the coming year are established. Results are evaluated and reported annually.

QI Work Plan

The QI Work Plan outlines key activities for the upcoming year. It is reviewed and approved by the QIC and ~~CalOptima's~~ the Board of Directors' Quality Assurance Committee. The QI Work Plan indicates objectives, scope, timeline, planned monitoring and accountable persons for each activity. Progress against the QI Work Plan is monitored throughout the year. A QI Work Plan addendum may be established to address the unique needs of members in special needs plans or other health plan products, as needed, to capture the specific scope of the plan.

The QI Work Plan is the operational and functional component of the QI Program and is based on CalOptima strategic priorities and the most recent and trended HEDIS, ~~Consumer Assessment of Healthcare Providers and Systems (~~CAHPS, Stars and Health Outcomes Survey (HOS) scores, physician quality measures and other measures identified for attention, including any specific requirements mandated by the state or accreditation standards, where these apply. As such, measures targeted for improvement may be adjusted mid-year when new scores or results are received.

The QI Program guides the development and implementation of an annual QI Work Plan, which includes, but is not limited to:

- Quality of clinical care
- Safety of clinical care
- Quality of service
- Member experience
- QI Program oversight
- Yearly objectives
- Yearly planned activities
- Time frame for each activity's completion

- Staff member responsible for each activity
- Monitoring of previously identified issues
- Annual evaluation of the QI Program

Priorities for QI activities based on CalOptima's organizational needs and specific needs of CalOptima's populations for key areas or issues are identified as opportunities for improvement. In addition, ongoing review and evaluation of the quality of individual ~~patient~~ care aids in the development of QI studies based on quality of care trends identified. These activities are included in Quality Improvement Project (QIP), Performance Improvement Project (PIP), Plan-Do-Study-Act (PDSA) and Chronic Care Improvement Projects (CCIP). They are reflected in the QI Work Plan. Additional COVID-19 focused initiatives are integrated into the ~~2021~~2022 QI Work Plan.

The QI Work Plan supports the comprehensive annual evaluation and planning process that includes review and revision of the QI Program and applicable policies and procedures.

See Appendix A — ~~2021~~2022 QI Work Plan

Methodology

QI Project Selections and Focus Areas

Performance and outcome improvement projects will be selected from the following areas:

- Areas for improvement identified through continuous internal monitoring activities, including, but not limited to, (a) potential quality issue (PQI) review processes, (b) provider and facility reviews, (c) preventive care audits, (d) access to care studies, (e) member experience surveys, (f) HEDIS results and (g) other opportunities for improvement as identified by subcommittee's data analysis

- Measures required by regulators, such as DHCS and CMS

The QI Project methodology described below will be used to continuously review, evaluate and improve the following aspects of clinical care: preventive services, perinatal care, primary care, specialty care, emergency services, inpatient services, ~~long-term services and supports,~~LTSS and ancillary care services, with specific emphasis on the following areas:

- Access to and availability of services, including appointment availability
- Coordination and continuity of care for ~~SPD~~Seniors and Persons with Disabilities (SPD)
- Provisions of chronic, complex case management and case management services
- Access to and provision of preventive services

Improvements in work processes, quality of care and service are derived from all levels of the organization. For example:

- Staff, administration and physicians provide vital information necessary to support continuous performance improvement and occurs at all levels of the organization.

- Individuals and administrators initiate improvement projects within their area of authority that support the strategic goals of the organization.

- Other prioritization criteria include the expected impact on performance (if the performance gap or potential of risk for non-performance is so great as to make it a priority), and items deemed to be high risk, high volume or problem-prone processes.

- Project coordination occurs through the various leadership structures: Board of Directors, management, QIC, UMC, etc., based upon the scope of work and impact of the effort.

- These improvement efforts are often cross-functional and require dedicated resources to assist in data collection, analysis and implementation. Improvement activity outcomes are shared through communication that occurs within the previously identified groups.

~~**QI Project Quality Measures**~~

~~Quality measures may be process measures (lead quality measures) or outcome measures (lag quality measures) where there is strong clinical evidence of the correlation between the process and member outcomes. This evidence, and the rationale for selection of the lead quality measure, must be cited in the project description, when appropriate.~~

~~Each QI Project will have at least one (and frequently more) lead measure(s) that are actionable in real time. The selected lead measures should be levers, drivers or predictors of the desired outcome measures or lag quality measure, such as HEDIS and STARS measures. While at least one lead measure must be identified at the start of a project, more may be identified after analysis of baseline measurement or re-measurement. Since quality measures will measure changes in health status, functional status, member satisfaction, and provider/staff, delegated HN, or system performance, quality measures will be clearly defined and objectively measurable.~~

QI Project Measurement Methodology

Methods for identification of target populations will be clearly defined. Data sources may include encounter data, authorization/claims data or pharmacy data. To prevent exclusion of specific member populations, data from the Clinical Data Warehouse will be utilized.

For outcomes studies or measures that require data from sources other than administrative data (e.g., medical records), sample sizes will be a minimum of 411 (with 5%–10% over sampling), in order to conduct statistically significant tests on any changes. Exceptions are studies for which the target population total is less than 411 and for certain HEDIS studies whose sample size is reduced from 411 based on CalOptima's previous year's score. Also, smaller sample size may be appropriate for QI pilot projects that are designed as small tests of change using rapid improvement cycle methodology. For example, a pilot sample of 30% or 100% of the sample size when target population is less than 30 can be statistically significant for QI pilot projects.

CalOptima also uses a variety of QI methodologies depending on the type of opportunity for improvement identified. The ~~Plan/Do/Study/Act~~PDSA model is the overall framework for continuous process improvement. This includes:

Plan 1) Identify opportunities for improvement
2) Define baseline
3) Describe root cause(s)
4) Develop an action plan
Do 5) Communicate change plan
6) Implement change plan
Study 7) Review and evaluate result of change
8) Communicate progress
Act 9) Reflect and act on learning
10) Standardize process and celebrate success

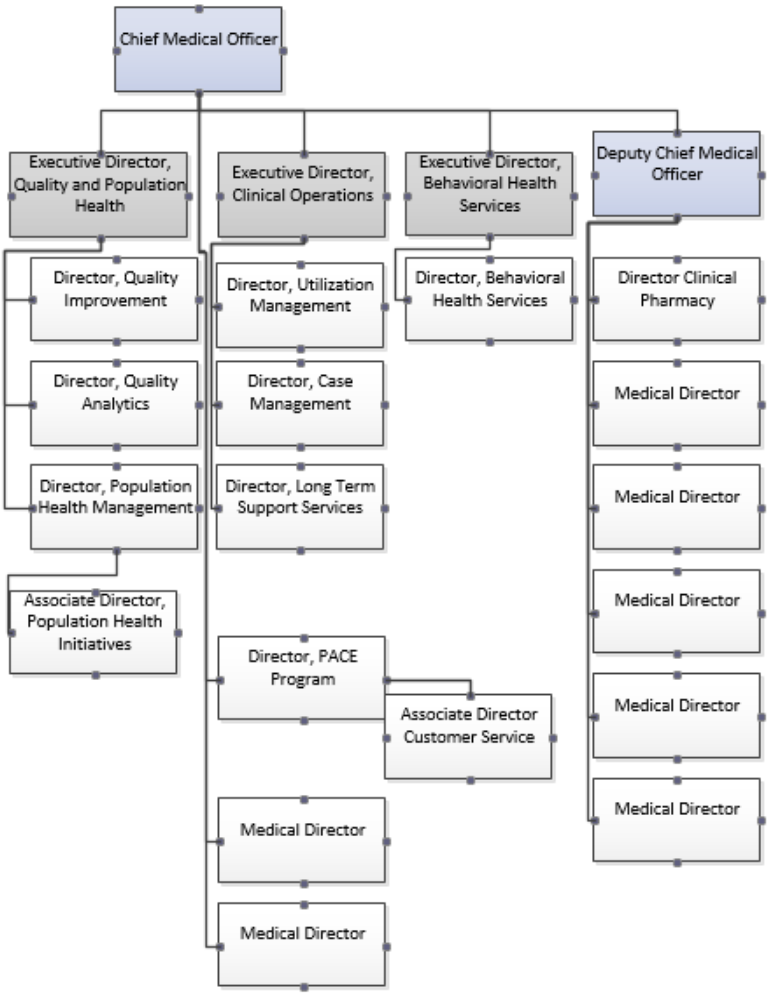
Communication of QI Activities

Results of performance improvement and collaborative activities will be communicated to the appropriate department, multidisciplinary committee or administrative team as determined by the nature of the issue. The frequency will be determined by the receiving groups and be reflected on the QI Work Plan or calendar. The QI subcommittees will report their summarized information to the QIC at least quarterly in order to facilitate communication along the continuum of care. The QIC reports activities to the ~~Quality Assurance Committee~~QAC of the Board of Directors, through the CMO or designee, on a quarterly basis. Communication of QI trends to CalOptima's contracted entities, ~~and~~ practitioners and providers is through the following:

- Practitioner participation in the QIC and its subcommittees
- HN Forums, ~~Medical~~ medical ~~Directors~~ directors' meetings, Quality Forums and other ongoing ad hoc meetings
- ~~Annual synopsized QI report is posted on CalOptima's website (both website and hard copy are available for both practitioners and members). The information includes a QI Program Executive Summary and highlights applicable to the Quality Program, its goals, processes and outcomes as they relate to member care and service. Notification on how to obtain a paper copy of QI Program information is posted on CalOptima's website, and is made available upon request~~

- MAC, OCC MAC, WCM FAC and PAC~~.~~

QUALITY PROGRAM ORGANIZATION STRUCTURE - DIAGRAM


Chief Medical Officer
Executive Director, Quality and Population Health
Executive Director, Clinical Operations
Executive Director, Behavioral Health Services
Deputy Chief Medical Officer
Director, Quality Improvement
Director, Utilization Management
Director, Behavioral Health Services
Director Clinical Pharmacy
Director, Quality Analytics
Director, Case Management
Medical Director
Director, Population Health Management
Director, Long Term Support Services
Medical Director
Associate Director, Population Health Initiatives
Medical Director
Director, PACE Program
Associate Director Customer Service
Medical Director
Medical Director
Medical Director
Medical Director

QUALITY IMPROVEMENT PROGRAM RESOURCES

CalOptima's budgeting process includes personnel, ~~IS~~ Information Technology Services resources and other administrative costs projected for the QI Program. The resources are revisited on a regular basis to promote adequate support for CalOptima's QI Program.

The QI staff directly impacts and influences the QI Committee and related committees through monitoring, evaluation and interventions, providing the various committees with outcomes and effectiveness of corrective actions.

In addition to CalOptima's CMO and ED, Q&PHM, the following staff positions provide direct support for organizational and operational QI Program functions and activities:

Director, Quality Improvement
Responsibilities include assigned day-to-day operations of the Quality Management ~~(QM)~~ functions, including credentialing, ~~Facility facility Site site Reviewsreview~~FSRs, ~~Physical~~ physical ~~Accessibility~~ accessibility ~~Compliance~~ compliance and working with the ED, Q&PHM to oversee the QI Program and maintain NCQA accreditation. This position is also responsible for implementation of the QI Program and QI Work Plan implementation.

The following positions report to the Director, Quality Improvement:

- Manager, Quality Improvement
- Supervisor, Quality Improvement (PQI)
- Supervisor, Quality Improvement (Nursing Facilities)~~and Master Trainer (FSR)~~ (CBAS) (FSR)
- Supervisor, Quality Improvement (Credentialing)
- QI Nurse Specialists (RN) (LVN)
- Program Policy Analyst
- Credentialing Coordinators
- Program Specialists (including Intermediate and Senior)
- Program Assistants
- Outreach Specialists
- Auditors

Director, Quality Analytics
Provides data analytical direction to support quality measurement activities for the agencywide QI Program by managing, executing and coordinating QI activities and projects, aligned with the QI department supporting clinical operational aspects of quality management and improvement. Provides coordination and support to the QIC and other committees to support compliance with regulatory and accreditation agencies.

The following positions report to the Director, Quality Analytics:

- ~~Quality Analytics HEDIS~~ Manager, Quality Analytics (HEDIS)
- ~~Quality Analytics Pay for Value~~ Manager, Quality Analytics (Pay for Value)
- ~~Quality Analytics Network Adequacy~~ Manager, Quality Analytics (Network Adequacy)
- ~~Quality Analytics Data Analytics~~ Manager, Quality Analytics (Data Analytics)

- ~~Quality Analytics~~ Analysts
- ~~Quality Analytics~~ Project Managers
- ~~Quality Analytics~~ Program Coordinators
- ~~Quality Analytics~~ Program Specialists

Director, Population Health Management
Provides direction for program development and implementation for agencywide population health initiatives, including telehealth. Ensures linkages supporting a whole-person perspective to health care with Case Management, UM, Pharmacy Management and Behavioral Health Integration. Provides direct care coordination and health education for members participating in non-delegated health programs, such as Perinatal Support Services (Bright Steps) and Childhood Obesity Prevention Program (Shape Your Life). Also, supports the MOC implementation for members. Reports program progress and effectiveness to QIC and other committees to support compliance with regulatory and accreditation agency requirements.

The following positions report to the Director, Population Health Management:
- Associate Director, Population Health Initiatives
- Population Health Management Manager (Quality Initiatives)
- Population Health Management Manager (Clinical Operations)
- Population Health Management Manager (Health Education)
- Population Health Management Manager (Maternal Health)
- Population Health Management Supervisors
- Program Managers
- Health Coaches
- Registered Dieticians
- Senior Health Educators
- Health Educators
- Quality Analysts
- Program Specialists
- Program Assistants
- ~~Population Health Management Manager (Program Design)~~
- ~~Population Health Management Manager (Operations)~~
- ~~Population Health Management Supervisor (Operations)~~
- ~~Health Education Manager~~
- ~~Health Education Supervisor~~
- ~~Population Health Management Health Coaches~~
- ~~Senior Health Educator~~
- ~~Health Educators~~
- ~~Registered Dietitians~~
- ~~Data Analyst~~
- ~~Program Manager~~
- ~~Program Specialists~~
- ~~Program Assistant~~

Director, Behavioral Health Integration
Provides program development and leadership to the implementation, expansion and/or improvement of processes and services that lead to the integration of physical and behavioral health care services for CalOptima members across all lines of business. The director is

responsible for the management and strategic direction of the Behavioral Health Integration department efforts in integrated care, quality initiatives and community partnerships. The director ensures departmental compliance with all local, state and federal regulations and that accreditation standards and all policies and procedures meet current requirements.

~~**Director, Behavioral Health Services (Clinical Operations)**~~

~~Provides clinical operational oversight and leadership to the implementation, expansion and/or improvement of processes and services of the Behavioral Health Integration department clinical services. The Director leads a team that provides behavioral health telephonic clinical triage, care coordination and UM for members in all lines of business.~~

~~In addition to the direct QI resources described above, the following positions and areas support key aspects of the overarching QI Program, and our member-focused approach to improving our members' health status.~~

Director, Utilization Management

Assists in the development and implementation of the UM program, policies and procedures. This director ensures the appropriate use of evidenced-based clinical review criteria/guidelines for medical necessity determinations. The director also provides supervisory oversight and administration of the UM program, oversees all clinical decisions rendered for concurrent, prospective and retrospective reviews that support UM medical management decisions, serves on the ~~Utilization~~ UM committees and participates in the QIC and the ~~Benefit Management subcommittee~~BMSC.

Director, Clinical Pharmacy Management

Leads the development and implementation of the Pharmacy Management ~~(PM)~~ program, develops and implements ~~PM~~ Pharmacy Management department policies and procedures, ensures that a licensed pharmacist conducts reviews on cases that do not meet review criteria/guidelines for any potential adverse determinations, provides supervision of the coordination of pharmacy-related clinical affairs, and serves on the ~~Pharmacy & Therapeutics Committee~~P&T and UMC ~~cCommittees~~. The director also guides the identification and interventions on key pharmacy quality and utilization measures.

Director, Case Management

Responsible for Case Management, Transitions of Care, Complex Case Management and the clinical operations of Medi-Cal, OCC and OC. The director supports improving quality and access through seamless care coordination for targeted member populations, and develops and implements policies, procedures and processes related to program operations and quality measures.

Director, Long-Term Services and Supports (LTSS)

Responsible for LTSS programs, which include CBAS, LTC and MSSP. The position supports a member-centric approach and helps keep members in the least restrictive living environment, collaborates with community partners and other stakeholders, and ensures LTSS are available to appropriate populations. The director also develops and implements policies, procedures and processes related to LTSS program operations and quality measures.

~~**Director, Enterprise Analytics**~~

~~Provides leadership across CalOptima in the development and distribution of analytical capabilities. The director drives the development of the strategy and road map for analytical capability and leads a centralized enterprise analytical team that interfaces with all departments and key external constituents to execute the road map. Working with departments that supply~~

~~data, the team is responsible for developing or extending the data architecture and data definitions. Through work with key users of data, the Enterprise Analytics department develops platforms and capabilities to meet critical information needs of CalOptima.~~

Staff Orientation, Training and Education

CalOptima seeks to recruit highly qualified individuals with extensive experience and expertise in health services ~~for staff positions~~. Qualifications and educational requirements are delineated in the respective position descriptions ~~of the respective positions~~.

Each new employee is provided intensive orientation and job-specific training with a staff member. The following topics are covered during the introductory period, with specific training, as applicable to individual job descriptions:

- CalOptima New Employee Orientation and Boot Camp (CalOptima programs)
- HIPAA and Privacy
- Fraud, Waste and Abuse, Compliance and Code of Conduct training
- Workplace Harassment Prevention training
- Use of technical equipment (phones, computers, printers, ~~facsimile~~ fax machines, etc.)
- Applicable department program training, policies and procedures, etc.
- Seniors and Persons with Disabilities Awareness training
- Cultural Competency, Bias or Inclusion and Trauma-Informed Care training

MOC-related employees, contracted providers and practitioner networks are trained at least annually on the MOC. The MOC training is a part of the comprehensive orientation process, and includes face-to-face, interactive and web-based platforms as well as paper format.

CalOptima encourages and supports continuing education and training for employees, which increases competency in their present jobs and/or prepares them for career advancement within CalOptima. Each year, a specific budget is set for education reimbursement for employees.

Annual Program Evaluation ~~*G:\QIC\QAC Holding Folder\2022_03-09 (Due 02.11.22)\QI Report*~~

The objectives, scope, organization and effectiveness of CalOptima's QI Program are reviewed and evaluated annually by the QIC and QAC, and approved by the Board of Directors, as reflected ~~on~~ in the QI Work Plan. Results of the written annual evaluation are used as the basis for formulating the next year's initiatives and are incorporated into the QI Work Plan and reported to DHCS and CMS on an annual basis. In the evaluation, the following are reviewed:

- A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of services, including the achievement or progress toward goals, as outlined in the QI Work Plan, and identification of opportunities for improvement

- Trending of measures to assess performance in the quality and safety of clinical care and quality of service, including aggregate data on utilization

- An assessment of the accomplishments from the previous year, as well as identification of the barriers encountered in implementing the annual plan through root cause and barrier analyses, to prepare for new interventions

- An evaluation of QI activities, including QIPs, PIPs, PDSAs and CCIPs

- An evaluation of member satisfaction surveys and initiatives

- A report to the QIC and QAC of a summary of all quality measures and identification of significant trends

- A critical review of the organizational resources involved in the QI Program through the CalOptima strategic planning process

- Recommended changes included in the revised QI Program Description for the subsequent year for QIC, QAC and the Board of Directors' review and approval

KEY BUSINESS PROCESSES, FUNCTIONS, IMPORTANT ASPECTS OF CARE AND SERVICE

CalOptima provides comprehensive acute and preventive care services, which are based on the philosophy of a medical home for each member. The primary care practitioner is this medical home for members who previously found it difficult to access services within their community.

The Institute of Medicine describes the concepts of primary care and community-oriented primary care, which apply to the CalOptima model:

- Primary care, by definition, is accessible, comprehensive, coordinated and continual care delivered by accountable providers of personal health services.

- Community-oriented primary care is the provision of primary care to a defined community, coupled with systematic efforts to identify and address the major health problems of that community.

The important aspects of care and service around which key business processes are designed include:

- Clinical care and service
- Access and availability
- Continuity and coordination of care
- Preventive care, including:
  - Initial Health Assessment
  - Initial Health Education
  - Behavioral Assessment
- ~~Patient d~~Diagnosis, care and treatment of acute and chronic conditions

- Complex case management: ~~CalOptima coordinates services for~~For members with multiple and/or complex conditions to obtain access to care and services via the ~~Utilization~~ UM and Case Management departments~~, which details this process in its UM and CM Programs and other related policies and procedures.~~
- Drug utilization
- Health education and promotion
- Over/underutilization
- Disease management

Administrative oversight:

- Delegation oversight
- Member rights and responsibilities
- Organizational ethics
- Effective utilization of resources
- Management of information
- Financial management
- Management of human resources
- Regulatory and contract compliance
- Customer satisfaction
- Fraud and abuse* as it relates to quality of care

* CalOptima has a zero-tolerance policy for fraud and abuse, as required by applicable laws and ~~its~~ regulatory contracts. The detection of fraud and abuse is a key function of the CalOptima program.

QUALITY IMPROVEMENT

The QI department is responsible for monitoring quality of care issues and assuring the credentialing standards, policies and procedures are implemented to provide a qualified provider network for our members. The QI department fully aligns with the other areas of the QI team to support the organizational mission, strategic goals and processes to monitor and drive improvements to the quality of care and services, and ensure that care and services are rendered appropriately and safely to all CalOptima members.

QI department activities include:

- Monitor, evaluate and act to improve clinical outcomes for members
- Design, manage and improve work processes, clinical, service, access, member safety and quality-related activities
  - Drive improvement of quality of care received
  - Minimize rework and unnecessary costs
  - Measure the member experience of accessing and getting needed care
  - Empower staff to be more effective
  - Coordinate and communicate organizational information, both ~~division, and~~ department-specific ~~, as well as~~and agencywide
- Evaluate and monitor provider credentials

- Support the maintenance of quality standards across the continuum of care for all lines of business
- Monitor and maintain agencywide practices that support accreditation and meet regulatory requirements

Peer Review Process for Potential Quality Issues

Peer Review is coordinated through the QI department. Medical staff triage potential quality of care issues and conduct reviews of suspected physician and ancillary quality of care issues. All potential quality of care cases are reviewed by a medical ~~Director~~ director who determines a proposed action, dependent on the severity of the case. The ~~Medical~~ medical ~~Director~~ director presents these cases to CPRC, which provides the final action(s). The QI department tracks, monitors and trends PQI cases to determine if there is an opportunity to improve care and service. Results of Quality of Care reviews, and tracking and trending of service and access issues, are reported to the CPRC and are also reviewed at the time of recredentialing. Potential quality of care case referrals are sent to the QI department from multiple areas at CalOptima, which include, but are not limited to, prior authorization, concurrent review, case management, legal, compliance, customer service, pharmacy or GARS, as well as from providers and other external sources.

Comprehensive Credentialing Program Standards

The comprehensive credentialing process is designed to provide ongoing verification of the practitioner's ability to render specific ~~patient~~ care and treatment within limits defined by licensure, education, experience, health status and judgment, thus ensuring the competency of practitioners working within the CalOptima contracted delivery system.

Practitioners are credentialed and recredentialed according to regulatory and accreditation standards (DHCS, CMS and NCQA). The scope of the credentialing program includes all licensed MDs, DOs, DPMs (doctors of podiatric medicine), DCs (doctors of chiropractic medicine), DDSs (doctors of dental surgery), allied health and midlevel practitioners, which include, but are not limited to, non-physician behavioral health practitioners, certified nurse midwives, certified nurse specialists, nurse practitioners, optometrists, physician assistants, registered physical therapists, occupational therapists, speech therapists and audiologists, both in the delegated and CalOptima direct environments. Credentialing and recredentialing activities for CCN are performed at CalOptima and delegated to HNs and other subdelegates for their providers.

Organizational Providers (OPs)

CalOptima performs credentialing and recredentialing of Ops, ~~such as~~including, but not limited to, acute care hospitals, home health agencies, skilled nursing facilities, free-standing surgery centers, dialysis centers, etc. The intent of this process is to assess that these entities meet standards for quality of care and are in good standing with state and federal regulatory agencies.

Use of QI Activities in the Recredentialing Process

Findings from QI activities and other performance monitoring are included in the recredentialing process.

Monitoring for Sanctions and Complaints

CalOptima has adopted policies and procedures for ongoing monitoring of sanctions, which include, but are not limited to, state or federal sanctions, restrictions on licensure or limitations on scope of practice, Medicare and Medicaid sanctions, potential quality concerns, and member complaints between recredentialing periods.

Facility Site Review, Medical Record and Physical Accessibility Review Survey

CalOptima does not delegate ~~primary care provider (~~PCP site and medical records review to ~~its~~ contracted HMOs, PHCs and SRGs. CalOptima does, however, delegate this function to designated health plans in accordance with standards set forth by ~~Medi-Cal Managed Care Division (MMCD) Policy Letter 14-004~~APL 20-006. CalOptima assumes responsibility and conducts and coordinates facility site review (FSR) and medical record review (MRR) for delegated HNs. CalOptima retains coordination, maintenance and oversight of the FSR/MRR process. CalOptima collaborates with the SRGs to coordinate the FSR/MRR process, minimize the duplication of site reviews and support consistency in PCP site reviews for shared PCPs.

CalOptima completes initial site reviews and subsequent periodic site reviews comprised of the FSR, MRR and Physical Accessibility Review Survey ~~physical accessibility review survey~~ (PARS) on all PCP sites that intend to participate in their provider networks regardless of the status of a PCP site's other accreditations and certifications.

Site reviews are conducted as part of the initial credentialing process. All PCP sites must undergo an initial site review and receive a minimum passing score of 80% on the FSR Survey Tool. This requirement is waived for precontracted provider sites with documented proof that another local managed care plan completed a site review with a passing score within the past three years. This is in accordance with APL 20-006 and CalOptima policies. ~~The~~ An Initial Medical Record Review shall be completed within 90 calendar days ~~of~~ from the date that members are first assigned to the provider. An additional extension of 90 calendar days may be allowed only if the provider does not have enough assigned members to complete review of the required number of medical records. Subsequent site reviews consisting of an FSR, MRR and PARS are completed no later than three years after the initial reviews. CalOptima may review sites more frequently per local collaborative decisions or when ~~determined~~ deemed necessary based on monitoring, evaluation or corrective action plan (CAP) follow-up issues.

Physical Accessibility Review Survey for Seniors and Persons ~~with~~ With Disabilities (SPD)

CalOptima conducts an additional DHCS-required physical accessibility review for Americans with Disabilities Act (ADA) compliance for SPD members, which includes access evaluation criteria to determine compliance with ADA requirements.

- Parking
- Building interior and exterior
- Participant areas, including the exam room
- Restroom
- Exam room

- Exam table/scale

Medical Record Documentation Standards

The medical record provides legal proof that the member received care. CalOptima requires that ~~its~~ contracted delegated HNs make certain that each member's medical record is maintained in an accurate, ~~manner that is~~ current, detailed, organized and easily accessible ~~to treating practitioners~~manner. Medical records are reviewed for format, legal protocols, and documented evidence of the provision of preventive care and coordination and continuity of care services. All ~~patient~~ data should be filed in the medical record in a timely manner (i.e., lab, X-ray, consultation notes, etc.)

The medical record should provide appropriate documentation of the member's medical care in such a way that it facilitates communication, coordination and continuity of care, and promotes efficiency and effectiveness of treatment. All medical records should, at a minimum, include all information required by state and federal laws and regulations, and the requirements of CalOptima's contracts with CMS and DHCS.

The medical record should be protected to ensure that medical information is released only in accordance with applicable federal and state law.

Corrective Action Plan(s) ~~To~~ to Improve Quality of Care and Service

When monitoring by either CalOptima's QI department, Audit & Oversight department or other functional areas identifies an opportunity for improvement, the relevant functional areas will determine the appropriate action(s) to be taken to correct the problem. Those activities specific to delegated entities will be conducted at the direction of the Audit & Oversight department as overseen by the Audit & Oversight Committee, reporting to the Compliance Committee. Those activities specific to CalOptima's functional areas will be overseen by the QI department as overseen by and reported to QIC. Actions for either delegates or functional areas may include the following:

- Development of cross-departmental teams ~~utilizing~~ using continuous improvement tools (i.e., quality improvement plans or ~~Plan-Do-Study-Act~~PDSA) to identify root causes, develop and implement solutions, and develop quality control mechanisms to maintain improvements.

- Formal or informal discussion of the data/problem with the involved practitioner, either in the respective committee or by a medical director.

- Further observation and monitoring of performance via the appropriate clinical monitor. (This process shall determine if follow-up action has resolved the original problem.)

- Intensified evaluation/investigation when a trigger for evaluation is attained, or when further study needs to be designed to gather more specific data, i.e., when the current data is insufficient to fully define the problem.

- Changes in policies and procedures when the monitoring and evaluation results may indicate ~~a problem, which can be~~problems that can be corrected by changing policy or procedure.

QUALITY ANALYTICS

The Quality Analytics (QA) department fully aligns with the ~~QI and PHM~~QI and PHM teams to support the organizational mission, strategic goals, required regulatory quality metrics, programs and processes to monitor and drive improvements to the quality of care and services, and ensure that care and services are rendered appropriately and safely to all CalOptima members.

The QA department activities include design, implementation, and evaluation of ~~initiatives~~ processes and programs to:

- Report, monitor and trend outcomes
- Support efforts to improve internal and external customer satisfaction
- Improve organizational quality improvement functions and processes to both internal and external customers
- Collect clear, accurate and appropriate data used to analyze performance of specific quality metrics and measure improvement
- Coordinate and communicate organizational, HN and provider-specific performance on quality metrics, as required
- Participate in various reviews through the QI Program, ~~such as~~including, but not limited to, network adequacy, access to care and availability of practitioners
- Facilitate satisfaction surveys for members
- Incentivize ~~health networks~~HNs and providers to meet quality performance targets and deliver ~~high quality of~~quality care

~~In addition to working directly with the contracted HNs, d~~Data sources available for ~~identification~~identifying, monitoring and evaluating ~~of~~ opportunities for improvement and intervention effectiveness ~~of interventions~~ include, but are not limited to:

- Claims information/activity
- Encounter data
- Utilization data
- Case management reports
- Pharmacy data
- Immunization registry
- Lab data
- CMS Star Ratings ~~(Stars) and Health Outcomes Survey (HOS) scores~~ data
- Population Needs Assessment
- ~~Results of risk stratification~~
- HEDIS performance
- Member and provider satisfaction surveys

By analyzing data that CalOptima currently receives (i.e., claims data, pharmacy data and encounter data), the data warehouse can identify members for quality improvement and access to care interventions, which will allow us to improve our HEDIS scores~~, Stars and HOS measures~~

and CMS Star Ratings. This information will guide CalOptima and our delegated HNs in identifying gaps in care and metrics requiring improvement.

POPULATION HEALTH MANAGEMENT

CalOptima strives to provide integrated ~~care of~~ physical health, behavioral health, LTSS, care coordination and complex case management to improve coordination of care between health care departments. This streamlined interaction will ultimately result in optimized member care. CalOptima's PHM strategy outlines programs that will focus on four key strategies:

1. Keeping members healthy
2. Managing members with emerging risks
3. Patient safety or outcomes across settings
4. Managing multiple chronic conditions

This is achieved through functions described ~~in~~ below in Health Promotion, Health Management, Care Coordination and Members with Complex Needs, LTSS, Behavioral Health Services and telehealth areas.

CalOptima developed a comprehensive PHM Strategy ~~for 2019, which was adopted again in 2020. The PHM Strategy will continue into 2021, which~~that includ~~es~~ing a plan of action for addressing our culturally diverse member needs across the continuum of care. CalOptima's PHM Strategy aims to ensure the care and services provided to ~~our~~ members are delivered in a whole-person-centered, safe, effective, timely, efficient and equitable manner ~~across the entire health care continuum and life span~~.

The PHM Strategy is based on numerous efforts to assess the health and well-being of CalOptima members. ~~such as the Member Health Needs Assessment that was completed in March 2018. It focused on ethnic and linguistic minorities within the Medi-Cal population from birth to age 101.~~ Additionally, CalOptima's annual Population Needs Assessment (requirement for California Medi-Cal Managed Care ~~Health~~ Plans) will aid the PHM ~~strategy~~ Strategy further in identifying member health status and behaviors, member health education and cultural and linguistic needs, health disparities and gaps in services related to these issues.

The PHM plan of action addresses the unique needs and challenges of specific ethnic communities including economic, social, spiritual and environmental stressors, to improve health outcomes. CalOptima will conduct quality initiatives designed to achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical and non-clinical services that can be expected to have a beneficial effect on health outcomes and member satisfaction. Quality initiatives that are conducted to improve quality of care and health services delivery to members may include QIPs, PIPs, PDSAs and CCIPs. Quality Initiatives for ~~2021~~2022 are tracked in the QI Work Plan and reported to the QIC.

In 202~~1~~2, the PHM Strategy will ~~be~~ include greater focus~~focused~~ on addressing health inequities and ~~social determinants of health for members~~SDOH. The COVID-19 pandemic brought worldwide attention to health disparities and inequity. PHM identified opportunities to expand ~~existing member~~ outreach ~~efforts~~ and~~or~~ initiate new initiatives focused on SDOH and health equity as follows:

- Back-to-school immunization clinics for school-aged children (Tdap, COVID-19 vaccine, etc.)
- COVID-19 Member Health Rewards for CalOptima m~~M~~embers, ~~Experiencing Homelessness~~with special focus on those experiencing homelessness
- Improving COVID-19 v~~V~~accine ~~A~~access for ~~H~~homebound ~~M~~members and other ~~H~~high-~~R~~risk populations
- Mobile ~~D~~diaper ~~B~~banks for ~~F~~families of ~~I~~infants and ~~A~~adolescent ~~M~~members in ~~C~~collaboration with Women, Infants & Children (WIC) and the Community Action Partnership
- Improving access for ~~E~~eligible CalOptima ~~M~~members to CalFresh benefits ~~with Social Services Agency~~
- Improving ~~A~~access to ~~Mmammography (mobile mammography)~~breast ~~C~~cancer ~~S~~screenings for Korean and Chinese members via mobile mammography
- ~~Fresh Produce Delivery for Members with Poorly Controlled Diabetes – CalOptima Community Network Specific~~
- Remote ~~M~~monitoring for ~~M~~members with ~~C~~chronic ~~C~~conditions
- Escape The Vape (Great American Smoke Out) ~~A~~annual event that offers vape and tobacco prevention to school--aged children
- Shape Your Life Childhood Obesity Program, ~~improving~~with group classes to improve ~~education~~ awareness of~~for~~ good nutrition and physical fitness for adolescents ~~through group classes~~
- Member Health Needs Assessment

~~expanding the MOC while integrating CalOptima's existing services, such as care coordination, case management, health promotion, preventive services and new programs with broader population health focus with an integrated model.~~

~~Additionally, as one of the high performing Medi-Cal managed care plans of California, CalOptima is positioned to increase provider awareness and support of the Office of the California Surgeon General's (CA-OSG) statewide effort to cut Adverse Childhood Experiences (ACE) and toxic stress in half in one generation starting with Medi-Cal members. Identifying and addressing ACE in adults could improve treatment adherence through seamless medical and behavioral health integration and reduce further risk of developing comorbid conditions. Addressing ACE upstream as public health issues in children can reverse the damaging epigenetic effect of ACE, improve population health outcomes, and promote affordable health care for the next generation. Implementing the evidence-based ACE screening and Trauma-Informed Care in the primary care setting will require CalOptima's commitment to promote awareness and consider proactive practice transformation and care delivery system to improve member-focused trauma informed care to be consistent with NCQA Population Health Management (PHM) Standards and Guidelines. The CalOptima Health Improvement Project (CHIP) is a Trauma-Informed Care Plan of Action that aims to promote awareness and reduce the impact of ACE.~~

The PHM team also focuses on improvement projects, such as QIPs, PIPs, CCIPs and PDSAs to improve processes and outcomes for ~~our~~ members.

For each QI Project, specific interventions to achieve stated goals and objectives are developed and implemented, as part of the PHM program. Interventions for each project must:

- Be clearly defined and outlined
- Have specific objectives and timelines

- Specify responsible departments and individuals
- Be evaluated for effectiveness
- Be tracked by QIC

For each project, there are specific system interventions that have a reasonable expectation of effecting long-term or permanent performance improvement. System interventions include education efforts, policy changes, development of practice guidelines (with appropriate dissemination and monitoring) and other plan-wide initiatives. In addition, provider- and member-specific interventions, such as reminder notices and informational communication, are developed and implemented.

Improvement Standards

A. Demonstrated Improvement
Each project is expected to demonstrate improvement over baseline measurement on the specific quality measures selected. In subsequent measurements, evidence of significant improvement over the initial performance to the measure(s) must be sustained over time.

B. Sustained Improvement
Sustained improvement is documented through the continued remeasurement of quality measures for at least one year after the improved performance has been achieved.

Once the requirement has been met for both ~~significant~~ demonstrated and sustained improvement on any given project, there are no other regulatory reporting requirements related to that project. CalOptima may ~~internally~~ choose to continue the project or ~~to go on to~~pursue another topic.

Documentation of QI Projects

Documentation of all aspects of each QI Project is required. Documentation includes, but is not ~~necessarily~~ limited to:

- Project description, including relevance, literature review (as appropriate), source and overall project goal
- Description of target population
- Description of data sources and evaluation of their accuracy and completeness
- Description of sampling methodology and methods for obtaining data
- List of data elements (quality measures). Where data elements are process measures, there must be documentation that the process indication is a valid proxy for the desired clinical outcome
- Baseline data collection and analysis timelines
- Data abstraction tools and guidelines
- Documentation of training for chart abstraction
- Rater-to-standard validation review results
- Measurable objectives for each quality measure
- Description of all interventions including timelines and responsibility
- Description of benchmarks
- Remeasurement sampling, data sources, data collection and analysis timelines
- Evaluation of remeasurement performance on each quality measure

Health Promotion

Health Education provides program development and implementation for agencywide PHM programs. PHM programs provide for the identification, assessment, stratification and implementation of appropriate interventions for members with certain conditions or chronic diseases. Programs and materials use educational strategies and methods appropriate for members. They and are designed to achieve behavioral change for improved health and are reviewed on an annual basis. Program topics include exercise, Nutritionnutrition, Hyperlipidemiahyperlipidemia, Hypertensionhypertension, Perinatal perinatal Healthhealth, Shape Shape Your Life/Weight weight Managementmanagement, Tobacco tobacco Cessationcessation, Asthmaasthma, Immunizationsimmunizations and Well well-Child child Visitsvisits.

Primary goals of the department are to achieve member wellness and autonomy through advocacy, communication, education, identification of services, resources and service facilitation throughout the continuum of care. Materials are written at the sixth-grade reading level and are culturally and linguistically appropriate for our members.

PHM supports CalOptima members with customized interventions, which may include:

- Healthy lifestyle management techniques and and health education programs and services at no charge to members
- Medication education to ensure adherence to appropriate pharmacotherapy treatment plans
- Informational booklets for key conditions
- Referrals to community or external resources
- Execution and coordination of programs with Case Management, QA and our HN providers

Managing Members with With Emerging Risk

CalOptima staff provide a comprehensive system of caring for members with chronic illnesses. The systemwide, multidisciplinary approach is utilized that entails the formation of a partnership between the patientmember, the health care practitioner and CalOptima. The PHM program stratifies the population and identifies appropriate interventions based on member needs.

These interventions include coordinating care for members, across locales and providing services, resources and support to members as they learn to care for themselves and their condition. The PHM program supports the CA OSGCalifornia Surgeon General and Proposition 56 requirements for ACE Adverse Childhood Event (ACE) screening, as well as identification of social determinates of health (SDOH. It proactively identifies those members in need of closer management, coordination and intervention. CalOptima assumes responsibility for the PHM program for all its lines of business; however, members with more acute needs receive coordinated care with delegated entities.

Care Coordination and Case Management

CalOptima is committed to serving the needs of all members ~~assigned,~~ and places additional emphasis on the management and coordination of care of the most vulnerable populations and members with complex health needs. Our goal is ~~promotion of the~~ delivery of effective, quality health care to members with special health care needs, including, but not limited to, physical and developmental disabilities, multiple chronic conditions, and complex behavioral health and social issues through:

- Standardized mechanisms for member identification through use of data, including Health Risk Assessment (HRA) or Health Needs Assessment (HNA) ~~data~~for ~~model of care~~MOC members. ~~Documented process to assess the needs of member population.~~

- Multiple avenues for referral to case management and disease management programs or management of transitions of care across the continuum of health care from outpatient or ambulatory to inpatient or institutionalized care, and back to ambulatory.

- Ability of member to opt out.

- Targeted promotion of the use of recommended preventive health care services for members with chronic conditions (e.g., diabetes, asthma) through health education and member incentive programs.

- Use of evidence-based guidelines distributed to ~~members and practitioners~~ providers who~~that~~ are relevant to chronic conditions prevalent in the member population (e.g., COPD, asthma, diabetes, ADHD).

- Comprehensive initial nursing assessment and evaluation of health status, clinical history, medications, functional ability, barriers to care, and adequacy of benefits and resources.

- Development of individualized care plans that include input from the member, care giver, ~~primary care provider~~PCP, specialists, social worker~~,~~ and providers involved in care management, as necessary.

- Coordination of services for members for appropriate levels of care and resources.

- Documentation of all findings.

- Monitoring, reassessing~~,~~ and modifying the plan of care to drive appropriate service quality, timeliness~~,~~ and effectiveness ~~of services~~.

- Ongoing assessment of outcomes.

CalOptima's ~~e~~Case ~~m~~Management program includes three care management levels ~~(CML)~~ that reflect the acuity of ~~care management~~ needs: ~~C~~complex case management, care coordination~~,~~ and basic case management. ~~-~~Members within defined ~~models of care~~MOCs ~~—:~~ ~~-~~SPD, WCM, OCC and OC ~~—~~ are risk~~-~~stratified ~~on~~upon enrollment~~ligibility~~ using a plan-developed tool. This risk stratification informs the HRA/HNA outreach process. The tool ~~utilizes~~uses information from data sources, such as acute hospital/emergency department utilization, severe and chronic

conditions, and pharmacy.~~This stratification results in the categorizing of members as "high" or "low" risk and informs outreach for the initial risk assessment.~~

~~Health Risk Assessment (~~HRA~~)~~ and ~~Health Needs Assessment (~~HNA~~)~~

The comprehensive risk assessment facilitates care planning and offers actionable items for the ~~Interdisciplinary Care Team (~~ICT~~)~~. Risk assessments are completed in person, telephonically or by mail and accommodate language preference. -The voice of our members is reflected within the risk assessment, which is specific to the assigned model of care. -Risk assessments are completed with the initial visit ~~eligibility~~ and then on an annual basis. ~~Oversight RN Review~~

~~CalOptima's delegated model reflects 100% RRN review of collected risk assessments (HRA/HNA) and CML assignment. The data is analyzed and sent to the delegated networks who develop the ICT and Individualized Care Plan (ICP). The delegated networks return the completed ICP/ICT and there is 100% RN review to ensure risk assessment needs are addressed and model of care requirements are met.~~

~~Interdisciplinary Care Team~~**ICT**

An ~~Interdisciplinary Care Team (~~ICT~~)~~ is linked to ~~these~~ members to assist in care coordination and services to achieve the individual's health goals. The ICT may occur at the PCP (basic) or the HN level (care coordination or complex), ~~dependent upon~~depending on the results of the member's HRA and/or evaluation or changes ~~in the member's~~in health status. The ICT always includes the member (and caregivers or an authorized representative with member approval or appropriate authorization to act on behalf of ~~a~~ the member) and PCP. For members with more needs, other disciplines are included, such as a medical director, specialist(s), ~~case management team~~case manager, behavioral health specialist, pharmacist, social worker, dietitian and/or long-term care manager. The ICT ~~teams are de~~is designed to ~~see~~ ensure that members' needs are identified and managed by an appropriately composed team.

The ~~Interdisciplinary Care Teams~~ICT ~~process~~ levels are~~includes~~:

- ~~Basic~~ ICT for Low-Risk Members — occurs at the PCP level
  - Team Composition: member, caregiver or authorized representative, PCP, PCP support staff (nurse, etc.)

    - Roles and responsibilities of this team:
      - Basic case management, including advanced care planning
      - Medication reconciliation
      - Identification of member at risk of planned and unplanned transitions
      - Referral and coordination with specialists
      - Development and implementation of an ~~ICP~~Individual Care Plan (ICP)
      - Communication with members or their representatives, vendors and medical group
      - Review and update the ICP at least annually, and when there is a change in ~~the member's~~ health status
      - Referral to the primary ICT, as needed

- ICT for Moderate- to High-Risk Members — ~~ICT~~ occurs at the HN, or at CalOptima for CCN ~~Members~~members.
  - Team Composition ~~(appropriate to identified needs)~~: member, caregiver or authorized representative, HN ~~Medical~~ medical ~~Director~~director, PCP and/or specialist,

ambulatory case manager ~~(CM)~~, hospitalist, hospital ~~CM~~ case manager and/or discharge planners, HN UM staff, behavioral health specialist and social worker

- Roles and responsibilities of this team:
  - Identification and management of planned transitions
  - Care coordination or complex case management
  - Case management of high-risk members
  - Coordination of ICPs for high-risk members
  - Facilitating communication among member, PCP, ~~and~~ specialists and vendors ~~communication~~
  - Meeting as frequently as is necessary to coordinate care and stabilize member's medical condition
  -

~~Individualized Care Plan (~~ICP

The ICP is developed through the ICT process. The ICP is a member-centric plan of care with prioritization of goals ~~including~~and target dates. ~~–~~Attention is paid to needs identified in the risk assessment (HRA/HNA) and by the ICT. Barriers to meeting treatment goals are addressed. Interventions reflect care manager or member activities required to meet stated goals. The ICP has an established plan for monitoring outcomes and ongoing follow-up per ~~CML~~case management level. The ICP is updated annually and with change in condition.~~with key events such as hospitalization and transitions of care.~~

~~Models of Care~~**MOCs:**

Dual Eligible Special Needs Plan (D-SNP)/OC and OCC

The goal of D-SNPs is to provide health care and services to those who can benefit the most from the special expertise of CalOptima providers and focused care management. Care management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet the comprehensive medical, behavioral health and psychosocial needs of an individual and the individual's family, while promoting quality and cost-effective outcomes.

The goal of care management is to help members regain optimum health or improved functional capability, cost-effectively and in the right setting. It involves comprehensive assessment of the ~~patient's~~ member's condition, determining benefits and resources, and developing and implementing a care management plan that includes performance goals, monitoring and follow up.

CalOptima's D-SNP care management program includes, but is not limited to:

- Complex case management program ~~aimed at~~for a subset of ~~patients~~ members whose critical event or diagnosis requires extensive use of resources, and who need help navigating the system to facilitate appropriate delivery of care and services.
- Transitional case management program focused on evaluating and coordinating transition needs for ~~patients~~ members who may be at risk of rehospitalization.

- High-risk and high-utilization program ~~aimed a~~fort ~~patients~~ members who frequently use emergency department ~~(ED)~~ services~~,~~ or ~~or~~ have frequent hospitalizations,~~,~~ and at-high-risk individuals.

- Hospital case management program ~~designed~~ to coordinate care for ~~patients~~ members during an inpatient admission and discharge planning.

Care management program focuses on ~~patient~~member-specific activities and the coordination of services identified in members' care plans. Care management performs these activities and coordinates services for members to optimize their health status and quality of life.

Seniors and Persons with Disability (SPD)

The goal of case management for SPD members is to facilitate the coordination of care and access to services in a vulnerable population that demonstrates higher utilization and higher risk of requiring complex health care services. -The model involves risk stratification and HRA that contributes to the ICT and ICP development.

Whole Child Model (WCM)

The goal of case management for WCM is a single integrated system of care that provides coordination for CCS-eligible and non-CCS-eligible conditions. CalOptima coordinates the ~~beneficiary's~~ full scope of health care needs inclusive of ~~primary~~ preventive care, specialty health, mental health, education and training. ~~The goal of~~ WCM ~~is to~~ ensures that each CCS-eligible member receives case management, care coordination, provider referral and/or service authorization from a CCS paneled provider; this ~~will be dependent~~depends upon the member's designation as high or low risk. The model uses risk stratification and an HNA that informs~~contributes to~~ the ICT and ICP development.

~~California Advancing and Innovating Medi-Cal for All (~~CalAIM~~IM's) and~~ Enhanced Care Management (ECM)

~~Implementation of ECM is scheduled for~~began Effective January 1, 2022, ~~.~~ ECM is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of m~~M~~embers with the most complex medical and social needs. ~~–~~These members are ~~expected to be~~ among the most vulnerable and highest-need Medi-Cal m~~M~~anaged ceare ~~M~~members. -ECM ~~will~~ reflects a systematic coordination of services and comprehensive care management that is community~~-~~-based, interdisciplinary, high~~-~~-touch and person-centered. The goal of ECM is to coordinate all primary, acute, behavioral, developmental, oral, social ~~needs,~~ and long-term ~~services and supports~~needs for members~~., including participating in the care planning process, regardless of setting. The model uses HNA, ….(what to say here as it is different?)~~ Eligible members may participate in ECM and/or Community Supports through ~~the~~ CalAIM ~~program~~.

Long-Term Services and Supports

CalOptima ensures LTSS are available to members with health care needs that meet program eligibility criteria and guidelines. LTSS include both institutional and community-based services.

~~CalOptima~~ The LTSS department monitors and reviews the quality and outcomes of services provided to members in both settings.

Nursing Facility Services for Long-Term Care:

- CalOptima LTSS is responsible for the clinical review and medical necessity determination for members receiving long-term Nursing Facility Level A, Nursing Facility Level B and Subacute levels of care. CalOptima LTSS monitors the levels of overall program utilization as well as care setting transitions for members in the program.

Home- and Community-Based Services:

- CBAS: An outpatient, facility-based program that offers health and social services to seniors and ~~persons~~ people with disabilities. CalOptima LTSS monitors the levels of member access to, utilization of and satisfaction with the program, as well as its role in diverting members from institutionalization.
- MSSP: Intensive home- and community-based care coordination of a wide range of services and equipment to support members in their home and avoid the need for institutionalization. CalOptima LTSS monitors the level of member access to the program as well as its role in diverting members from institutionalization.

Behavioral Health Integration Services

Medi-Cal

CalOptima is responsible for providing outpatient mental health services to members with mild to moderate impairment of mental, emotional~~,~~ or behavioral functioning, resulting from a mental health disorder, as defined in the current diagnostic and statistical manual of mental disorders. Mental health services include, but are not limited to, individual and group psychotherapy, psychology, psychiatric consultation, medication management and psychological testing, when clinically indicated to evaluate a mental health condition.

In addition, CalOptima covers behavioral health treatment (BHT) for members 20 years of age and younger who meet medical necessity criteria. BHT services are provided under a specific behavioral treatment plan that has measurable goals over a specific time frame. CalOptima provides direct oversight, review and authorization of BHT services.

CalOptima offers ~~Alcohol Misuse Screening and Counseling (AMSC)~~ Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT) services at the ~~primary care physician (~~PCP setting to members ~~eleven (~~11 ~~)8~~ years and older, including pregnant women. ~~who may misuse alcohol. Providers in primary care settings screen for~~ When a screening is positive, providers conduct a brief assessment. Brief misuse counseling is offered when unhealthy alcohol ~~misuse~~ or substance use is detected. Appropriate referral for additional evaluation and treatment, including medications for addiction treatment, is offered to members whose brief assessment demonstrates probable alcohol use disorder (AUD) or substance use disorder (SUD) ~~and provide with brief behavioral counseling interventions to reduce alcohol misuse and/or referral to mental health and/or alcohol use disorder services as medically necessary~~.

CalOptima members can access mental health services directly, without a physician referral, by contacting the CalOptima Behavioral Health Line at 855-877-3885. A CalOptima representative

will conduct a brief mental health telephonic screening to make an initial determination of the member's impairment level. If the member has mild to moderate impairments, the member will be referred to behavioral health practitioners within the CalOptima provider network. If the member has ~~significant to severe~~moderate to severe impairments, the member will be referred to specialty mental health services through the Orange County Mental Health Plan.

CalOptima ensures members with coexisting medical and mental health care needs have adequate coordination and continuity of ~~their~~ care. Communication with both the medical and mental health specialists occurs as needed to enhance continuity by ensuring members receive timely and appropriate access ~~and to facilitate communication between the medical and mental health practitioners involved~~.

CalOptima directly manages all administrative functions of the Medi-Cal mental health benefits, including UM, claims, credentialing the provider network, member services and quality improvement.

CalOptima is participating in two of DHCS' incentive programs focused on improving behavioral health care and outcomes. First, the Behavioral Health Integration Incentive Program (BHIIP) is designed to improve physical and behavioral health outcomes, care delivery efficiency and ~~patient~~ member experience. CalOptima is providing program oversight, including readiness, milestones tracking, reporting and incentive reimbursement for the seven provider groups approved to participate in 12~~twelve~~ projects. The second incentive program is the Student Behavioral Health Incentive Program (SBHIP), part of ~~the Administration administration and State state Legislature legislature~~a state effort to prioritize behavioral health services for youth ages 0–25. The new program is intended to establish and strengthen partnerships and collaboration with school districts, county behavioral health and CalOptima by developing infrastructure to improve access and increase the number of transitional kindergarten ~~(TK)~~ through 12th~~th~~-grade students receiving ~~preventative,~~ early interventions and preventive ~~and behavioral health~~BH services.

OC and OCC

In 2022, OC ~~/~~and OCC behavioral health continues to be fully integrated within CalOptima internal operations. OC and OCC members can access mental health services by calling the CalOptima Behavioral Health Line. Members will be connected to a CalOptima representative for behavioral health assistance.

CalOptima offers ~~Alcohol Misuse Screening and Counseling (AMSC)~~ Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT) services at the PCP setting to members 11 years and older, including pregnant women. When a screening is positive, providers conduct a brief assessment. Brief misuse counseling is offered when unhealthy alcohol or substance use is detected. Appropriate referral for additional evaluation and treatment, including medications for addiction treatment, is offered to members whose brief assessment demonstrates probable alcohol use disorder (AUD) or substance use disorder (SUD). ~~18 and older who misuse alcohol. Providers in primary care settings screen for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse and/or refer to mental health and/or alcohol use disorder services as medically necessary.~~

Utilization Management

Coverage for health care services, treatment and supplies in all lines of business is based on the terms of the plan, member eligibility at the time of service and subject to medical necessity. Contracts specify that medically necessary services are those that are established as safe and effective, consistent with symptoms and diagnoses, and furnished in accordance with generally accepted professional standards to treat an illness, disease or injury consistent with CalOptima medical policy and not furnished primarily for the convenience of the ~~patient~~member, attending physician or other provider.

Use of evidence-based, peer reviewed, industry-recognized criteria ~~promotes~~~~promote efforts to~~ ensures that medical decisions are not influenced by fiscal and administrative management considerations. As described in the 2022~~0~~ UM Program, all review staff are trained and audited in these principles. Licensed clinical staff review and approve requested services based on medical necessity, utilizing evidence-based review criteria. Requests not meeting medical necessity criteria are reviewed by a physician reviewer or other qualified reviewer.

Further details of the UM Program, activities and measurements can be found in the ~~2021~~2022 UM Program Description.

~~Enterprise Analytics~~

~~Enterprise Analytics (EA) provides leadership across CalOptima in the development and distribution of analytical capabilities. In conjunction with the executive team and key leaders across the organization, EA drives the development of the strategy and road map for analytical capability. Operationally, there is a centralized enterprise analytics team to interface with all departments within CalOptima and key external constituents to execute on the road map. Working with departments that supply data, notably, Information Services, Claims, Customer Service, Provider Services, and Medical Affairs, the EA team develops or extends the data architecture and data definitions which express a future state for the CalOptima Data Warehouse. Through work with key users of data, EA develops the platform(s) and capabilities to meet CalOptima's critical information needs. This capability for QI in the past has included provider preventable conditions, trimester specific member mailing lists, high impact specialists, PDSA on LTC inpatient admissions and under utilization information. As QI needs evolve, so will the EA contribution.~~

Safety Program

Member safety is very important to CalOptima; it aligns with CalOptima's mission statement: *To provide members with access to quality health care services delivered in a cost-effective and compassionate manner*. By encouraging members and families to play an active role in making their care safe, medical errors will be reduced. Active, involved and informed ~~patients~~ members and families are vital members of the health care team.

Member safety is integrated into all components of ~~member~~ enrollment and health care delivery and is a significant part of our quality and risk management functions. Our member safety endeavors are clearly articulated both internally and externally and include strategic efforts ~~specific to member safety~~.

This safety program is based on a member-specific needs assessment, and includes the following areas:

- Identification and prioritization of member safety-related risks for all CalOptima members, regardless of line of business and contracted health care delivery organizations
- Operational objectives, roles and responsibilities, and targets based on ~~the~~ risk assessment
- Health education and promotion
- Over/under utilization monitoring
- Medication management
- PHM
- Operational aspects of care and service

To ensure member safety, activities for prevention, monitoring and evaluation include:

- Providing education and communication through the Group Needs Assessment to ~~assess~~ consider the member's language comprehension ~~through their language~~, culture and diverse needs
- Distributing member information that improves their knowledge about clinical safety in their own care (such as member ~~brochures, which~~brochures that outline member concerns or questions that they should address with their practitioners for their care)

Collaborating with HNs and practitioners in performing the following activities:

- Improving medical record documentation and legibility, establishing timely follow up for lab results, addressing and distributing data on adverse outcomes or polypharmacy issues by the P&T ~~Committee~~, and maintaining continuous quality improvement with pharmaceutical management practices to require safeguards to enhance ~~patient~~ safety

- Alerting the pharmacy to potential drug interactions and/or duplicate therapies, and discussing these potential problems with the prescribing physician(s), which ~~allows the opportunity for the practitioner to~~ helps ensure the ~~amount of the~~ appropriate drug is being delivered

- Improving continuity and coordination between sites of care, such as hospitals and skilled nursing facilities, to assure timely and accurate communication

- ~~Utilizing~~ Using ~~facility site review~~FSRs, Physical Accessibility Review Survey (PARS) and medical record review results from ~~practitioner~~ providers and health care delivery organization at the time of credentialing to improve safe practices, and incorporate~~ing~~ ADA and SPD site reviews ~~audits~~ into the general ~~facility site review~~FSR process

- Tracking and trending of adverse event reporting to identify system issues that contribute to poor safety

Elements of the safety program address the environment of care and the safety of members, staff and others in a variety of settings. The focus of the program is to identify and remediate potential and actual safety issues, and to monitor ongoing staff education and training, including:

- Ambulatory setting
  - Adherence to ADA standards, including provisions for access and assistance in procuring appropriate equipment, such as electric exam tables
  - Annual blood-borne pathogen and hazardous material training
  - Preventative maintenance contracts to promote keeping equipment in good working order
  - Fire, disaster and evacuation plan testing and annual training

- Institutional settings, including CBAS, SNF and MSSP settings
  - Falls and other prevention programs
  - Identification and corrective action implemented to address postoperative complications
  - Sentinel events, critical incident identification, appropriate investigation and remedial action
  - Administration of flu and pneumonia vaccines
  - COVID-19 infection ~~Prevention~~ prevention and ~~Protective~~ protective ~~Equipment~~equipment
  - MRSA prevention program – Shared Healthcare Intervention to Eliminate Life-Threatening Dissemination of Multi-drug Resistant Organisms (~~Shield~~SHIELD)

- Administrative offices
  - Fire, disaster and evacuation plan testing and annual training

CULTURAL & LINGUISTIC SERVICES

As a health care organization in the diverse community of Orange County, CalOptima strongly believes in the importance of providing culturally and linguistically appropriate services to ~~its~~ members. To ensure effective communication regarding treatment, diagnosis, medical history and health education, CalOptima has developed a program that integrates culturally and linguistically appropriate services at all levels of the operation. ~~Such s~~Services include, but are not limited to, ~~Face-to-Face Interpreter~~face-to-face interpreter services, including American Sign Language, at key points of contact~~,~~; 24-hour access to telephonic interpreter services~~,~~; and member information materials translated into CalOptima's threshold languages and in alternate formats, such as braille, large-print or audio.

~~Since CalOptima serves a large and culturally diverse population, t~~The seven most common languages spoken for all CalOptima programs are: English, 59~~86~~ %~~percent,~~; Spanish, ~~28~~ 26 ~~percent~~%~~,~~; Vietnamese, ~~11~~10 ~~percent~~%~~,~~; Farsi, 1 ~~percent~~%~~,~~; Korean, 1 ~~percent~~%~~,~~; Chinese, ~~<~~less than 1 ~~percent~~%; and Arabic, less than ~~<~~1 ~~percent~~% ~~and all others at 3 percent, combined~~. CalOptima provides member materials as follows:

- Medi-Cal member materials are ~~provided~~ in seven languages: English, Spanish, Vietnamese, ~~Korean,~~ Farsi, Korean, Chinese and Arabic
- OC member materials are ~~provided~~ in three languages: English, Spanish and Vietnamese
- OCC member materials are ~~provided~~ in seven languages: English, Spanish, Vietnamese, Farsi, Korean, ~~Farsi,~~ Chinese and Arabic
- PACE participant materials are provided in four languages: English, Spanish, Vietnamese and Korean

CalOptima is committed to member-centric care that recognizes the beliefs, traditions, customs and individual differences of ~~the~~ our diverse population ~~we serve~~. Beginning with identification of needs through a Group Needs Assessment, programs are developed to address the specific education, treatment and cultural norms of the population impacting the overall wellness of the community we serve. Identified needs and planned interventions involve member input and are vetted through the ~~Member and Provider a~~Advisory ~~c~~Committees~~s~~MAC and PAC prior to full implementation.

Objectives for serving a culturally and linguistically diverse membership include:

- Reduce health care disparities in clinical areas
- Improve cultural competency in materials and communications
- Improve network adequacy to meet the needs of underserved groups
- Improve other areas of need~~s the organization deems~~as appropriate~~.~~

~~The approach for~~Serving a culturally and linguistically diverse membership include~~s~~:

- Analyzing significant health care disparities in clinical areas to ensure health equity
- Using practitioner and provider medical record reviews to understand the differences in care provided and outcomes achieved
- Considering outcomes of member grievances and complaints
- Conducting member-focused interventions with culturally competent outreach materials that focus on race~~/~~-, ethnic~~ity /~~-, language- or gender-specific risks
- Conducting member-focused groups or key informant interviews with cultural or linguistic members to determine how to meet their needs
- Identifying and reducing a specific health care disparity affecting a cultural, racial or gender group.
- Providing information, training and tools to staff and practitioners to support culturally competent communication

DELEGATED AND NON-DELEGATED ACTIVITIES

CalOptima delegates certain functions and/or processes to delegated HNs that are required to meet all contractual, statutory and ~~and~~ regulatory requirements, as well as accreditation standards, CalOptima policies and other guidelines applicable to the delegated functions.

Delegation Oversight

Participating entities are required to meet CalOptima's QI standards and to participate in CalOptima's QI Program. CalOptima has a comprehensive interdisciplinary team that is assembled for evaluating any new potential delegate's ~~for~~ ability to perform its contractual scope of responsibilities. A Readiness Assessment is conducted by the Audit & Oversight department and overseen by the Audit & Oversight Committee, reporting to the Compliance Committee.

NON-DELEGATED ACTIVITIES

The following activities are not delegated, and remain the responsibility of CalOptima:

- QI, as delineated in the Contract for Health Care Services
- QI ~~program~~ Program for all lines of business (delegated HNs must comply with all quality-related operational, regulatory and accreditation standards)
- Behavioral Health for ~~MC~~Medi-Cal, OC and OCC ~~lines of business~~
- PHM Program, previously referred to as Disease Management or Chronic Care Improvement Program
- Health education (as applicable)
- Grievance and appeals process for all lines of business, and peer review process on specific, referred cases
- Potential Quality Issue investigations
- Development of systemwide measures, thresholds and standards
- Satisfaction surveys of members, practitioners and providers
- Survey for Annual Access and Availability
- Access and availability oversight and monitoring
- Second-level review of provider grievances
- Development of credentialing and recredentialing standards for both practitioners and ~~organizational providers (~~OPs
- Credentialing and recredentialing of OPs
- Development of UM and Case Management standards
- Development of QI standards
- Management of Perinatal Support Services (PSS)
- Risk management
- Pharmacy and drug utilization review as it relates to quality of care
- Interfacing with state and federal agencies, medical boards, insurance companies, and other managed care entities and health care organizations

Further details of the delegated and non-delegated activities can be found in the ~~2021~~2022 Delegation Grid.

See Appendix B — ~~2021~~2022 Delegation Grid

In Summary

As stated previously, CalOptima~~we~~ cannot achieve our mission and our vision alone. We must work together with providers, community health centers, county agencies, state and federal agencies, and other community stakeholders to provide quality health care to ~~our~~ members. Together, we can be innovative in developing solutions that meet our diverse members' health care needs. We are truly "Better. Together."

~~Appendix APPENDIX A — 2021 QI Work Plan~~

Appendix A — 2022 QI Work Plan

Appendix B — ~~2021~~2022 Delegation Grid

~~**Appendix C — Organizational Chart**~~

I. PROGRAM OVERSIGHT

A. 2022 QI Annual Oversight of Program and Work Plan
B. 2021 QI Program Evaluation
C. 2022 UM Program
D. 2021 UM Program Evaluation
E. Population Health Management Strategy
F. Credentialing Peer Review Committee (CPRC) Oversight
G. Grievance and Appeals Resolution Services (GARS) Committee
H. Member Experience (MEMX) Committee Oversight
I. Utilization Management Committee (UMC) Oversight
J. Whole Child Model - Clinical Advisory Committee (WCM CAC)
K. Quality Withold for OCC
L. New Quality Program Updates (Health Network Quality Rating, MCAS, P4V, OC P4V, Data Mining/Bridge efforts)
M. Improvement Projects (All LOB)PIPs
N. Improvement Projects (All LOB)QIPs
O. Improvement Projects (All LOB)CCIP's
P. PPME/QIPE: HRA's
Q. BHI Incentive Program (DHCS - under prop 56 funding) and ABA P4V
R. Homeless Health Initiatives (HHI): Homeless Response Team (HRT)
S. CalAIM
T. Health Equity
U. DHCS Comprehensive Quality Strategy
V. Student Behavioral Health Incentive Program (SBHIP)

II. QUALITY OF CLINICAL CARE- Adult Wellness

A. Cancer Screenings: Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL), Breast Cancer Screening (BCS)
B. COVID-19 Vaccination and Communication Strategy

III. QUALITY OF CLINICAL CARE- Behavioral Health

A. Follow-up After Hospitalization for Mental illness within 7 and 30 days of discharge (FUH).

INITIAL WORK PLAN AND APPROVAL:

Submitted and approved by QIC: Date:

Submitted and approved by QAC: Date:

Quality Improvement Committee Chairperson:

Richard Pitts, D.O., Ph.D Date:

Board of Directors' Quality Assurance Committee Chairperson:

Trieu Thanh Tran, M.D. Date:

B. Follow-up Care for Children with Prescribed ADHD Medication (ADD): Continuation Phase. Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.

C. Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD)(Medicaid only)

D. Follow-Up After Emergency Department Visit for Mental Illness (FUM)

IV. QUALITY OF CLINICAL CARE- Chronic Conditions

A. Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): HbA1c Poor Control (this measure evaluates % of members with poor A1C control-lower rate is better)

B. Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): Eye Exam

C. Implement multi-disciplinary approach to improving diabetes care for CCN Members Pilot

V. QUALITY OF CLINICAL CARE- Maternal Child Health

A. Prenatal and Postpartum Care Services (PPC): Timeliness of Prenatal Care and Postpartum Care (PHM Strategy).

VI. QUALITY OF CLINICAL CARE- Pediatric/Adolescent Wellness

A. Pediatric Well-Care Visits and Immunizations - Includes measures such as W30 and IMA, Child and Adolescent Well-Care Visits and Immunizations - Includes measures such as WCV and IMA

B. Blood Lead Screening (BLS) (LSC)

VII. QUALITY OF SERVICE- Access

A. Improve Access: Reducing gaps in provider network
B. Improve Access: Expanding Network of Providers Accepting New Patients
C. Improve Access: Timely Access (Appointment Availability)
D. Improve Access: Telephone Access
E. Improving Access: Subcontracted Network Certification

VIII. SAFETY OF CLINICAL CARE

A. Plan All-Cause Readmissions (PCR) - MCAS Measure. OCC Quality Withhold measure.
B. Post-Acute Infection Prevention Quality Incentive (PIPQI)
C. Orange County COVID Nursing Home Prevention Program.

2022 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Health Equity and/or SDOH	Con't Monitoring from 2021	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
I. PROGRAM OVERSIGHT									
2022 QI Annual Oversight of Program and Work Plan	Obtain Board Approval of 2022 QI Program and Workplan	QI Program and QI Work Plan will be adopted on an annual basis; QI Program Description-QIC-BOD; QI Work Plan-QIC-QAC	Annual Adoption by April 2022	Marsha Choo		X			
2021 QI Program Evaluation	Complete Evaluation 2021 QI Program	QI Program and QI Work Plan will be evaluated for effectiveness on an annual basis	Annual Evaluation by April 2022	Marsha Choo		X			
2022 UM Program	Obtain Board Approval of 2022 UM Program	UM Program will be adopted on an annual basis.	Annual Adoption by April 2022	Mike Shook		X			
2021 UM Program Evaluation	Complete Evaluation of 2021 UM Program	UM Program and UM Work Plan will be evaluated for effectiveness on an annual basis.	Annual Evaluation by April 2022	Mike Shook		X			
Population Health Management Strategy	Implement PHM strategy	Review and adopt on an annual basis.	Annual Review and Adoption	Marie Jeannis/Kelly Giardina		X			
Credentialing Peer Review Committee (CPRC) Oversight - Conduct Peer Review of Provider Network by reviewing Credentialing Files, Quality of Care cases, and Facility Site Review, to ensure quality of care delivered to members		Review of Initial and Recredentialing applications approved and denied; Facility Site Review (including Physical Accessibility Reviews); Quality of Care cases leveled by committee.	Quarterly Adoption of Report	Marsha Choo/Laura Guest		X			
Grievance and Appeals Resolution Services (GARS) Committee - Conduct oversight of Grievances and Appeals to resolve complaints and appeals for members and providers in a timely manner.		The GARS Committee oversees the Grievances, Appeals and Resolution of complaints by members and providers for CalOptima's network and the delegated health netwoks. Trends and results are presented to the committee quarterly.	Quarterly Adoption of Report	Tyronda Moses		X			
Member Experience (MEMX) Committee Oversight - Oversight of Member Experience activities to improve quality of service and member experience to achieve the 2021 QI Goal of improving CAHPS and Access to Care.		The MEMX Subcommittee assesses the annual results of CalOptima's CAHPS surveys, monitor the provider network including access & availability (CCN & the HNs), review customer service metrics and evaluate complaints, grievances, appeals, authorizations and referrals for the "pain points" in health care that impact our members.	Quarterly Adoption of Report	Kelly Rex-Kimmet/Marsha Choo		X			
Utilization Management Committee (UMC) Oversight - Conduct Internal and External oversight of UM Activities to ensure over and under utilization patters do not adversely impact member's care.		UMC meets quarterly; monitors medical necessity, cost-effectiveness of care and services, reviewed utilization patterns, monitored over/under-utilization, and reviewed inter-rater reliability results. P&T and BMSC reports to the UMC, and minutes are submitted to UMC quarterly.	Quarterly Adoption of Report	Mike Shook		X			
Whole Child Model - Clinical Advisory Committee (WCM CAC)- Conduct Clinical Oversight for WCM and provide clinical advice for issues related to implementation.		Meet quarterly, provide clinical advice regarding Whole Child Model operations to Medical Affairs.	Quarterly Adoption of Report	T.T. Nguyen, MD		X			
Quality Withhold for OCC	Earn **75**% of Quality Withhold Dollars back for OneCare Connect in OCC QW program end of MY 2021	Monitor and report to QIC	Annual Assessment	Sandeep Mital		X			

2022 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Health Equity and/or SDOH	Con't Monitoring from 2021	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
New Quality Program Updates (Health Network Quality Rating, MCAS, P4V, **OC P4V**, Data Mining/Bridge efforts)	Achieve 50th percentile on all MCAS measures in 2021	Report of new quality program updates including but not limited to Health Network Quality Rating, MCAS reports and P4V. Data Mining/Bridge efforts include Office Ally EMR, CAIR Registry Data, efforts to immunization registry (CAIR) and lab data gaps Activities requiring intervention are listed below in the Quality of Clinical Care measures. **[NEW] Development of the OC P4V program for MY2023**	Quarterly Report or As needed	Kelly Rex-Kimmet/ Paul Jiang/Sandeep Mital		X			
Improvement Projects (All LOB) PIPs	Meet and exceed goals set forth on all improvement projects	Conduct quarterly/Annual oversight of specific goals All LOB PIPs **MC PIPs:** 1) Improving Breast Cancer Screening (BCS) rates for Korean and Chinese CalOptima Medi-Cal Members.(March 1, 2020-December 31, 2022) 2) Improving Well-Care Visits for Children in Their First 30 Months of Life (W30) for CalOptima Medi-Cal Members (March 1, 2020-December 31, 2022)	Quarterly/Annual Assessment	Helen Syn	Health Equity	X			
Improvement Projects (All LOB) QIPs	Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals)	Conduct quarterly/Annual oversight of specific goals All LOB QIPs **MC QIP:** 1) COVID QIP Phase 2 - a. Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (SSD) b. CCS - Increase the number of Medi-Cal members ages 21-64 who complete cervical cancer screening. c. CIS Combo 10 - Increase immunization rates of Medi-Cal members turning 2 years old. 2) Improving Statin Use for People with Diabetes (SPD)	Quarterly/Annual Assessment	Natalie Zavala/Helen Syn	Health Equity	X			
Improvement Projects (All LOB) CCIP's	Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals)	Conduct quarterly/Annual oversight of specific goals on **All LOB CCIPs** 1) OC and OCC CCIP: Improving CDC measure, HbA1C good control <8% - Targeted outreach calls to those with emerging risk >8% (2019 - 2022) 2) OCC QIP: Improving Statin Use for People with Diabetes (SPD) Oversight (review of MOC ICP/ICT Bundles) 2019-2022	Quarterly/Annual Assessment	Helen Syn		X			
PPME/QIPE: HRA's	Goal 95% timely completion on all HRA HN MOC oversight 90% CA MMP 1.5 ICP High/Low risk Goal is 75% CA MMP 1.6 Care Goal Discussion 95% MMP 3.2 ICP completion 90 days 85%	Conduct quarterly/Annual oversight of specific goals **OC and OCC** PPME and QIPEs 1) PME (OC): HRA's, HN MOC Oversight(Review of MOC ICP/ICT bundles) 2) QIPE (OCC): HRA's, ICP High/Low Risk, ICP Completed within 90 days, HN MOC 3) LTSS HRA OCC: Monitor for timeliness on outreach for completion.	Quarterly/Annual Assessment	Sloane Petrillo/S. Hickman		X			
BHI Incentive Program (DHCS - under prop 56 funding) and ABA P4V	Achieve program milestones quarterly and annual performance goals	1) Monitor the 12 projects approved by DHCS for the BHI Incentive Program. Program launched in January 2021. CalOptima is responsible for program oversight (i.e., milestones tracking, reporting and incentive reimbursement). Quarterly program update at QIC. 2) Monitor the ABA P4V program's performance metrics -% of supervision hours completed by BCBA /BMC and % of 1:1 hours utilized vs. authorized. Submit results quarterly to the program's eligible contracted providers. Program launched January 2021 and approved to continue through January 2022.	Quarterly Adoption of Report	Natalie Zavala/Sheri Hopson		X			

2022 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Health Equity and/or SDOH	Con't Monitoring from 2021	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
Homeless Health Initiatives (HHI): Homeless Response Team (HRT)	Increase access to Care for individuals experiencing homelessness.	1) Regular planned visits to shelters, hot spots and recuparative care facilities- to resume post-COVID-19 addition of virtual outreach visits to shelters. 2)Primary point of contact for coordinating care with collaborating partners and HNs 3) Serve as a resource in pre-enforcement engagements, as needed. -to resume post-COVID-19	Quarterly Report	Katie Balderas/Sloane Petrillo	SDOH	X			
CalAIM	Improve Health & Access to care for enrolled members	1) Complete transition of all enrolled HHP members to CalAIM ECM Q1 2022 2) Complete transition of all enrolled WPC members to CalAIM ECM Q1 2022 3) Establish DHCS reporting process 4) Establish oversight strategy for the CalAIM program	Quarterly Report	Sloane Petrillo/Natalie Zavala	SDOH	X			
Health Equity	Adapt Institute for Healthcare Improvement Health Equity Framework	1) Make health equity a strategic priority 2) Develop structure and process to support health equity work 3) Deploy specific strategies to address the multiple determinants of health on which health care organizations can have direct impact 4) Develop partnerships with community organizations to improve health and equity 5) Ensure COVID-19 vaccination and communication strategy incorporate health equity.	Quarterly Report	Katie Balderas/Marie Jeannis	Health Equity	x			
DHCS Comprehensive Quality Strategy	**Develop CalOptima quality strategy in alignment with the final DHCS comprehensive quality strategy.**	**[NEW} to 2022 QI Work Plan 1) Work with DHCS to define the final 2022 Comprehensive Quality Strategy. 2) Collaborate with Internal and external stakeholders in the development quality strategy**	**12/31/2022**	**Marie Jeannis/Marsha Choo**	Health Equity				
Student Behavioral Health Incentive Program (SBHIP)	**Achieve program implementation period deliverables**	**[NEW} to 2022 QI Work Plan SBHIP is part of the Administration and State Legislature effort to prioritize behavioral health services for youth ages 0-25. The new program is intended to establish and strengthen partnerships and collaboration with school districts, county BH and CalOptima by developing infrastructure to improve access and increase the number of TK-12 grade students receiving preventative, early interventions and BH services.**	**12/31/2022**	**Natalie Zavala**	**Health Equity**				
II. QUALITY OF CLINICAL CARE- Adult Wellness									
Cancer Screenings: Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL), Breast Cancer Screening (BCS)	HEDIS MY2021 Goal: CCS: MC 59.12% BCS: MC 61.24% OCC 69% OC 69% COL: OCC 71% OC 62% Based on HEDIS MY2020 NCQA Quality Compass Benchmarks, 50th percentile (released September 2021): CCS: MC 59.12% BCS: MC 53.93%	1) Transition to the Member Health Reward vendor to continue rewards established for CCS, BCS and COL programs. Track member health reward impact on HEDIS rates for cancer screening measures. 2) Targeted member engagement and outreach campaigns to promote cancer screenings in coordination with health network partners. 3) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. 4) Community and Mobile Cancer Screening Events with community partners and agencies. eg. Mobile Mammography Events.	12/31/2022	Helen Syn	Health Equity	X			
COVID-19 Vaccination and Communication Strategy	Vaccine rate of 80% or more of CalOptima members (12 and over).	1) Efforts to support APL for COVID Vaccination from DHS. 2) Continue COVID Vaccination member health reward fulfillment process for all eligible age groups including Kaiser population and homeless population. 3) Implement the COVID QIP Interventions: Listed in Improvement Projects Section. 4) Continue Communication Strategy for COVID vaccine that address members based on zip codes, ethnicity, and pre-existing risk conditions.	12/31/2022	Helen Syn		X			

2022 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Health Equity and/or SDOH	Con't Monitoring from 2021	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
III. QUALITY OF CLINICAL CARE- Behavioral Health									
Follow-up After Hospitalization for Mental illness within 7 and 30 days of discharge (FUH).	**HEDIS MY2021 Goal:** FUH 30-Days: MC: NA; OC: NA; OCC: 56% (Quality Withhold measure) 7-Days: MC: NA; OC:NA;OCC:34.67%	1) Conduct additional hospital visits to educate discharge planning staff on FUH requirements and address any questions or concerns. 2) Continue to conduct post discharge member outreach to ensure members are able to attend follow up appointment, and identify and address potential barriers. 3) Incorporate successful interventions identified by the BHI Incentive Program project to improve follow-up after hospitalization.	12/31/2022	Natalie Zavala		X			
Follow-up Care for Children with Prescribed ADHD Medication (ADD): Continuation Phase. Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	**HEDIS MY2021 Goal:** MC - Init Phase - 44.51% MC -Cont Phase - 55.96%	1) Continue the non-compliant providers letter activity. 2) Participate in educational events on importance of attending follow-up visits. 3) Continue member outreach to improve appointment scheduling by identifying and addressing potential barriers for not attending visits.	12/31/2022	Natalie Zavala		X			
Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD) (Medicaid only)	**HEDIS 2021 Goal: MC 73.69% OC (Medicaid only) OCC (Medicaid only)**	**[NEW} to 2022 QI Work Plan 1) Identify members in need of diabetes screening test. 2) Conduct outreach to prescribing provider to remind of best practice and provide list of members still in need of screening. 3) Remind prescribing providers to contact members' primary care physician (PCP) with lab results by providing name and contact information to promote coordination of care.**	**12/31/2022**	**Natalie Zavala**					
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	**HEDIS Goal: MC 30-Day: 53.54%; 7-day: 38.55% OC (Medicaid only) OCC (Medicaid only)**	**[NEW] to 2022 QI Work Plan 1) Create and distribute provider and member educational materials on the importance of follow-up visits. 2) Collaborate with health networks to identify and address potential barriers.**	**12/31/2022**	**Natalie Zavala**					
IV. QUALITY OF CLINICAL CARE- Chronic Conditions									
Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): HbA1c Poor Control (this measure evaluates % of members with poor A1C control-lower rate is better)	**MY2021** HEDIS Goals: MC: 34.06%; OC: 19% OCC: 19%	1) Transition to the Member Health Reward vendor to continue rewards established for A1c Testing. Implement new member health rewards targeting CCN members with diabetes with poor control. Track member health reward impact on HEDIS rates for CDC measures. 2) Targeted member engagement and outreach campaigns to promote CDC compliance in coordination with health network partners. 3) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. 4) Prop 56 provider value based payments for diabetes care measures	12/31/2022	Helen Syn		X			
Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): Eye Exam	MY2020 HEDIS Goals:: MC 63.2% OC: 71%; OCC: 79%	1) Transition to the Member Health Reward vendor to continue rewards established for Eye Exams. 2) Targeted member engagement and outreach campaigns to promote CDC compliance in coordination with health network partners. 3) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. 4) Prop 56 provider value based payments for diabetes care measures	12/31/2022	Helen Syn		X			

2022 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Health Equity and/or SDOH	Con't Monitoring from 2021	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
Implement multi-disciplinary approach to improving diabetes care for CCN Members Pilot	**1) lower HbA1c level to avoid complications 2) reduce emergency department (ED) visits 3) reduce hospitalization rates 4) reduce costs for diabetic medications 5) improve member and provider satisfaction; and 6) optimize diabetes medication management during the transition to Medi Cal Rx.**	**There are four parts to this multidispclinary approach: 1) Pharmacist Involvement and Intervention- Nicki G. • CalOptima Pharmacist's role will include individual member outreach and provider consultations for members enrolled in the pilot program. CalOptima pharmacists will promote proper medication utilization, provide medication adherence counseling, and support behavior changes needed for diabetic members with a multidisciplinary team approach, including collaboration with PCPs and health coaches/registered dieticians/case managers. 2) Health Coach/Registered Dietician Intervention - Jocelyn J. • CalOptima Health Coaches will provide CCN-focused interventions such as assessment/care planning, motivational interviewing, member education materials, referral to other community resources based on needs. Health Coaches/Registered Dieticians would also participate in Interdisciplinary Care Team (ICT) meetings, as applicable, and connect members to case management if other acute needs are identified during an intervention. 3) Member Health Rewards - Helen Syn • CalOptima would like to support member engagement and compliance by providing members with health rewards (non- monetary incentives). 4) Provider Incentives - TBD • In order to have successful provider buy-ins, CalOptima proposes providing incentives for their dedicated participation in this multidisciplinary DM program. Providers are eligible for incentives when they participate in the program to manage a member with known or potentially poorly controlled diabetes and meet the eligibility criteria for participation year.**	12/31/2024	**Nicki Ghazanfarpour /Helen Syn/ Jocelyn Johnson**		X			
V. QUALITY OF CLINICAL CARE- Maternal Child Health									
Prenatal and Postpartum Care Services (PPC): Timeliness of Prenatal Care and Postpartum Care (PHM Strategy).	HEDIS MY2021 Goal: Postpartum: 79.56% Prenatal: 90.75% Based on HEDIS MY2020 NCQA Quality Compass Benchmarks (released September 2021)	1)Transition to the Member Health Reward vendor to continue rewards established for Postpartum care. 2) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, events, and other modes. 3) Continue expansion of Bright steps comprehensive maternal health program through community partnerships, provider/ health network partnerships, and member engagement. Examples: WIC Coordination, Diaper Bank Events 4) Implement Collaborative Member Engagement Event with OC CAP Diaper Bank and other community-based partners 5) Prop 56 provider value based performance incentives for prenatal and postpartum care visits	12/31/2022	Ann Mino/Helen Syn	Health Equity	X			
VI. QUALITY OF CLINICAL CARE- Pediatric/Adolescent Wellness									
Pediatric Well-Care Visits and Immunizations - Includes measures such as W30 and IMA, Child and Adolescent Well-Care Visits and Immunizations - Includes measures such as WCV and IMA	HEDIS **MY2021** Goal CIS-Combo 10: 49.58% IMA-Combo 2: 50.61% W30-First 15 Months: 54.92% W30-15 to 30 Months: 74.42% WCV (Total): 53.83% Based on HEDIS MY2020 NCQA Quality Compass Benchmarks (released September 2021)	1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. 3) EPSDT DHCS promotional campaign emphasizing immunizations and well care EPSDT visits 4) Implement Community events to promote well-care visits and immunizations for children and adolescents; and track the number of participants and impact on rates. Examples: Back-to-School Immunization Clinics 5) Prop 56 provider value based payments for relevant child and adolescent measures	12/31/2022	Helen Syn	Health Equity	X			

2022 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Health Equity and/or SDOH	Con't Monitoring from 2021	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
Blood Lead Screening (BLS) (LSC)	1) Comply with APL requirements as stated 2) Send quarterly reports to CalOptima contracted PCPs timely 3) **HEDIS MY2021 Goal (3 Year Goal)**: Lead Screening 50th percentile 71.53%	1) Continue providing quarterly report to CalOptima contracted PCPs identifying children with gaps in blood lead screening recommended schedule. 2)Targeted member engagement and outreach campaigns to promote blood lead screenings in coordination with health network partners 3) Prop 56 provider value based payments for Blood Lead Screening	12/31/2022	Helen Syn		X			
VII. QUALITY OF SERVICE- Access									
Improve Access: Reducing gaps in provider network	Reduce the rate of OON requests for these top 3 specialties by 10%	1) Actively recruit specialties with the most out-of-network (OON) requests for CCN (General Surgery, Ophthalmology and Orthopedic Surgery)	12/31/2022	Michelle Laughlin/Jennifer Bamberg/Maggie Hart		X			
Improve Access: Expanding Network of Providers Accepting New Patients	**Increase the number of providers accepting new patients: PCPs from 60.3% to 65.3% Specialists from 56.7% to 61.7%**	**[NEW] to 2022 QI Work Plan 1) Targeted outreach campaign to open their panels 2) Business consideration to require providers to participate in all programs.**	**12/31/2022**	**Marsha Choo/Jennifer Bamberg**					
Improve Access: Timely Access (Appointment Availability)	Improve Timely Access compliance with Appointment Wait Times: Routine PCP from 76.2% to 80% MPL Urgent PCP from 68.4% to 73.4% Routine SPEC from 67.7% to 72.7% Urgent SPEC from 56.1% to 61.1%	1) Communication and corrective action to providers not meeting timely access standards 2) Communication and PDSAs to HNs not meeting timely access standards 3) See Virtual Care Strategies	12/31/2022	Marsha Choo/Jennifer Bamberg		X			
Improve Access: Telephone Access	Reduce the rate of **No Live Contacts After 3 Attempts** from 29.9% to 26.9% (or 10% of the performance gap)	1) Improve provider data in FACETs (i.e. Provider Directory Attestations, DHCS Quarterly and Monthly Provider Data Audits) 2) Individual Provider Outreach and Education (Timely Access Survey)	12/31/2022	Marsha Choo/Jennifer Bamberg		X			
Improving Access: Subcontracted Network Certification	**Certifiy all HNs for network adequacy**	**[NEW] 2022 QI Work Plan 1) Mandatory Provider Types 2) Provider to Member Ratios 3) Time/Distance 4) Timely Access If 1-3 are not met, HN to identify a provider to fill the gap. If 4 not met, HN to be issued a PDSA.**	**7/31/2022**	**Marsha Choo/Jennifer Bamberg**					

2022 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Health Equity and/or SDOH	Con't Monitoring from 2021	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
VIII. SAFETY OF CLINICAL CARE									
Plan All-Cause Readmissions (PCR) - MCAS Measure. OCC Quality Withhold measure.	**HEDIS MY2021** Goal: MC - NA OC 8%; OCC 1.0 (O/E Ratio)	1) Update the existing CORE report(RR0012) to include Medical LOB, Members with First Follow-up Visit within 30 days Discharge (CA 1.11) 2) Improve PCP Visit Access 3) Continue to engage work group to address barriers, thereby achieving inctreased post hospitalization visits with PCP Continue to discuss barriers with internal team to improve members having a follow up PCP visit at time of discharge. Currently developing a communication strategy to hospitals and members regardign the importance of having a post dischage visit with the members PCP.	12/31/2022	Mike Shook		X			
Post-Acute Infection Prevention Quality Incentive (PIPQI)	1) To reduce the number of nosocomial infections for LTC members. 2) To reduce the number of acute care hospitalizations related to infections for LTC members.	1) Nurses will be visiting each facilitiy/ out reach minimally once a week. 2) Facility Staff bathe residents in Chlorhexidine (CHG) antiseptic soap for routine bathing and showering. And administer Iodofor (nasal swabs) per PIPQI Protocols. 3) CalOptima will pay participating facilities via reimbursement for product purchasing and quarterly quality incentive payments. 4) CalOptima will market and expand the PIPQI Program into additional CalOptima Contracted Nursing facilities providing onboarding training, new branding and educational materials.	12/31/2022	Michelle Findlater/Scott Robinson		X			
Orange County COVID Nursing Home Prevention Program.	Conduct in-person training of 12 CalOptima contracted nursing facilities in collaboration with UCI to reduce the spread of COVID/Infections in nursing facilities; toolkit, consultative services and webinars provided to all Orange County nursing homes free of charge	Program includes intense in-person training of contracted nursing facilities provided by UCI, along with consultative sessions, comprehensive toolkit, weekly educational emails, and training webinars provided free to all CalOptima Orange County contracted nursing facilities. Program funding through May 2022. Planned activities include: 1) Provide expertise on infection prevention for COVID-19/SARS-CoV-2 2) Provide guidance, protocols for preventing spread of COVID 3) Support training on how to stock and use protective gear 4) Develop high compliance processes for protection of staff and residents. 5) Make toolkit available for free at www.ucihealth.org/stopcovid 6) Provide COVID prevention helpline to offer guidance and information to nursing home staff 7) Conduct point prevalence sweeps of residents for multi-drug organisms	5/31/2022	Cathy Osborn/**Scott Robinson**		X			

APPENDIX B- 2022 QI Delegation Grid

2022 QI Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
1.1.1	QI1A: QI Program Structure	X		X	
1.1.2	QI1B: Annual Work Plan	X		X	
1.1.3	QI1C: Annual Evaluation	X		X	
1.1.4	QI1D: QI Committee Responsibilities	X		X	
New	**QI1E: Promoting Organizational Diversity, Equity and Inclusion**	**X**		**X**	**[NEW] Effective 7/1/2022, 2022 HP Standards**
1.2.1	QI2A: Practitioner Contracts	X		X	
1.2.2	QI2B: Provider Contracts	X		X	Not Required for Renewal Survey
1.3.1	QI3A: Identifying Opportunities-Continuity & Coordination of Care of Medical Care (C&C)	X		X	
1.3.2	QI3B: Acting on Opportunities-Continuity & Coordination of Care of Medical Care (C&C)	X		X	
1.3.3	QI3C: Measuring Effectiveness-Continuity & Coordination of Care of Medical Care (C&C)	X		X	
1.3.4	QI3D: Transition to other Care-Continuity & Coordination of Care of Medical Care (C&C)	X		X	
1.4.1	QI4A: Data Collection- C&C Between Medical Care and Behavioral Health	X		X	

APPENDIX B- 2022 QI Delegation Grid

2022 QI Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
1.4.2	QI4B: Collaborative Activities- C&C Between Medical Care and Behavioral Health	X		X	
1.4.3	QI4C: Measuring Effectiveness- C&C Between Medical Care and Behavioral Health	X		X	
1.5.1	QI5A: Delegation Agreement	X			May not be Delegated
1.5.2	QI5B: Predelegation Evaluation	X			May not be Delegated
1.5.3	QI5C: Review of QI Program	X			May not be Delegated
1.5.4	QI5D: Opportunuties for Improvement	X			May not be Delegated
2.1.1	PHM1A: Strategy Description-PHM	X		X	
2.1.2	PHM1B: Informing Members-PHM	X		X	
2.2.1	PHM2A: Data Integration-PHM	X		X	
2.2.2	PHM2B: Population Assessment-PHM	X		X	
2.2.3	PHM2C: Activities and Resources-PHM	X		X	
2.2.4	PHM2D: Segmentation-PHM	X		X	

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2022 QI Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
2.3.1	PHM3A: Practitioner or Provider Support	X		X	
2.3.2	PHM3B: Value-Based Payment Arrangement	X			May not be Delegated
2.4.1	PHM4A: Frequency of HA Completion	X		X	
2.4.2	PHM4B: Topics of Self- Management Tools	X		X	
2.5.1	PHM5A: Access to Case Management-CCM	X	X	X	
2.5.2	PHM5B: Case Management Systems-CCM	X	X	X	
2.5.3	PHM5C: Case Management Process-CCM	X	X	X	Not Required for Renewal Survey
2.5.4	PHM5D: Initial Assessment-CCM	X	X	X	
2.5.5	PHM5E: Case Management- Ongoing Management-CCM	X	X	X	
2.6.1	PHM6A: Measuring Effectiveness-PHM	X		X	
2.6.2	PHM6B: Improvement and Action -PHM	X		X	
2.7.1	PHM7A: Delegation Agreement	X			May not be Delegated

APPENDIX B- 2022 QI Delegation Grid

2022 QI Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
2.7.2	PHM7B: Predelegation Evaluation	X			May not be Delegated
2.7.3	PHM7C: Review of PHM Program	X			May not be Delegated
2.7.4	PHM7D: Opportunities for Improvement	X			May not be Delegated
3.1.1	NET1A: Cultural Needs and Preferences	X		X	
3.1.2	NET1B: Practitioners Providing Primary Care	X		X	
3.1.3	NET1C: Practitioners Providing Specialty Care	X		X	
3.1.4	NET1D: Practitioners Providing Behavioral Health (BH)	X		X	
3.2.1	NET2A: Access to Primary Care	X		X	
3.2.2	NET2B: Access to BH	X		X	
3.2.3	NET2C: Access to Specialty Care	X		X	
3.3.1	NET3A: Assessment of Member Experience Accessing the Network	X		X	
3.3.2	NET3B: Opportunities to Improve Access to Non-behavioral Healthcare Services	X		X	

APPENDIX B- 2022 QI Delegation Grid

2022 QI Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
3.3.3	NET3C: Opportunities to Improve Access to BH Services	X		X	
3.4.1	NET4A: Notification of Termination	X	X	X	
3.4.2	NET4B: Continued Access to Practitioners	X	X	X	
3.5.1	NET5A: Physician Directory Data	X		X	
3.5.2	NET5B: Physician Directory Updates	X		X	
3.5.3	NET5C: Assessment of Physician Directory Accuracy	X		X	
3.5.4	NET5D: Identifying and Acting on Opportunities	X		X	
3.5.5	NET5E: Searchable Physician Web-Based Directory	X		X	
3.5.6	NET5F: Hospital Directory Data	X		X	
3.5.7	NET5G: Hospital Directory Updates	X		X	
3.5.8	NET5H: Searchable Hospital Web-Based Directory	X		X	
3.5.9	NET5I: Usability Testing	X		X	

APPENDIX B- 2022 QI Delegation Grid

2022 QI Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
3.5.10	NET5J: Availability of Directories	X		X	
3.6.1	NET6A: Delegation Agreement	X			May not be Delegated
3.6.2	NET6B:Pre-Delegation Evaluation	X			May not be Delegated
3.6.3	NET6C: Review of Delegated Activities	X			May not be Delegated
3.6.4	NET6D: Opportunities for Improvement	X			May not be Delegated
4.1.1	UM1A: Written Program Description	X	X	X	
4.1.2	UM1B: Annual Evaluation	X	X	X	
4.2.1	UM2A: UM Criteria	X	X	X	
4.2.2	UM2B: Availability of Criteria	X	X	X	Not Required for Renewal Survey
4.2.3	UM2C: Consistency in Applying Criteria	X	X	X	
4.3.1	UM3A: Access to Staff	X	X	X	
4.4.1	UM4A: Licensed Health Professionals	X	X	X	

APPENDIX B- 2022 QI Delegation Grid

2022 QI Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
4.4.2	UM4B: Use of Practitioners for UM Decisions	X	X	X	
4.4.3	UM4C: Practitioner Review of Non-Behavioral Healthcare Denials	X	X	X	
4.4.4	UM4D: Practitioner Review of BH Denials	X		X	
4.4.5	UM4E: Practitioner Review of Pharmacy Denials	X		X	
4.4.6	UM4F: Use of Board-Certified Consultants	X	X	X	
4.5.1	UM5A: Notification of Non-Behavioral Decisions	X	X	X	
4.5.2	UM5B: Notification of Behavioral Healthcare Decisions	X		X	
4.5.3	UM5C: Notification of Pharmacy Decisions	X		X	
4.5.4	UM5D: UM Timeliness Report	X		X	
4.5.5	UM5E: Interim- Policies and Procedures				NA (Interim Surveys only)
4.6.1	UM6A: Relevant Information for Non-Behavioral Decisions	X	X	X	
4.6.2	UM6B: Relevant Information for BH Decisions	X		X	

APPENDIX B- 2022 QI Delegation Grid

2022 QI Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
4.6.3	UM6C: Relevant Information for Pharmacy Decisions	X		X	
4.7.1	UM7A: Discussing a Denial with a Reviewer	X	X	X	
4.7.2	UM7B: Written Notification of Non-Behavioral Healthcare Denials	X	X	X	
4.7.3	UM7C: Non-Behavioral Notice of Appeal Rights/Process	X	X	X	
4.7.4	UM7D: Discussing a BH Denial with a Reviewer	X		X	
4.7.5	UM7E: Written Notification of BH Denials	X		X	
4.7.6	UM7F: BH Notice of Appeal Rights/Process	X		X	
4.7.7	UM7G: Discussing a Pharmacy Denial with a Reviewer	X		X	
4.7.8	UM7H: Written Notification of Pharmacy Denials	X		X	
4.7.9	UM7I: Pharmacy Notice of Appeal Rights/Process	X		X	
4.8.1	UM8A: Internal Appeals (Policies and Procedures)	X		X	
4.9.1	UM9A: Pre-service and Post-service Appeals	X		X	

APPENDIX B- 2022 QI Delegation Grid

2022 QI Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
4.9.2	UM9B: Timeliness of the Appeal Process	X		X	
4.9.3	UM9C: Appeal Reviewers	X		X	
4.9.4	UM9D: Notification of Appeal Decision/Rights	X		X	
4.9.5	UM9E: Final Internal and External Decision Rights				For Medi-Cal or OC/OCC this function or activity is not Applicable
4.9.6	UM9F: Appeals Overturned by the IRO				For Medi-Cal or OC/OCC this function or activity is not Applicable
4.9.7	Provider Level 1 UM Appeals	X	X	X	
4.9.8	Provider Level 2 UM Appeals	X			
4.10.1	UM10A: Written Process	X			For Medi-Cal, this function or activity is no applicable. For OC/OCC, this function or activity is retained by CalOptima and is not delegated to the Delegate.
4.10.2	UM10B: Description of the evaluation Process	X			For Medi-Cal, this function or activity is no applicable. For OC/OCC, this function or activity is retained by CalOptima and is not delegated to the Delegate.
~~4.11.1~~	~~UM11A: Pharmaceutical Management Procedures (Policies and Procedures)~~	~~X~~		~~X~~	Effective 1/1/2022, Pharmacy Benefit Management will be carved out.
~~4.11.2~~	~~UM11B: Pharmaceutical Restrictions/Preferences~~	~~X~~		~~X~~	Effective 1/1/2022, Pharmacy Benefit Management will be carved out.

APPENDIX B- 2022 QI Delegation Grid

2022 QI Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
~~4.11.3~~	~~UM11C: Pharmaceutical Patient Safety Issues~~	~~X~~		~~X~~	Effective 1/1/2022, Pharmacy Benefit Management will be carved out.
~~4.11.4~~	~~UM11D: Reviewing and Updating Procedures~~	~~X~~		~~X~~	Effective 1/1/2022, Pharmacy Benefit Management will be carved out.
~~4.11.5~~	~~UM11E: Considering Exceptions~~	~~X~~		~~X~~	Effective 1/1/2022, Pharmacy Benefit Management will be carved out.
4.12.1	UM12A: UM Denial System Controls	X	X	X	
New	**UM12B: UM Denials System Controls Oversight**	**X**	**X**	**X**	**[NEW] Effective 7/1/2022, 2022 HP Standards**
4.12.2	UM12C: UM Appeal System Controls	X		X	
New	**UM12D: UM Appeals System Controls Oversight**	**X**		**X**	**[NEW] Effective 7/1/2022, 2022 HP Standards**
4.13.1	UM13A: Delegation agreement	X			May not be Delegated
4.13.2	UM13B: Predelegation Evaluation	X			May not be Delegated
4.13.3	UM13C: Review of the UM Program	X			May not be Delegated
4.13.4	UM13D: Opportunities for Improvement	X			May not be Delegated
4.14.1	Second Opinion	X	X	X	

APPENDIX B- 2022 QI Delegation Grid

2022 QI Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
5.1.1	CR1A: Practitioner Credentialing Guidelines	X	X	X	
5.1.2	CR1B: Practitioner Rights	X	X	X	
5.1.3	CR1C: Credentialing System Controls	X	X	X	
New	**CR1D: Credentialing System Controls Oversight**	**X**	**X**	**X**	**[NEW] Effective 7/1/2022, 2022 HP Standards**
5.2.1	CR2A: Credentialing Committee	X	X	X	
5.3.1	CR3A: Verification of Credentials	X	X	X	
5.3.2	CR3B: Sanction Information	X	X	X	
5.3.3	CR3C: Credentialing Application	X	X	X	
5.4.1	CR4A: Recredentialing Cycle Length	X	X	X	
5.5.1	CR5A: Ongoing Monitoring and Interventions	X	X	X	
5.6.1	CR6A: Actions Against Practitioners	X	X	X	Not Required for Renewal Survey
5.7.1	CR7A: Review and Approval of Provider	X	X	X	Not Required for Renewal Survey

APPENDIX B- 2022 QI Delegation Grid

2022 QI Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
5.7.2	CR7B: Medical Providers	X	X	X	Not Required for Renewal Survey
5.7.3	CR7C: Behavioral Health Providers				For Medi-Cal, this standard is not applicalbe because behavioral health facilities are carved out to the HCA. For OC/OCC, this function or activities is retained by CalOptima and is not delegated to the Delegate.
5.7.4	CR7D: Assessing Medical Providers	X	X	X	
5.7.5	CR7E: Assessing Behavioral Healthcare Providers	X			For Medi-Cal, this standard is not applicable because behavioral health facilities are carved out to the HCA. For OC/OCC, this function or activities is retained by CalOptima and is not delegated to the Delegate.
5.8.1	CR8A: Delegation Agreement	X			May not be Delegated
5.8.2	CR8B: Predelegation Evaluation	X			May not be Delegated
5.8.3	CR8C: Review of Delegate's Credentilaing Activities	X			May not be Delegated
5.8.4	CR8D: Opportunities for Improvement	X			May not be Delegated
6.1.1	ME1A: Rights and Responsibility Statement	X			May not be Delegated
6.1.2	ME1B: Distribution of Rights Statement	X		X	

APPENDIX B- 2022 QI Delegation Grid

2022 QI Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
6.2.1	ME2A: Subscriber Information	X			May not be Delegated
6.2.2	ME2B: Interpreter Services	X		X	
6.3.1	ME3A: Materials and Presentations	X			For Medi-Cal , this function or activity is not applicable. For OC/OCC, this function or activity is retained by CalOptima and is not delegated to the Delegate
6.3.2	ME3B: Communication with Prospective Members	X			For Medi-Cal , this function or activity is not applicable. For OC/OCC, this function or activity is retained by CalOptima and is not delegated to the Delegate
6.3.3	ME3C: Assessing Member Understanding	X			For Medi-Cal , this function or activity is no applicable. For OC/OCC, this function or activity is retained by CalOptima and is not delegated to the Delegate
6.4.1	ME4A: Functionality: Website	X			Not Required for Renewal Survey
6.4.2	ME4B: Functionality: Telephone Requests	X			Not Required for Renewal Survey
6.5.1	ME5A: Pharmacy Benefit Information: Website	X		X	Not Required for Renewal Survey
6.5.2	ME5B: Pharmacy Benefit Information: Telephone	X		X	Not Required for Renewal Survey
6.5.3	ME5C: QI Process on Accuracy of Information	X		X	

APPENDIX B- 2022 QI Delegation Grid

2022 QI Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
6.5.4	ME5D: Pharmacy Benefit Updates	X		X	
6.6.1	ME6A: Functionality: Web Site	X		X	
6.6.2	ME6B: Functionality: Telephone	X		X	
6.6.3	ME6C: Quality and Accuracy of Information	X		X	
6.6.4	ME6D: E-Mail Response Evaluation	X		X	
6.7.1	ME7A: Policies and Procedures for Complaints	X		X	
6.7.2	ME7B: Policies and Procedures for Appeals	X		X	
6.7.3	ME7C: Annual Assessment- Nonbehavioral Healthcare Complaints and Appeals	X		X	
6.7.4	ME7D: Opportunities for Improvement-Non-behavioral Opportunities for Improvement	X			May not be Delegated
6.7.5	ME7E: Annual Assessment of BH and Services-Member Experience	X		X	
6.7.6	ME7F: BH Opportunities for Improvement-Behavioral Healthcare Opportunities for Improvement	X			
6.8.1	ME8A: Delegation Agreement	X			May not be Delegated

APPENDIX B- 2022 QI Delegation Grid

2022 QI Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
6.8.2	ME8B: Predelegation Evaluation	X			May not be Delegated
6.8.3	ME8C: Review of Performance	X			May not be Delegated
6.8.4	ME8D: Opportunities for Improvement	X			May not be Delegated
7.1.1	Claims Processing Exclusion and Preclusion Monitoring	X	X	X	
7.1.2	Claims Forwarding	X	X	X	
7.1.3	Interest Payment of Emergency Services Claims	X	X	X	
7.1.4	Timeliness of Claims Processing	X	X	X	
7.1.5	Claims Processing and Coordination of Benefits	X	X	X	
7.1.6	Claims Processing and Provider Dispute Resolution (PDR) related to Claims Payment Decisions- Level 1	X	X	X	
7.1.7	Provider Dispute Resolution related to Claims Payment Decisions- Level 2	X			
7.1.8	Third Party Liability (TPL)	X	X	X	
8.1.1	Provider Complaint Processing	X			

APPENDIX B- 2022 QI Delegation Grid

2022 QI Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
9.1.1	MED1H: Notification of Termination of a Practitioner or Practice Group	X		X	
9.2.1	MED2A: Adoption of Practice Guidelines	X		X	
9.2.2	MED2B: Distributions of Practice Guidelines	X		X	
9.3.1	MED3B: Site Visits and Ongoing Monitoring	X		X	
9.4.1	MED5A: Coordination Health Care Services for Members	X	X	X	
9.4.2	MED5B: Maintaining and Sharing Member Health Records	X		X	
9.5.1	MED8D: Informing Members About the QI Program	X		X	
9.6.1	MED9D: Affirmative Statement about Incentives	X		X	
9.7.1	MED12D: Providing Information to Medicaid Members in the Practitioner Directory	X		X	
9.7.2	MED12F: Providing Information to Medicaid Members in Denial Notifications	X		X	
9.7.3	MED12G: Providing Information to Members in Appeal and Grievance Notifications	X		X	
9.7.4	MED12H: Interpreter Services for Medicaid Members	X		X	

APPENDIX B- 2022 QI Delegation Grid

2022 QI Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
9.7.5	MED12I: Usability Testing of Member Materials	X		X	
9.8.1	MED13B: Offering Special Communication Assistance	X		X	
9.9.1	MED14A: Directory Data	X		X	
9.9.2	MED14B: Pharmacy Directory Data	X		X	
9.9.3	MED14C: Behavorial Healthcare Directory Data	X		X	
9.9.4	MED14D: Long-Term Services and Supports Provider Directory Data	X		X	
9.10.1	MED15A: Delegation Agreement	X			May not be Delegated
9.10.2	MED15B: Provisions for PHI	X			May not be Delegated
9.10.3	MED15C: Predelegation Evaluation	X			May not be Delegated
9.10.4	MED15D: Review of Delegates MED Activities	X			May not be Delegated
9.10.5	MED15E: Opportunities for Improvement	X			May not be Delegated
Note: NCQA Delegated Elements are based on 2021 HP Standards. QI1E, UM12B,UM12D, CR1D are new to 2022 HP Standards (will be added new Delegation Agreements in 2022)					

A Public Agency

CalOptima

Better. Together.

2022

QUALITY IMPROVEMENT PROGRAM

2022 QUALITY IMPROVEMENT PROGRAM SIGNATURE PAGE

Quality Improvement Committee Chair:

Richard Pitts, D.O., Ph.D. **Date**
Chief Medical Officer

Board of Directors' Quality Assurance Committee Chair:

Trieu Tran, M.D. **Date**

Board of Directors Chair:

Supervisor Andrew Do **Date**

TABLE OF CONTENTS

WE ARE CALOPTIMA

Caring for the people of Orange County has been CalOptima's privilege since 1995. We believe that our Medicaid (Medi-Cal) and Medicare members deserve the highest quality care and service throughout the health care continuum. CalOptima works in collaboration with providers, community stakeholders and government agencies to achieve our mission and vision while upholding our values.

Our Mission

To provide members with access to quality health care services delivered in a cost-effective and compassionate manner

The mission of CalOptima is the foundation of everything we do. It permeates every level of the organization. Our mission is focused on our members, and our members are the sole reason CalOptima exists.

Our Vision

To be a model public agency and community health plan that provides an integrated and well-coordinated system of care to ensure optimal health outcomes for all our members.

Our Values — CalOptima CARES

Collaboration

We seek regular input and act upon it. We believe outcomes are better through teamwork and effective communication with our members, providers, community health centers and community stakeholders.

Accountability

We were created by the community, for the community and are accountable to the community. Meetings open to the public are: Board of Directors, Board Finance and Audit Committee, Board Quality Assurance Committee, Investment Advisory Committee, Member Advisory Committee, OneCare Connect Member Advisory Committee, Provider Advisory Committee and Whole-Child Model Family Advisory Committee.

Respect

We respect and care about our members. We listen attentively, assess our members' health care needs, identify issues and options, access resources and resolve problems.

- We treat members with dignity in our words and actions.
- We respect the privacy rights of our members.
- We speak to our members in their languages.

- We respect the cultural traditions of our members.
- We respect and care about our partners.
- We develop supportive working relationships with providers, community health centers and community stakeholders.

Excellence

We base our decisions and actions on evidence, data analysis and industry-recognized standards so our providers and community stakeholders deliver quality programs and services that meet our members' health needs. We embrace innovation and welcome differences of opinion and individual initiative. We take risks and seek new and practical solutions to meet health needs or solve challenges for our members.

Stewardship

We recognize that public funds are limited, so we use our time, talent and funding wisely and maintain historically low administrative costs. We continually strive for efficiency.

We are "Better. Together."

We cannot achieve our mission and our vision alone. We must work together with providers, community health centers, county agencies, state and federal agencies, and other community stakeholders. Together, we develop innovative solutions and meet our diverse members' health care needs. We are "Better. Together."

Our Strategic Plan

In late 2019, CalOptima's Board and executive team worked together to develop our next three-year Strategic Plan. After engaging a wide variety of stakeholders and collecting feedback, the strategic plan was approved in December 2019. Members are the essential focus of the 2020–2022 Strategic Plan, and our Priorities and Objectives are designed to enhance the programs and services provided to members by CalOptima.

The five Strategic Priorities and Objectives are:

- Innovate and Be Proactive
- Expand CalOptima's Member-Centric Focus
- Strengthen Community Partnerships
- Increase Value and Improve Care Delivery
- Enhance Operational Excellence and Efficiency

WHAT IS CALOPTIMA?

Our Unique Dual Role

CalOptima is unusual in that it is both a public agency and a community health plan.

As both, CalOptima must:

- Provide quality health care to ensure optimal health outcomes for our members
- Support member and provider engagement and satisfaction
- Be good stewards of public funds by making the best use of our resources and expertise
- Ensure transparency in our governance procedures, including providing opportunities for stakeholder input
- Be accountable for the decisions we make

WHAT WE OFFER

Medi-Cal

In California, Medicaid is known as Medi-Cal. CalOptima marked 25 years of service to Orange County's Medi-Cal population in 2020.

Medi-Cal covers low-income adults, families with children, seniors, people with disabilities, children in foster care (as well as former foster youth up to age 26), pregnant women and low-income people with specific diseases, such as tuberculosis, breast cancer or HIV/AIDS. A Medi-Cal member must reside in Orange County to be enrolled in CalOptima Medi-Cal.

Scope of Services

Under our Medi-Cal program, CalOptima provides a comprehensive scope of acute and preventive care services for Orange County's Medi-Cal and dual eligible population, including eligible conditions under California Children's Services (CCS) managed by CalOptima through the Whole-Child Model (WCM) Program that went into effect in 2019.

Certain services are not covered by CalOptima but may be provided by a different agency, including those indicated below:

- Specialty mental health services are administered by the Orange County Health Care Agency (HCA)
- Substance use disorder services are administered by HCA
- Dental services are provided through the Medi-Cal Dental Program

Members With Special Health Care Needs

To ensure that clinical services as described above are accessible and available to members with special health care needs — such as seniors, people with disabilities and people with chronic conditions — CalOptima has developed specialized case management services. These case management services are designed to ensure coordination and continuity of care and are described in the Utilization Management (UM) Program and the Population Health Management (PHM) Strategy.

Additionally, CalOptima works with community programs to ensure that members with special health care needs (or with high risk or complex medical and developmental conditions) receive additional services that enhance their Medi-Cal benefits. These partnerships are established as special services through specific Memoranda of Understanding (MOU) with certain community agencies, including HCA and the Regional Center of Orange County (RCOC).

Medi-Cal Managed Long-Term Services and Supports

Since July 1, 2015, DHCS integrated Long-Term Services and Supports (LTSS) benefits for CalOptima Medi-Cal members. CalOptima ensures LTSS services are available to members who have health care needs and meet the program eligibility criteria and guidelines.

These integrated LTSS benefits include three programs:

- Community-Based Adult Services (CBAS)
- Nursing Facility (NF) Services for Long-Term Care (LTC)
- Multipurpose Senior Services Program (MSSP)

OneCare (HMO SNP)

Our OneCare (OC) members have Medicare and Medi-Cal benefits covered in one single plan, making it easier for our members to get the health care they need. Since 2005, CalOptima has been offering OC to low-income seniors and people with disabilities who qualify for both Medicare and Medi-Cal. OC has extensive experience serving the complex needs of the frail, disabled, dual eligible members in Orange County. With the start of OneCare Connect (OCC) in 2015, only individuals not eligible for OCC can enroll in OneCare.

OneCare provides a comprehensive scope of services for dual eligible members enrolled in Medi-Cal and Medicare Parts A and B. OneCare has an innovative Model of Care, which is the structure for supporting consistent provision of quality care. Each member has a Personal Care Coordinator (PCC) whose role is to help the member navigate the health care system and receive integrated medical, behavioral and supportive services. Also, the PCCs work with our members and their doctors to create individualized health care plans that fit each member's needs. Addressing individual needs results in a better, more efficient and higher quality health care experience for the member.

To be a member of OC, a person must live in Orange County and not be eligible for OCC. Enrollment in OC is voluntary and by member choice.

Scope of Services

In addition to the comprehensive scope of acute care, preventive care and behavioral health services covered under Medi-Cal and Medicare, CalOptima OC members are eligible for enhanced services, such as gym memberships.

OneCare Connect

The OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) launched in 2015 for people who qualify for both Medicare and Medi-Cal. OneCare Connect (OCC) is part of Cal MediConnect, a demonstration program operating in seven counties throughout California. The demonstration aims to transform the health care delivery system for people eligible for both Medicare and Medi-Cal.

These members frequently have several chronic health conditions and multiple providers, yet their separate insurance plans often create confusion and fragmented care. By combining all benefits into one plan, OCC delivers coordinated care. Care coordination eliminates duplicated

services and shifts services from more expensive institutions to home- and community-based settings.

At no extra cost, OCC adds benefits such as vision care, gym benefits and an out-of-the-country urgent/emergency care benefit. Additionally, OCC integrates CBAS, MSSP and LTC into the plan benefits. OCC includes personalized support — all to ensure each member receives the services they need when they need them.

OneCare Connect achieves these advancements via CalOptima's innovative Model of Care. Each member has a Personal Care Coordinator (PCC) whose role is to help the member navigate the health care system and receive integrated medical, behavioral and supportive services. Also, the PCCs work with our members and their doctors to create individualized health care plans that fit each member's needs. Addressing individual needs results in a better, more efficient and higher quality health care experience for the member.

To join OCC, a member must live in Orange County, have both Medicare Parts A and B and Medi-Cal, and be 21 years of age or older. Members cannot be receiving services from a regional center or be enrolled in certain waiver programs. Other exceptions also apply.

The Cal MediConnect demonstration program is ending in 2022, and CalOptima is planning to transition OCC members to OC, effective January 1, 2023.

Scope of Services

OCC simplifies and improves health care for low-income seniors and people with disabilities, while ensuring timely access to the comprehensive scope of acute care, preventive care and behavioral health services covered under Medi-Cal and Medicare. At no extra cost, OCC adds enhanced benefits such as vision care, gym benefits and over-the-counter benefits. OCC also includes personalized services through the PCCs to ensure each member receives the services they need when they need them.

PROGRAM INITIATIVES

Mitigate Impact and Improve Health Equity: COVID-19 Pandemic

The COVID-19 pandemic created a public health emergency (PHE) that has changed the landscape of delivering quality health care to our members. The 2022 QI Program goals and initiatives are designed to address the COVID-19 PHE and include initiatives to mitigate the impact of the pandemic. Examples include the Orange County COVID-19 Nursing Home Prevention Program, the LTC Facility Transfer Plan due to COVID-19 pandemic, the Health Equity strategy, as well as the COVID-19 Vaccination and Communication strategy.

Health care disparities play a major role in quality outcomes. Historic and academic publications have shown that health care disparities in race and ethnicity have existed for decades. The COVID-19 pandemic shined a bright light on the health disparities and inequity. The California Department of Public Health COVID-19 analysis by race and ethnicity in September 2021 revealed that Latinx account for 45.9% of coronavirus deaths, in a state where they make up 38.9% of the population; and Blacks account for 6.7% of the deaths, but make up only 6% of the

population. Since health care disparities play a major role in quality outcomes, CalOptima identified opportunities to improve health equity as part of the QI Work Plan.

Department of Health Care Services (DHCS) Comprehensive Quality Strategy (CQS)

The 2022 Draft CQS lays out DHCS' quality and health equity strategy to support a 10-year vision for Medi-Cal, whereby people served by Medi-Cal should have longer, healthier and happier lives. The goals and guiding principles summarized below are built upon the Population Health Management (PHM) framework that is the foundation of California Advancing and Innovating Medi-Cal (CalAIM) and stress DHCS' commitment to health equity, member involvement and accountability in all program initiatives.

Quality Strategy Goals

- Engaging members as owners of their own care
- Keeping families and communities healthy via prevention
- Providing early interventions for rising risk and member-centered chronic disease management
- Providing whole-person care for high-risk populations, addressing drivers of health

Quality Strategy Guiding Principles

- Eliminating health disparities through anti-racism and community-based partnerships
- Data-driven improvements that address the whole person
- Transparency, accountability and member involvement

Health Equity Framework is a depiction of how DHCS intends to approach the elimination of health disparities. The following domains represent DHCS' multipronged vision to building analytic, workforce and programmatic capacity, at all levels, to eliminate health disparities.

- Data collection and stratification
- Workforce diversity and cultural responsiveness
- Reducing health care disparities

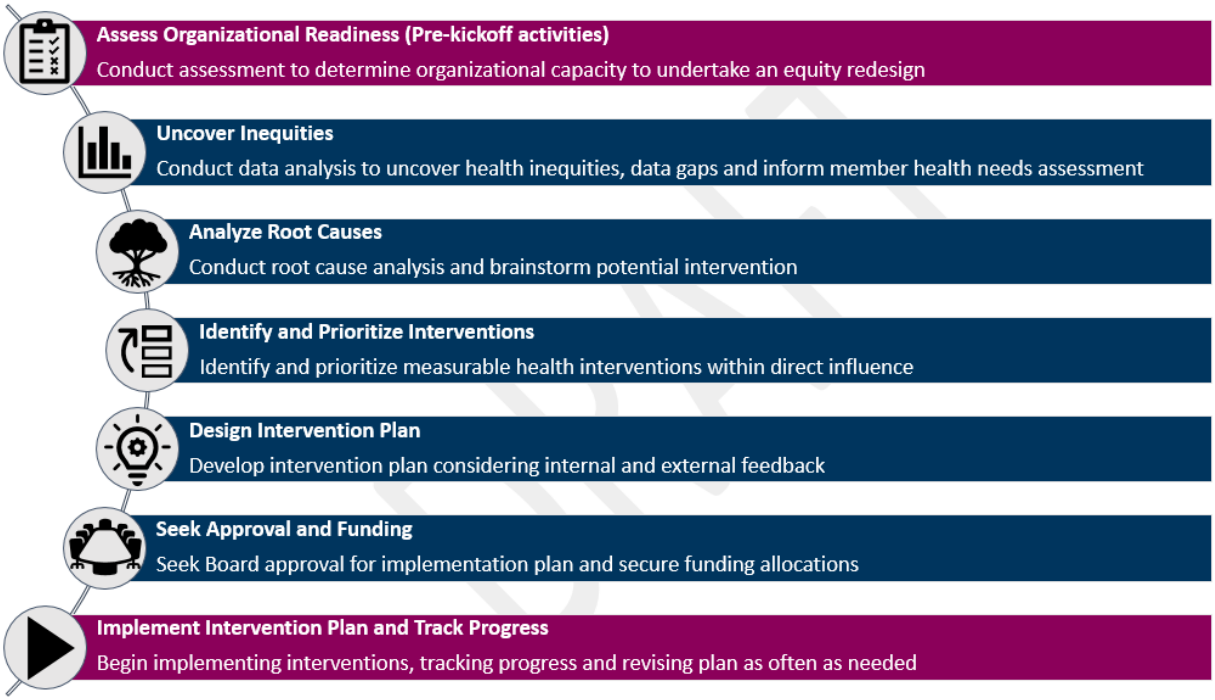
Health Equity Framework

Health equity is achieved when an individual has the opportunity to "attain his or her full health potential" and no one is "disadvantaged from achieving this potential because of social position or other socially determined circumstances" (Centers for Disease Control and Prevention).

Social Determinants of Health (SDOH) are the conditions that exist in the places where people are born, live, learn, work, play, worship and age that affect health outcomes (Henry J. Kaiser Family Foundation).

In response to CalOptima's strategic plan, staff began the process to identify and address health equity and SDOH for vulnerable populations throughout Orange County. The framework includes several milestones from uncovering inequities, looking at root causes and designing a comprehensive intervention plan to planning and tracking progress. It begins with a comprehensive Readiness Assessment to determine organizational capacity to undertake a health equity redesign. As the framework is developed, there will be opportunities to obtain feedback

from internal and external stakeholders and include their input in the intervention and design process.



California Advancing and Innovating Medi-Cal (CalAIM)

California Advancing and Innovating Medi-Cal (CalAIM) is a multiyear initiative, spanning from 2022 to 2027, by DHCS to improve the quality of life and health outcomes of the Medi-Cal population by implementing broad delivery system, program and payment reforms.

CalAIM has three primary goals:

1. Identify and manage member risk and need through whole-person care approaches and addressing SDOH.
2. Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility.
3. Improve quality outcomes, reduce health disparities and drive delivery system transformation and innovation through value-based initiatives, modernization of systems and payment reform.

Enhanced Care Management and Community Supports

Beginning on January 1, 2022, CalOptima implemented two CalAIM components: Enhanced Care Management (ECM) and Community Supports. Enhanced Care Management provides a whole-person approach to care that addresses the clinical and non-clinical circumstances of high-need Medi-Cal members. Community Supports are medically appropriate, flexible, wrap-around services that addresses the member's complex medical and social needs. Community Supports are alternatives to covered services, which are provided to reduce or avoid admissions to a hospital or skilled nursing facility admission, emergency department visits and discharge delays.

CalOptima's implementation of ECM and Community Supports build upon the Health Homes Program (HHP) and Whole-Person Care (WPC) Pilot infrastructures by preserving existing member relationships with HHP and WPC service providers. CalOptima's HHP Community-Based Care Management Entities will transition to become ECM Providers. This means that CalOptima and our delegated health networks (HNs) will provide ECM services as ECM providers to eligible populations. These providers will be responsible for coordinating care with members' existing providers and other agencies to deliver the following seven core service components:

1. Outreach and engagement
2. Comprehensive assessment and care management plan
3. Enhanced coordination of care
4. Health promotion
5. Comprehensive transitional care
6. Member and family supports
7. Coordination of and referral to community and social support services

Beginning January 1, 2022, ECM went live for the following populations of focus:

- Members experiencing homelessness (adults and children)
- High utilizer adults
- Adults with Serious Mental Illness (SMI)/Substance Use Disorder (SUD)

Additionally, members participating in WPC and/or HHP automatically transitioned into ECM.

HHP and WPC service providers will continue to provide services under Community Supports as CalOptima works to expand the network of Community Supports providers that have the expertise and capacity to provide the specific types of services. Members eligible for Community Services must consent to participate and receive services. Community Support services include the following:

1. Housing transition navigation services
2. Housing deposits
3. Housing tenancy and sustaining services
4. Short-term post-hospitalization housing
5. Recuperative care (medical respite)
6. Respite services
7. Day habilitation programs
8. Nursing facility transition/diversion to assisted living facilities
9. Community transition services/nursing facility transition to a home
10. Personal care and homemaker services
11. Environmental accessibility adaptations (home modifications)
12. Medically tailored meals/medically supportive foods
13. Sobering centers
14. Asthma remediation

Beginning January 1, 2022, CalOptima offers the following four Community Supports services:

1. Housing transition navigation services
2. Housing deposits
3. Housing tenancy and sustaining services
4. Recuperative care (medical respite)

CalOptima will continue to assess the needs the of members and collaborate with community stakeholders to add new Community Supports.

2021–22 CalOptima Community Network (CCN) Pilot Program

Diabetes Mellitus Program to Improve Health Care Quality for Medi-Cal Members With Poorly Controlled Diabetics

To address high rates of poorly controlled diabetics identified in the CCN network, the following pilot program was proposed and approved by the CalOptima Board of Directors.

1. Pharmacist Involvement and Intervention:
   CalOptima pharmacists' role will be extended to include individual member outreach and provider consultations. CalOptima believes that our internal pharmacists can promote and support behavior changes needed for diabetic members with a multidisciplinary team approach, including collaboration with primary care providers (PCPs) and health coaches/registered dietitians/case managers.
2. Health Coach/Registered Dietitian Management Intervention:
   CalOptima health coaches will provide CCN-focused interventions such as assessment/care planning, motivational interviewing, member education materials and referral to other community resources based on needs. Health coaches/registered dietitians will also participate in Interdisciplinary Care Team (ICT) meetings, as applicable, and connect members to case management if other acute needs are identified during an intervention.
3. Non-Monetary Member Incentives:
   CalOptima would like to support member engagement and compliance by providing members with health rewards (non-monetary incentives). The non-monetary incentives will be provided as gift cards subject to DHCS approval in the near future.
4. Provider Incentives:
   In order to have successful provider support, CalOptima proposes providing incentives for their dedicated participation in this multidisciplinary diabetes program. Providers are eligible for incentives when they manage a member with known or potentially poorly controlled diabetes and meet the eligibility criteria for participation year.

Pharmacy Administration Changes

Effective January 1, 2022, DHCS carved out the outpatient pharmacy benefit for Medi-Cal beneficiaries from managed care plans and moved it to a state fee-for-service program, known as Medi-Cal Rx. Outpatient pharmacy claims processing/prior authorizations, formulary administration and pharmacy-related grievances will be the responsibility of Medi-Cal Rx. CalOptima-retained responsibilities will include physician-administered drug claims processing/prior authorizations, pharmacy care coordination, clinical aspects of pharmacy adherence, disease and medication management, and participation on the Medi-Cal Global Drug Utilization Review (DUR) Board. This change is for Medi-Cal only and does not affect OC, OCC or PACE.

WITH WHOM WE WORK

Contracted Health Networks/Contracted Network Providers

Providers have options for participating in CalOptima's programs to provide health care to CalOptima members. Providers can contract through CalOptima Direct, CalOptima Direct-Administrative and/or CalOptima Community Network (CCN) and/or contract with a CalOptima HN. CalOptima members can choose CCN or one of 12 HNs representing more than 9,400 practitioners.

CalOptima Direct (COD)

CalOptima Direct has two elements: CalOptima Direct-Administrative and CCN.

- CalOptima Direct-Administrative (COD-A)

  CalOptima Direct-Administrative is a self-directed program administered by CalOptima to serve Medi-Cal members in special situations, including dual-eligibles (those with both Medicare and Medi-Cal who elect not to participate in OC or OCC), share-of-cost members, newly eligible members transitioning to a HN and members residing outside of Orange County.

- CalOptima Community Network (CCN)

  CCN doctors with an alternate path to contract directly with CalOptima to serve our members. CCN is administered directly by CalOptima and available for HN-eligible members to select, supplementing the existing HN delivery model and creating additional capacity for access.

CalOptima Contracted Health Networks

CalOptima has contracts with delegated HNs through a variety of risk models to provide care to members. The following contract risk models are currently in place:

- Health Maintenance Organization (HMO)
- Physician/Hospital Consortia (PHC)
- Shared-Risk Groups (SRG)

Through our delegated HNs, CalOptima members have access to more than 1,500 PCPs, more than 7,900 specialists, 40 acute and rehabilitative hospitals, 31 community health centers and nearly 100 long-term care facilities.

CalOptima contracts with the following HNs:

Health Network	Medi-Cal	OneCare	OneCare Connect
AltaMed Health Services	SRG	SRG	SRG
AMVI Care Health Network	PHC	-	PHC
AMVI/Prospect Medical Group	-	SRG	-
CHOC Health Alliance	PHC	-	-
Family Choice Medical Group	PHC	SRG	SRG
HPN-Regal Medical Group	HMO	-	HMO
Kaiser Permanente	HMO	-	-
Noble Mid-Orange County	SRG	SRG	SRG
Optum Care Network - Arta	SRG	SRG	SRG
Optum Care Network - Monarch	HMO	SRG	HMO
Optum Care Network - Talbert	SRG	SRG	SRG
Prospect Medical Group	HMO	-	HMO
United Care Medical Group	SRG	SRG	SRG
Delegate	**Medi-Cal**	**OneCare**	**OneCare Connect**
Vision Service Plan	VS	VS	VS

HMO=Health Maintenance Organization
PHC=Physician-Hospital Consortium
SRG=Shared Risk Group
VS=Vision Service

Upon successful completion of readiness reviews and audits, the HNs may be delegated for clinical and administrative functions, which may include:

- Utilization management
- Basic and complex case management
- Claims
- Contracting
- Credentialing of practitioners
- Customer service

MEMBERSHIP DEMOGRAPHICS

CalOptima
A Public Agency
Better. Together.

Fast Facts: February 2022

Mission: To provide members with access to quality health care services delivered in a cost-effective and compassionate manner

Membership Data from December 31, 2021, Financial Information

Total CalOptima Membership
870,489

Program	Members
Medi-Cal*	852,805
OneCare Connect	14,933
OneCare (HMO SNP)	2,330
Program of All-Inclusive Care for the Elderly (PACE)	421

Note: Fiscal Year 2021–22 Membership Data began on July 1, 2021.
* Based on unaudited financial report and includes prior year adjustment

Member Age (All Programs)

9%	0 to 5
27%	6 to 18
33%	19 to 44
19%	45 to 64
12%	65+

Languages Spoken (All Programs)

59%	English
26%	Spanish
10%	Vietnamese
2%	Other
1%	Korean
1%	Farsi
<1%	Chinese
<1%	Arabic

Medi-Cal Aid Categories

41%	Temporary Assistance for Needy Families
35%	Expansion
9%	Optional Targeted Low-Income Children
9%	Seniors
5%	People with Disabilities
<1%	Long-Term Care
<1%	Other

Financial Information FY 2021–22 Budget

Program	Annual Budgeted Revenue	% Total Budgeted Revenue
Medi-Cal	$3,249,878,660	88.89%
OneCare Connect	$339,332,450	9.28%
OneCare	$25,409,771	0.69%
PACE	$40,274,039	1.10%
MSSP**	$1,218,536	0.03%

Note: Fiscal Year 2021–22 Operating Budget began on July 1, 2021.
** Multipurpose Senior Services Program (MSSP)

Total Budgeted Annual Revenue
$3.7 billion

CalOptima spends nearly 96 cents of every dollar on member care.

QUALITY IMPROVEMENT PROGRAM

CalOptima's Quality Improvement (QI) Program encompasses all clinical care, health and wellness services, and customer service provided to our members, which aligns with our vision to provide an integrated and well-coordinated system of care to ensure optimal health outcomes for all our members.

CalOptima developed programs using evidence-based guidelines that incorporate data and best practices tailored to our populations. Our focus extends across the health care continuum, from primary care, urgent care, acute and subacute care to long-term care and end-of-life care. Our comprehensive person-centered approach integrates physical and behavioral health, leveraging the care delivery systems and community partners for our members with vulnerabilities, disabilities and chronic illnesses.

CalOptima's QI Program includes processes and procedures designed to ensure that all medically necessary covered services are available and accessible to all members, including those with limited English proficiency or diverse cultural and ethnic backgrounds, regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, gender identity, health status or disability. All covered services are provided in a culturally and linguistically appropriate manner.

CalOptima is committed to promoting diversity in practices throughout the organization, including HR best practices for recruiting and hiring. Also, as part of the new hire process as well as annual compliance, employees are trained on cultural competency, bias and inclusion.

QUALITY IMPROVEMENT PROGRAM PURPOSE

The purpose of the CalOptima QI Program is to establish objective methods for systematically evaluating and improving the quality of care provided to CalOptima members through CalOptima CCN and COD-A, as well as our contracted HNs. Through the QI Program — and in collaboration with providers and community partners — CalOptima strives to continuously

improve the structure, processes and outcomes of its health care delivery system to serve our members.

The CalOptima QI Program incorporates the continuous QI methodology of Plan-Do-Study-Act (PDSA) that focuses on the specific needs of CalOptima's multiple customers (members, health care providers, community-based organizations and government agencies). The QI Program is organized around a systematic approach to accomplish the following annually:

- Identify and analyze significant opportunities for improvement in care and service to advance CalOptima's strategic mission, goals and objectives.

- Foster the development of improvement actions, along with systematic monitoring and evaluation, to determine whether these actions result in progress toward established benchmarks or goals.

- Focus on QI activities carried out on an ongoing basis to support early identification and timely correction of quality-of-care issues to ensure safe care and experiences.

- Maintain agencywide practices that support accreditation by NCQA and meet DHCS/CMS quality and measurement reporting requirements.

In addition, the QI Program's ongoing responsibilities include the following:

- Setting expectations to develop plans to design, measure, assess and improve the quality of the organization's governance, management and support processes.

- Supporting the provision of a consistent level of high-quality care and service for members throughout the contracted provider networks, as well as monitoring utilization practice patterns of practitioners, contracted hospitals, contracted services, ancillary services and specialty providers.

- Providing oversight of quality monitors from the contracted facilities to continuously assess that the care and service provided satisfactorily meet quality goals.

- Ensuring certain contracted facilities report to the public health authority (HCA) outbreaks of conditions and/or diseases, which may include, but are not limited to, methicillin resistant Staphylococcus aureus (MRSA), scabies, tuberculosis, etc.

- Promoting member safety and minimizing risk through the implementation of safety programs and early identification of issues that require intervention and/or education and working with appropriate committees, departments, staff, practitioners, provider medical groups and other related organizational providers (OPs) to assure that steps are taken to resolve and prevent recurrences.

- Educating the workforce and promoting a continuous quality improvement culture at CalOptima.

In collaboration with the Compliance Audit & Oversight departments, the QI Program ensures the following standards or outcomes are carried out and achieved by CalOptima's contracted HNs, including CCN and/or COD network providers serving CalOptima's various populations:

- Support the agency's strategic quality and business goals by utilizing resources appropriately, effectively and efficiently
- Continuously improve clinical care and service quality provided by the health care delivery system in all settings, especially as it pertains to the unique needs of the population
- Timely identify important clinical and service issues facing the Medi-Cal, OC and OCC populations relevant to their demographics, high risks, disease profiles for both acute and chronic illnesses, and preventive care
- Ensure continuity and coordination of care between specialists and primary care practitioners, and between medical and behavioral health practitioners by annually evaluating and acting on identified opportunities
- Ensure accessibility and availability of appropriate clinical care and a network of providers with experience in providing care to the population
- Monitor the qualifications and practice patterns of all individual providers in the network to deliver quality care and service
- Promote the continuous improvement of member and provider satisfaction, including the timely resolution of complaints and grievances
- Ensure the reliability of risk prevention and risk management processes
- Ensure compliance with regulatory agencies and accreditation standards
- Ensure the annual review and acceptance of the UM Program Description and other relevant Population Health Programs and Work Plans
- Promote the effectiveness and efficiency of internal operations
- Ensure the effectiveness and efficiency of operations associated with functions delegated to the contracted HNs
- Ensure the effectiveness of aligning ongoing quality initiatives and performance measurements with CalOptima's strategic direction in support of its mission, vision and values
- Ensure compliance with up-to-date Clinical Practice Guidelines and evidence-based medicine.

The Quality and Clinical Operations departments and Medical Directors, in conjunction with multiple CalOptima departments, support the organization's mission and strategic goals, and

oversee the processes to monitor, evaluate and act on the quality of care and services that members receive.

AUTHORITY, BOARD OF DIRECTORS' COMMITTEES AND RESPONSIBILITIES

Board of Directors

The CalOptima Board of Directors has ultimate accountability and responsibility for the quality of care and services provided to CalOptima members. The responsibility to oversee the program is delegated by the Board of Directors to the Board's Quality Assurance Committee — which oversees the functions of the QI Committee described in CalOptima's state and federal contracts — and to CalOptima's Chief Executive Officer (CEO), as described below.

The Board holds the CEO and Chief Medical Officer (CMO) accountable and responsible for the quality of care and services provided to members. The Board promotes the separation of medical services from fiscal and administrative management to ensure that medical decisions will not be unduly influenced by financial considerations. The Board approves and evaluates the QI Program annually.

The QI Program is based on ongoing systematic collection, integration and analysis of clinical and administrative data to identify member needs, risk levels and appropriate interventions to make certain that the program meets the specific needs of the individual member and promotes health equity among specific population segments, while improving overall population health and member experience. The CMO is charged with identifying appropriate interventions and allocating resources necessary to implement the QI Program. Such recommendations shall be aligned with federal and state regulations, contractual obligations and fiscal parameters.

CalOptima is required under California's open meeting law, the Ralph M. Brown Act, Government Code §54950 *et seq.*, to hold public meetings except under specific circumstances described in the Act. CalOptima's Board meetings are open to the public.

Board of Directors' Quality Assurance Committee

The Board of Directors appoints the Quality Assurance Committee (QAC) to conduct annual evaluation, provide strategic direction and make recommendations to the Board regarding the overall QI Program. QAC routinely receives progress reports from the QIC describing improvement actions taken, progress in meeting objectives and quality performance results achieved. The QAC also makes recommendations to the Board for annual approval with modifications and appropriate resources allocations of the QI Program aimed to achieve the Institute for Healthcare Improvement's Quadruple Aim (which expands on CMS' Triple Aim):

1. Enhancing patient experience
2. Improving population health
3. Reducing per capita cost
4. Enhancing provider satisfaction

Member Advisory Committee

The Member Advisory Committee (MAC) has 15 voting members, with each seat representing a constituency served by CalOptima. The MAC ensures that CalOptima members' values and needs are integrated into the design, implementation, operation and evaluation of the overall QI Program. The MAC provides advice and recommendations on community outreach, cultural and linguistic needs and needs assessment, member survey results, access to health care, and preventive services. The MAC meets on a monthly basis and reports directly to the CalOptima Board of Directors. MAC meetings are open to the public.

The MAC membership includes representatives from the following constituencies:

- Adult beneficiaries
- Behavioral/mental health
- Children
- Consumers
- Family support
- Foster children
- HCA
- LTSS
- Medi-Cal beneficiaries
- Medical safety net
- County of Orange Social Services Agency (OC SSA)
- Persons with disabilities
- Persons with special needs
- Recipients of CalWORKs
- Seniors

Two of the 15 positions — held by HCA and OC SSA — are permanent. Each of the remaining 13 appointed members serve two-year terms with no term limits.

OneCare Connect Member Advisory Committee

The OCC Member Advisory Committee (OCC MAC) reports directly to the CalOptima Board of Directors. The OCC MAC has 10 voting members, each seat representing a constituency served by OCC, and four non-voting liaisons representing county agencies collaborating on the program.

The OCC MAC membership includes representatives from the following constituencies:

- OCC beneficiaries or family members of OCC beneficiaries (three seats)
- CBAS provider representative
- Home- and Community-Based Services (HCBS) representative serving persons with disabilities
- HCBS representative serving seniors
- HCBS representative serving members from an ethnic or cultural community
- In-Home Supportive Services (IHSS) provider or union representative
- LTC facility representative

- Member advocate, such as Health Insurance Counseling and Advocacy Program, Legal Aid Society or Public Law Center
- Non-voting liaisons include seats representing the following county agencies:
    - HCA Behavioral Health
    - OC SSA
    - OC Community Resources Agency, Office on Aging
    - OC IHSS Public Authority

The four non-voting liaison seats held by county agencies are standing seats. The 10 appointed voting members serve two-year terms with no term limits. The bimonthly meetings are open to the public.

Provider Advisory Committee

The Provider Advisory Committee (PAC) was established by the CalOptima Board of Directors to advise the Board on issues impacting the CalOptima provider community. The PAC members represent the broad provider community that serves CalOptima members. The PAC has 15 members, 14 of whom serve three-year terms with two consecutive term limits, along with a representative of HCA, which maintains a standing seat. PAC meets monthly and is open to the public. The 15 seats include:

- Health networks
- Hospitals
- Physicians (three seats)
- Nurse
- Allied health services (two seats)
- Community health centers
- HCA (one standing seat)
- LTSS (LTC facilities and CBAS) (one seat)
- Non-physician medical practitioner
- Safety net
- Behavioral/mental health
- Pharmacy

Whole-Child Model Family Advisory Committee

Whole-Child Model Family Advisory Committee (WCM FAC) has been required by the state as part of California Children's Services (CCS) since it became a Medi-Cal managed care plan benefit. The WCM FAC provides advice and recommendations to the Board and staff on issues concerning the WCM program, serves as a liaison between interested parties and the Board, and assists the Board and staff in obtaining public opinion on issues relating to CalOptima's WCM program. The committee can initiate recommendations on issues for study and facilitate community outreach.

The WCM FAC includes the following 11 voting seats:

- Family representatives (seven seats)
    - Authorized representatives, which includes parents, foster parents and caregivers of a CalOptima member who is a current recipient of CCS services; or

    - CalOptima members age 18–21 who are current recipients of CCS services; or
    - Current CalOptima members over the age of 21 who transitioned from CCS services

- Interests of children representatives (four seats)
    - Community-based organizations; or
    - Consumer advocates

Members of the committee serve staggered two-year terms. WCM FAC meets bimonthly, and meetings are open to the public.

Role of CalOptima Officers for Quality Improvement Program

Chief Executive Officer (CEO) allocates financial and employee resources to fulfill program objectives. The CEO delegates authority, when appropriate, to the Chief Medical Officer (CMO), the Chief Financial Officer (CFO) and the Chief Operating Officer (COO). The CEO makes certain that the QI Committee (QIC) satisfies all remaining requirements of the QI Program, as specified in the state and federal contracts.

Chief Information Officer (CIO) provides oversight of CalOptima's enterprise-wide technology needs, operations and strategy. The CIO also serves as the Chief Information Security Officer responsible for security and risk management to proactively manage and decrease the agency's risk exposure.

Chief Operating Officer (COO) is responsible for oversight and day-to-day operations of several departments, including Customer Service, Information Technology Services, Program Implementation, Process Excellence, Network Operations, Grievance and Appeals Resolution Services (GARS), Claims Administration, and Coding Initiatives.

Chief Medical Officer (CMO) oversees strategies, programs, policies and procedures as they relate to CalOptima's quality and safety of clinical care delivered to members. The CMO has overall responsibility of the QI Program and supports efforts so that the QI Program objectives are coordinated, integrated and accomplished. At least quarterly, the CMO presents reports on QI activities to the Board of Directors' Quality Assurance Committee.

Deputy Chief Medical Officer (DCMO), along with the CMO, oversees strategies, programs, policies and procedures as they relate to CalOptima's medical care delivery system. The DCMO collaborates with directors and medical directors in the operational oversight of the medical division, including Quality Improvement, Quality Analytics, Utilization Management, Case Management, Population Health Management, Pharmacy Management, LTSS and other medical management programs.

Chief of Staff (COS) acts as advisor to the CEO and facilitates cross-collaborative development, implementation and improvement of organizational programs and initiatives. COS is responsible for achieving operational efficiencies to support CalOptima's strategic plan, goals and objectives.

Medical Director (Quality) is the physician designee who chairs the QIC and is responsible for overseeing QI activities and quality management functions. The medical director provides direction and support to CalOptima's Quality and Population Health Management teams to ensure QI Program objectives are met. The medical director is also the physician designee who chairs the Credentialing Peer Review Committee (CPRC).

Medical Director (Behavioral Health) is the designated behavioral health care physician in the QI Program who serves as a participating member of the QIC, as well as the Utilization Management Committee (UMC) and CPRC. The medical director is also the chair of the Pharmacy & Therapeutics Committee (P&T).

Executive Director, Quality & Population Health Management (ED Q&PHM) is responsible for facilitating the companywide QI Program deployment; driving performance results in Healthcare Effectiveness Data and Information Set (HEDIS), DHCS, CMS Star measures and ratings; and maintaining NCQA accreditation standing as a high performing health plan. The ED Q&PHM serves as a member of the executive team, and with the CMO, DCMO and Executive Director, Clinical Operations, supports efforts to promote adherence to established quality improvement strategies and integrate behavioral health across the delivery system and populations served. Reporting to the ED Q&PHM are the directors of Quality Analytics, Quality Improvement and Population Health Management.

Executive Director, Behavioral Health Integration (ED BH) is responsible for oversight of CalOptima's Behavioral Health (BH) program including utilization of services, quality outcomes and the coordination and true integration of care between physical and BH practitioners across all lines of businesses.

Executive Director, Clinical Operations (ED CO) is responsible for oversight of all operational aspects of key Medical Affairs functions, including UM, Care Coordination, Complex Case Management, LTSS and MSSP services, along with new program implementation related to initiatives in these areas. The ED CO serves as a member of the executive team and, with the CMO, DCMO and ED Q&PHM, makes certain that Medical Affairs is aligned with CalOptima's strategic and operational priorities.

Executive Director, Program Implementation (ED PI) is responsible for maintaining the organization's strategic plan, development and implementation of new programs, operational process improvement activities and community relations. Reporting to ED PI is the director of Process Excellence.

Executive Director, Public Affairs (ED PA) is responsible for CalOptima's Communications, Government Affairs, Community Relations and Strategic Development departments. ED PA is charged with assisting the CEO in carrying out organizational goals, including overseeing the development of the CalOptima Strategic Plan and implementation of communications strategies to highlight CalOptima programs and priorities. Under ED PA's leadership, the Public Affairs team members collaborate on efforts that support the CalOptima mission and reach internal and external audiences, ranging from employees and members to government officials and the media. Reporting to ED PA are the directors of both Communications and Strategic Development.

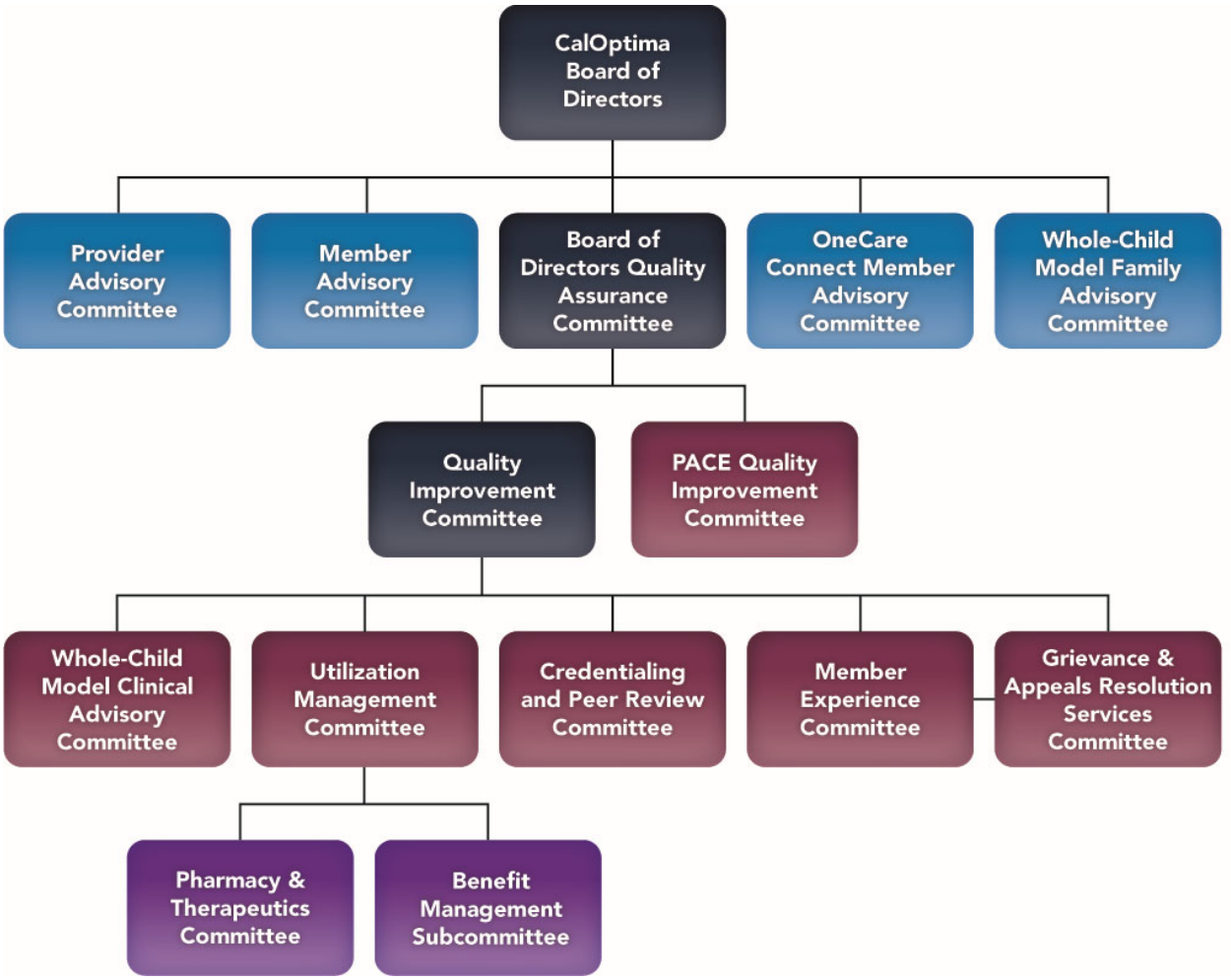
Executive Director, Compliance (ED C) is responsible for monitoring and driving interventions so that CalOptima and its HNs and other First Tier, Downstream and Related Entities (FDRs) meet the requirements set forth by DHCS, CMS and DMHC. The Compliance staff works in

collaboration with the Audit & Oversight department to refer any potential noncompliance issues or trends encountered during audits of HNs and other functional areas. The ED C serves as the State Liaison and is responsible for legislative advocacy. Also, the ED C oversees CalOptima's regulatory and compliance functions, including the development and amendment of CalOptima's policies and procedures to ensure adherence to state and federal requirements.

Executive Director, Network Operations (ED NO) leads and directs the integrated operations of the HNs and coordinates organizational efforts internally and externally with members, providers and community stakeholders. The ED NO is responsible for building an effective and efficient operational unit to serve CalOptima's networks and making sure the delivery of accessible, cost-effective and quality health care services is maintained throughout the service delivery network.

Executive Director, Operations (ED O) is responsible for overseeing and guiding Claims Administration, Customer Service, GARS, Coding Initiatives and Electronic Business.

Committee Organization Structure — Diagram



QUALITY IMPROVEMENT COMMITTEES AND SUBCOMMITTEES

Quality Improvement Committee (QIC)
The QIC is the foundation of the QI Program and is accountable to the QAC. The QIC assists the CMO in overseeing, maintaining and supporting the QI Program and QI Work Plan activities.

The purpose of the QIC is to assure that all QI activities are performed, integrated and communicated internally and to the contracted delegated HNs to achieve the result of improved care and services for members. In collaboration with the Compliance Committee, the QIC oversees the performance of delegated functions by monitoring delegated HNs and their contracted provider and practitioner partners.

The composition of the QIC includes participating practitioners who are external to CalOptima, including a behavioral health practitioner to specifically address integration of behavioral and physical health, appropriate utilization of recognized criteria, development of policies and procedures, case review as needed and identification of opportunities to improve care.

The QIC provides overall direction for the continuous improvement process and evaluates whether activities are consistent with CalOptima's strategic goals and priorities. It supports efforts to ensure that an interdisciplinary and interdepartmental approach is taken, and adequate resources are committed to the program. It monitors compliance with regulatory and accrediting body standards relating to QI Projects, activities and initiatives. In addition, and most importantly, it makes certain that members are provided optimal quality of care. HEDIS activities and interventions are reviewed, approved, processed, monitored and reported through the QIC.

Responsibilities of the QI Committee include:

- Recommending policy decisions and priority alignment of the QI subcommittees for effective operation and achievement of objectives
- Overseeing the analysis and evaluation of QI activities
- Making certain that there is practitioner participation through attendance and discussion in the planning, design, implementation and review of QI Program activities
- Identifying and prioritizing needed actions and interventions to improve quality
- Making certain that there is follow up as necessary to determine the effectiveness of quality improvement-related actions and interventions

Practice patterns of providers, practitioners and delegated HNs are evaluated, such as UM over/under utilization in collaboration with applied behavioral analysis utilization. Recommendations are made to promote practices that all members receive medical and behavioral health care that meets CalOptima standards.

The QIC oversees and coordinates member outcome-related quality improvement actions. Member outcome-related QI actions consist of well-defined, planned QI projects by which the

plan addresses and achieves improvement in major focus areas of clinical and non-clinical services.

The QIC also recommends strategies for dissemination of all study results to CalOptima-contracted providers and practitioners, and delegated HNs.

The QI Program adopts the classic Continuous Quality Improvement cycle with four basic steps:

- **Plan** Goals with detailed description of an implementation plan
- **Do** Implementation of the plan
- **Study** Data collection
- **Act** Analyze data and develop conclusions

The composition of the QIC is defined in the QIC Charter and includes, but may not be limited to:

Voting Members

- Four physicians or practitioners, with at least two practicing physicians or practitioners
- County Behavioral Health Representative
- CalOptima Chief Medical Officer (Chair or Designee)
- CalOptima Medical Directors
- CalOptima Behavioral Health Integration Medical Director (or Designee)
- Executive Director, Quality & Population Health Management
- Executive Director, Clinical Operations
- Executive Director, Network Management
- Executive Director, Operations

The QIC is supported by:

- Director, Quality Improvement
- Director, Quality Analytics
- Director, Population Health Management
- Director, Behavioral Health Integration
- Committee Recorder as assigned

Quorum

A quorum consists of a minimum of six voting members of which at least four are physicians or practitioners. Once a quorum is attained, the meeting may proceed and any vote will be considered official, even if the quorum is not maintained. Participation is defined as attendance in person or participation by telephone.

The QIC shall meet at least eight times per calendar year and report to the Board QAC quarterly.

QIC and all QI subcommittee reports and proceedings are covered under California Welfare & Institution Code § 14087.58(b), Health and Safety Code § 1370, and California Evidence Code §1157. Section 14087.58(b) renders records of QI proceedings, including peer review and quality assessment records, exempt from disclosure under the Public Records Act.

Minutes of the QIC and Subcommittees

Contemporaneous minutes reflect all committee decisions and actions. These minutes are dated and signed by the committee chair to demonstrate that they are representative of the official findings of the committee.

Minutes of the QIC meeting include, but are not limited to:

- Goals and objectives outlined in the QIC Charter
- Active discussion and analysis of quality issues
- Credentialing or re-credentialing issues, as appropriate
- Reports from various committees and subcommittees
- Recommendations, actions and follow-up actions
- Plans to disseminate Quality Management/Improvement information to network providers and practitioners
- Tracking of Work Plan activities

All agendas, minutes, reports and documents presented to the QIC are maintained in a confidential manner. Minutes are maintained in an electronic format and produced only for committee approval.

Credentialing and Peer Review Committee (CPRC)

The CPRC provides guidance and peer input into the CalOptima practitioner and provider selection process and determines corrective actions, as necessary, to ensure that all practitioners and providers who serve CalOptima members meet generally accepted standards for their profession or industry.

The CPRC reviews, investigates and evaluates the credentials of all CalOptima practitioners, which include internal and external physicians who participate on the committee. The committee maintains a continuing review of the qualifications and performance of all practitioners every three years. In addition, the CPRC reviews and monitors sentinel events, quality of care issues and identified trends across the entire continuum of CalOptima's contracted providers, delegated HNs and OPs to ensure member safety aiming for zero defects. The CPRC, chaired by the CalOptima CMO or physician designee, consists of representation of active physicians from CCN and HNs. Physician participants represent a range of practitioners and specialties from CalOptima's network. CPRC meets a minimum of six times per year and reports through the QIC. The voting member composition and quorum requirements of the CPRC are defined in its charter.

Utilization Management Committee (UMC)

The UMC promotes the optimum utilization of health care services, while protecting and acknowledging member rights and responsibilities, including their right to appeal denials of service. The UMC is multidisciplinary and provides a comprehensive approach to support the UM Program in the management of resource allocation through systematic monitoring of medical necessity and quality, while maximizing the cost effectiveness of the care and services provided to members.

The UMC monitors the utilization of medical, behavioral health and LTSS services for CCN and through the delegated HNs to identify areas of underutilization or overutilization that may adversely impact member care. The UMC oversees Inter-Rater Reliability (IRR) testing to support consistency of application in nationally recognized criteria for making medical necessity determinations, as well as development of evidence-based clinical practice guidelines, and completes an annual review and updates the clinical practice guidelines to make certain they are in accordance with recognized clinical organizations, are evidence-based, and comply with regulatory and other agency standards. These clinical practice guidelines and nationally recognized evidenced-based guidelines are approved annually, at minimum, at the UMC. The UMC meets quarterly and reports through the QIC. The voting member composition (including a behavioral health practitioner*) and the quorum requirements of the UMC are defined in its charter.

* Behavioral Health practitioner is defined as medical director, clinical director or participating practitioner from the organization.

Pharmacy & Therapeutics Committee (P&T)

The P&T is a forum for an evidence-based formulary review process. The P&T promotes clinically sound and cost-effective pharmaceutical care for all CalOptima members. It reviews anticipated and actual drug utilization trends, parameters and results based on specific categories of drugs and formulary initiatives, as well as the overall program. In addition, the P&T reviews and evaluates current pharmacy-related issues that are interdisciplinary, involving interface between medicine, pharmacy and other practitioners involved in the delivery of health care to CalOptima's members. The P&T includes practicing physicians (including both CalOptima employee physicians and participating provider physicians), and the membership represents a cross-section of clinical specialties and clinical pharmacists in order to adequately represent the needs and interests of all plan members. The P&T provides written decisions regarding all formulary development decisions and revisions. The P&T meets at least quarterly and reports to the UMC. The voting member composition and quorum requirements of the P&T are defined in its charter.

Benefit Management Subcommittee (BMSC)

The purpose of the BMSC is to oversee, coordinate and maintain a consistent benefit system as it relates to CalOptima's responsibilities for administration of benefits, prior authorization and financial responsibility requirements. The BMSC reports to the UMC and ensures that benefit updates are implemented and communicated accordingly to internal CalOptima staff, and are provided to contracted HMOs, PHCs and SRGs. The Regulatory Affairs and Compliance department provides technical support to the subcommittee, which includes, but is not limited to, analyzing regulations and guidance that impacts the benefit sets and CalOptima's authorization rules. The voting member composition and quorum requirements of the BMSC are defined in its charter.

Whole-Child Model Clinical Advisory Committee (WCM CAC)

The WCM CAC advises on clinical and behavioral issues relating to CCS conditions, including such matters as treatment authorization guidelines, and ensuring they are integrated into the design, implementation, operation and evaluation of the CalOptima WCM program. The WCM

CAC works in collaboration with county CCS, the WCM FAC and HN CCS providers. The WCM CAC meets four times a year and reports to the QIC. The voting member composition and quorum requirements of the WCM CAC are defined in its charter.

Member Experience Committee (MEMX)

Improving member experience is a top priority of CalOptima. The MEMX committee was formed to ensure strategic focus on the issues and factors that influence the member's experience with the health care system for Medi-Cal, OC and OCC. NCQA's Health Insurance Plan Ratings measure three dimensions: prevention, treatment and customer satisfaction. The MEMX committee is designed to assess the annual results of CalOptima's Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys; monitor the provider network, including access and availability; review customer service metrics; and evaluate complaints, grievances, appeals, authorizations and referrals for "pain points" in health care that impact our members at the plan and HN level (including CCN), where appropriate. In 2022, the MEMX committee, which includes the Access and Availability workgroup, will continue to meet at least quarterly and will be held accountable to implement targeted initiatives to improve member experience and demonstrate significant improvement in the MY 2022 and MY 2023 CAHPS survey results.

Grievance and Appeals Resolution Services (GARS) Committee

The GARS Committee serves to protect the rights of members, promote the provision of quality health care services and ensure that the policies of CalOptima are consistently applied to resolve member complaints in an equitable and compassionate manner through oversight and monitoring. The GARS Committee serves to provide a mechanism to resolve provider complaints and appeals expeditiously for all CalOptima providers. It protects the rights of practitioners and providers by providing a multilevel process that is fair and progressive in nature, leading to the resolution of provider complaints. The GARS Committee meets at least quarterly and reports through the QIC. The voting member composition and quorum requirements of the GARS Committee are defined in its charter.

Confidentiality

CalOptima has policies and procedures to protect and promote proper handling of confidential and privileged medical record information. Upon employment, all CalOptima employees — including contracted professionals who have access to confidential or member information — sign a written statement delineating responsibility for maintaining confidentiality. In addition, all committee members of each entity are required to sign a confidentiality agreement on an annual basis. Invited guests must sign a confidentiality agreement at the time of committee attendance.

All records and proceedings of the QI Committee and the subcommittees related to member- or practitioner-specific information are confidential and are subject to applicable laws regarding confidentiality of medical and peer review information, including Welfare and Institutions Code section 14087.58, which exempts the records of QI proceedings from the California Public Records Act. All information is maintained in confidential files. The delegated networks hold all information in the strictest confidence. Members of the QI Committee and the subcommittees sign a confidentiality agreement. This agreement requires the committee member to maintain confidentiality of any and all information discussed during the meeting. The CEO, in accordance

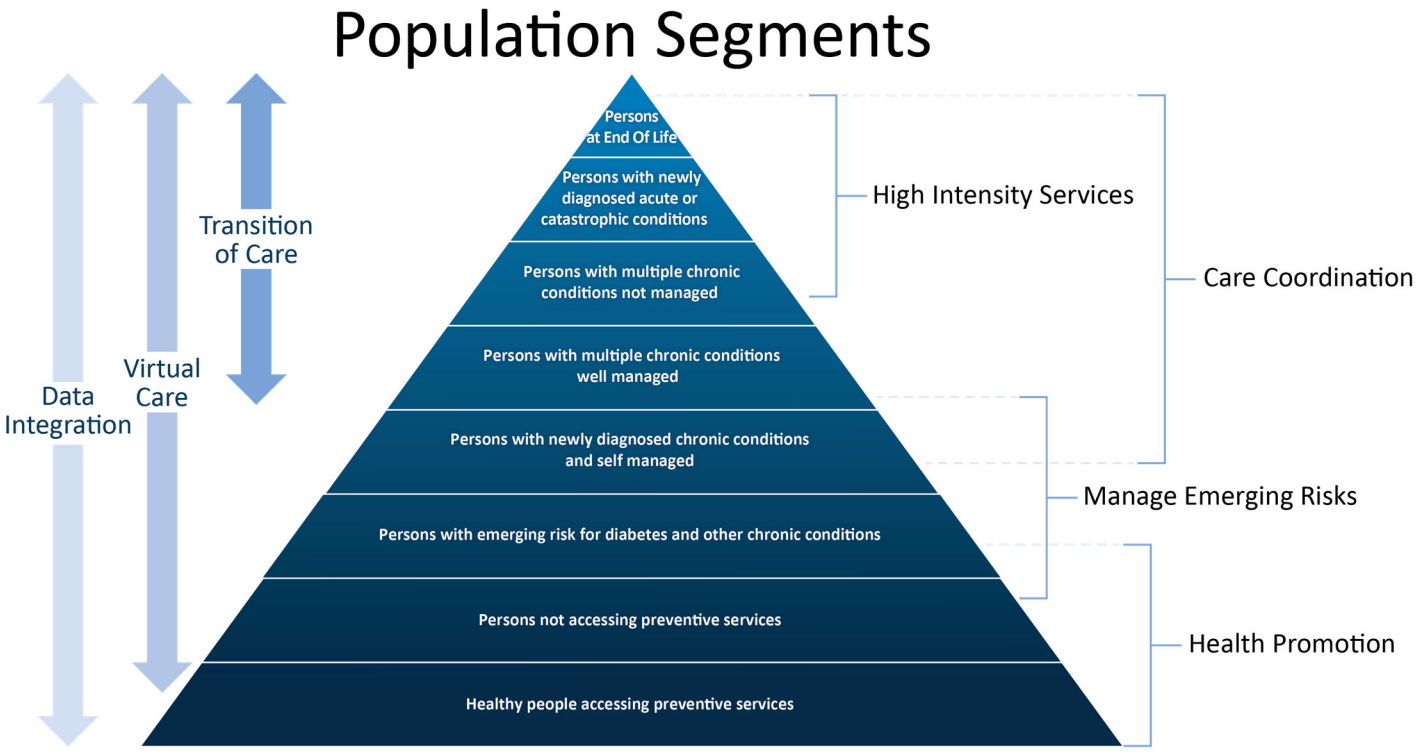
with applicable laws regarding confidentiality, issues any QI reports required by law or by the state contract.

Conflict of Interest

CalOptima maintains a Conflict of Interest policy that addresses the process to identify and evaluate potential social, economic and professional conflicts of interest and take appropriate actions so that they do not compromise or bias professional judgment and objectivity in quality, credentialing and peer review matters. This policy precludes using proprietary or confidential CalOptima information for personal gain or the gain of others, as well as direct or indirect financial interests in, or relationships with, current or potential providers, suppliers or members, except when it is determined that the financial interest does not create a conflict. The policy includes an attestation that is completed annually by all appointed, volunteer or employed positions serving on the QI/UM committees and subcommittees. Additionally, all employees who make or participate in the making of decisions that may foreseeably have a material effect on economic interests file a Statement of Economic Interests form on an annual basis.

QUALITY IMPROVEMENT STRATEGIC GOALS

The QI Program and structure provides operational support and oversight to a member-centric Population Health Management (PHM) approach, by stratifying the population based on their health needs, conditions and issues, and aligns the appropriate resources to meet these needs. Building upon CalOptima's existing innovative Model of Care (MOC), the 2022 QI Work Plan will focus on building out additional services leveraging telehealth technology to engage the new population segments currently not served, such as the population with emerging risk or experiencing social determinants of health. The Population Segments with an integrated intervention hierarchy, is shown below.



CalOptima's MOC recognizes the importance of mobilizing multiple resources to support our members' health needs. The coordination between our various medical and behavioral health providers, pharmacists and care settings, plus our internal experts, supports a member-centric approach to care/care coordination. The current high-touch MOC is effective in managing the health care needs of high-risk members one by one. By enhancing the service capabilities and the transition of care process leveraging telehealth and mobile technology, the current MOC can be scaled to address the health care needs of the population segments identified through systematic member segmentation and stratification using integrated data sets.

2022 QI Goals and Objectives

CalOptima's QI Goals and Objectives are aligned with CalOptima's 2022–23 Strategic Goals.

1) Develop and implement a comprehensive Health Equity framework that transforms practices, policies and systems at the member, organizational, and community levels.
2) Ensure member's safety during COVID-19 pandemic by aiming for 80% COVID-19 vaccine rate or community immunity
3) Improve quality of care and member experience by maintaining NCQA Health Plan Rating of 4.0, and at least a Three-Star Rating for Medicare.
4) Engage providers through the provision of new Pay for Value (P4V) program for Medi-Cal and the new OneCare programs through incentivize measures related to our STAR rating

These top four priority goals were chosen to be aligned with CalOptima's strategic objectives, the pandemic, as well as continued goals related to access to care and NCQA accreditation. The 2022 QI Workplan details the planned activities to meet the COVID-19 vaccine aim, which include strategies for immunization, targeted communication and a member incentive. The planned activities related to members' ability to access care are captured as a communication and corrective action strategy for providers not meeting timely access standards (as measured by the annual Timely Access study). All goals and sub-goals will be measured and monitored in the QI Workplan, reported to QIC quarterly and evaluated annually.

QI Measurable Goals for the Model of Care

The MOC is member-centric by design, and it monitors, evaluates and acts upon the coordinated provisions of seamless access to individualized, quality health care for OC and OCC. The MOC meets the needs of special member populations through strategic activities. Measurable goals are established and reported annually.

The MOC goals are:

- Improving access to essential services
- Improving access to preventive health services
- Assuring appropriate utilization of services
- Assuring proper identification of SDOH
- Improving coordination of care through an identified point of contact
- Improving seamless transitions of care across health care settings, providers and health services

- Improving integration of medical, behavioral health and pharmacy services
- Improving beneficiary health outcomes

A formal annual performance evaluation is conducted and strategies for continuous improvement for the coming year are established. Results are evaluated and reported annually.

QI Work Plan

The QI Work Plan outlines key activities for the upcoming year. It is reviewed and approved by the QIC and the Board of Directors' Quality Assurance Committee. The QI Work Plan indicates objectives, scope, timeline, planned monitoring and accountable persons for each activity. Progress against the QI Work Plan is monitored throughout the year. A QI Work Plan addendum may be established to address the unique needs of members in special needs plans or other health plan products, as needed, to capture the specific scope of the plan.

The QI Work Plan is the operational and functional component of the QI Program and is based on CalOptima strategic priorities and the most recent and trended HEDIS, CAHPS, Stars and Health Outcomes Survey (HOS) scores, physician quality measures and other measures identified for attention, including any specific requirements mandated by the state or accreditation standards, where these apply. As such, measures targeted for improvement may be adjusted mid-year when new scores or results are received.

The QI Program guides the development and implementation of an annual QI Work Plan, which includes, but is not limited to:

- Quality of clinical care
- Safety of clinical care
- Quality of service
- Member experience
- QI Program oversight
- Yearly objectives
- Yearly planned activities
- Time frame for each activity's completion
- Staff member responsible for each activity
- Monitoring of previously identified issues
- Annual evaluation of the QI Program

Priorities for QI activities based on CalOptima's organizational needs and specific needs of CalOptima's populations for key areas or issues are identified as opportunities for improvement. In addition, ongoing review and evaluation of the quality of individual care aids in the development of QI studies based on quality of care trends identified. These activities are included in Quality Improvement Project (QIP), Performance Improvement Project (PIP), Plan-Do-Study-Act (PDSA) and Chronic Care Improvement Projects (CCIP). They are reflected in the QI Work Plan. Additional COVID-19 focused initiatives are integrated into the 2022 QI Work Plan.

The QI Work Plan supports the comprehensive annual evaluation and planning process that includes review and revision of the QI Program and applicable policies and procedures.

See Appendix A — 2022 QI Work Plan

Methodology

QI Project Selections and Focus Areas

Performance and outcome improvement projects will be selected from the following areas:

- Areas for improvement identified through continuous internal monitoring activities, including, but not limited to, (a) potential quality issue (PQI) review processes, (b) provider and facility reviews, (c) preventive care audits, (d) access to care studies, (e) member experience surveys, (f) HEDIS results and (g) other opportunities for improvement as identified by subcommittee's data analysis

- Measures required by regulators, such as DHCS and CMS

The QI Project methodology described below will be used to continuously review, evaluate and improve the following aspects of clinical care: preventive services, perinatal care, primary care, specialty care, emergency services, inpatient services, LTSS and ancillary care services, with specific emphasis on the following areas:

- Access to and availability of services, including appointment availability
- Coordination and continuity of care for Seniors and Persons with Disabilities (SPD)
- Provisions of chronic, complex case management and case management services
- Access to and provision of preventive services

Improvements in work processes, quality of care and service are derived from all levels of the organization. For example:

- Staff, administration and physicians provide vital information necessary to support continuous performance improvement and occurs at all levels of the organization.

- Individuals and administrators initiate improvement projects within their area of authority that support the strategic goals of the organization.

- Other prioritization criteria include the expected impact on performance (if the performance gap or potential of risk for non-performance is so great as to make it a priority), and items deemed to be high risk, high volume or problem-prone processes.

- Project coordination occurs through the various leadership structures: Board of Directors, management, QIC, UMC, etc., based upon the scope of work and impact of the effort.

- These improvement efforts are often cross-functional and require dedicated resources to assist in data collection, analysis and implementation. Improvement activity outcomes are shared through communication that occurs within the previously identified groups.

QI Project Measurement Methodology

Methods for identification of target populations will be clearly defined. Data sources may include encounter data, authorization/claims data or pharmacy data. To prevent exclusion of specific member populations, data from the Clinical Data Warehouse will be utilized.

For outcomes studies or measures that require data from sources other than administrative data (e.g., medical records), sample sizes will be a minimum of 411 (with 5%–10% over sampling), in order to conduct statistically significant tests on any changes. Exceptions are studies for which the target population total is less than 411 and for certain HEDIS studies whose sample size is reduced from 411 based on CalOptima's previous year's score. Also, smaller sample size may be appropriate for QI pilot projects that are designed as small tests of change using rapid improvement cycle methodology. For example, a pilot sample of 30% or 100% of the sample size when target population is less than 30 can be statistically significant for QI pilot projects.

CalOptima also uses a variety of QI methodologies depending on the type of opportunity for improvement identified. The PDSA model is the overall framework for continuous process improvement. This includes:

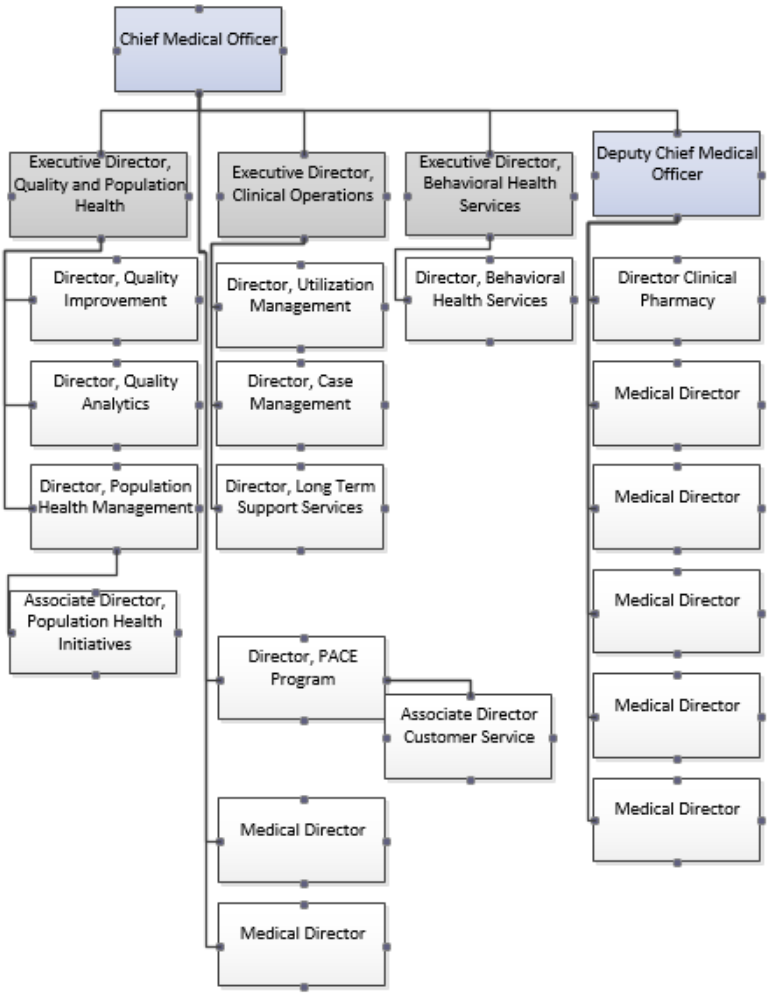
Plan 1) Identify opportunities for improvement
2) Define baseline
3) Describe root cause(s)
4) Develop an action plan
Do 5) Communicate change plan
6) Implement change plan
Study 7) Review and evaluate result of change
8) Communicate progress
Act 9) Reflect and act on learning
10) Standardize process and celebrate success

Communication of QI Activities

Results of performance improvement and collaborative activities will be communicated to the appropriate department, multidisciplinary committee or administrative team as determined by the nature of the issue. The frequency will be determined by the receiving groups and be reflected on the QI Work Plan or calendar. The QI subcommittees will report their summarized information to the QIC at least quarterly in order to facilitate communication along the continuum of care. The QIC reports activities to the QAC of the Board of Directors, through the CMO or designee, on a quarterly basis. Communication of QI trends to CalOptima's contracted entities, practitioners and providers is through the following:

- Practitioner participation in the QIC and its subcommittees
- HN Forums, medical directors' meetings, Quality Forums and other ongoing ad hoc meetings
- MAC, OCC MAC, WCM FAC and PAC

QUALITY PROGRAM ORGANIZATION STRUCTURE - DIAGRAM



QUALITY IMPROVEMENT PROGRAM RESOURCES

CalOptima's budgeting process includes personnel, Information Technology Services resources and other administrative costs projected for the QI Program. The resources are revisited on a regular basis to promote adequate support for CalOptima's QI Program.

The QI staff directly impacts and influences the QI Committee and related committees through monitoring, evaluation and interventions, providing the various committees with outcomes and effectiveness of corrective actions.

In addition to CalOptima's CMO and ED, Q&PHM, the following staff positions provide direct support for organizational and operational QI Program functions and activities:

Director, Quality Improvement
Responsibilities include assigned day-to-day operations of the Quality Management functions, including credentialing, FSRs, physical accessibility compliance and working with the ED, Q&PHM to oversee the QI Program and maintain NCQA accreditation. This position is also responsible for implementation of the QI Program and QI Work Plan implementation.

The following positions report to the Director, Quality Improvement:

- Manager, Quality Improvement
- Supervisor, Quality Improvement (PQI)
- Supervisor, Quality Improvement (Nursing Facilities) (CBAS) (FSR)
- Supervisor, Quality Improvement (Credentialing)
- QI Nurse Specialists (RN) (LVN)
- Program Policy Analyst
- Credentialing Coordinators
- Program Specialists (including Intermediate and Senior)
- Program Assistants
- Outreach Specialists
- Auditors

Director, Quality Analytics
Provides data analytical direction to support quality measurement activities for the agencywide QI Program by managing, executing and coordinating QI activities and projects, aligned with the QI department supporting clinical operational aspects of quality management and improvement. Provides coordination and support to the QIC and other committees to support compliance with regulatory and accreditation agencies.

The following positions report to the Director, Quality Analytics:

- Manager, Quality Analytics (HEDIS)
- Manager, Quality Analytics (Pay for Value)
- Manager, Quality Analytics (Network Adequacy)
- Manager, Quality Analytics (Data Analytics)
- Analysts
- Project Managers

- Program Coordinators
- Program Specialists

Director, Population Health Management
Provides direction for program development and implementation for agencywide population health initiatives, including telehealth. Ensures linkages supporting a whole-person perspective to health care with Case Management, UM, Pharmacy Management and Behavioral Health Integration. Provides direct care coordination and health education for members participating in non-delegated health programs, such as Perinatal Support Services (Bright Steps) and Childhood Obesity Prevention Program (Shape Your Life). Also, supports the MOC implementation for members. Reports program progress and effectiveness to QIC and other committees to support compliance with regulatory and accreditation agency requirements.

The following positions report to the Director, Population Health Management:
- Associate Director, Population Health Initiatives
- Population Health Management Manager (Quality Initiatives)
- Population Health Management Manager (Clinical Operations)
- Population Health Management Manager (Health Education)
- Population Health Management Manager (Maternal Health)
- Population Health Management Supervisors
- Program Managers
- Health Coaches
- Registered Dieticians
- Senior Health Educators
- Health Educators
- Quality Analysts
- Program Specialists
- Program Assistants

Director, Behavioral Health Integration
Provides program development and leadership to the implementation, expansion and/or improvement of processes and services that lead to the integration of physical and behavioral health care services for CalOptima members across all lines of business. The director is responsible for the management and strategic direction of the Behavioral Health Integration department efforts in integrated care, quality initiatives and community partnerships. The director ensures departmental compliance with all local, state and federal regulations and that accreditation standards and all policies and procedures meet current requirements.

Director, Utilization Management
Assists in the development and implementation of the UM program, policies and procedures. This director ensures the appropriate use of evidenced-based clinical review criteria/guidelines for medical necessity determinations. The director also provides supervisory oversight and administration of the UM program, oversees all clinical decisions rendered for concurrent, prospective and retrospective reviews that support UM medical management decisions, serves on the UM committees and participates in the QIC and the BMSC.

Director, Clinical Pharmacy Management
Leads the development and implementation of the Pharmacy Management program, develops and implements Pharmacy Management department policies and procedures, ensures that a

licensed pharmacist conducts reviews on cases that do not meet review criteria/guidelines for any potential adverse determinations, provides supervision of the coordination of pharmacy-related clinical affairs, and serves on the P&T and UMC. The director also guides the identification and interventions on key pharmacy quality and utilization measures.

Director, Case Management
Responsible for Case Management, Transitions of Care, Complex Case Management and the clinical operations of Medi-Cal, OCC and OC. The director supports improving quality and access through seamless care coordination for targeted member populations, and develops and implements policies, procedures and processes related to program operations and quality measures.

Director, Long-Term Services and Supports (LTSS)
Responsible for LTSS programs, which include CBAS, LTC and MSSP. The position supports a member-centric approach and helps keep members in the least restrictive living environment, collaborates with community partners and other stakeholders, and ensures LTSS are available to appropriate populations. The director also develops and implements policies, procedures and processes related to LTSS program operations and quality measures.

Staff Orientation, Training and Education

CalOptima seeks to recruit highly qualified individuals with extensive experience and expertise in health services. Qualifications and educational requirements are delineated in the respective position descriptions.

Each new employee is provided intensive orientation and job-specific training with a staff member. The following topics are covered during the introductory period, with specific training, as applicable to individual job descriptions:

- CalOptima New Employee Orientation and Boot Camp (CalOptima programs)
- HIPAA and Privacy
- Fraud, Waste and Abuse, Compliance and Code of Conduct training
- Workplace Harassment Prevention training
- Use of technical equipment (phones, computers, printers, fax machines, etc.)
- Applicable department program training, policies and procedures, etc.
- Seniors and Persons with Disabilities Awareness training
- Cultural Competency, Bias or Inclusion and Trauma-Informed Care training

MOC-related employees, contracted providers and practitioner networks are trained at least annually on the MOC. The MOC training is a part of the comprehensive orientation process, and includes face-to-face, interactive and web-based platforms as well as paper format.

CalOptima encourages and supports continuing education and training for employees, which increases competency in their present jobs and/or prepares them for career advancement within CalOptima. Each year, a specific budget is set for education reimbursement for employees.

Annual Program Evaluation

The objectives, scope, organization and effectiveness of CalOptima's QI Program are reviewed and evaluated annually by the QIC and QAC, and approved by the Board of Directors, as reflected in the QI Work Plan. Results of the written annual evaluation are used as the basis for formulating the next year's initiatives and are incorporated into the QI Work Plan and reported to DHCS and CMS on an annual basis. In the evaluation, the following are reviewed:

- A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of services, including the achievement or progress toward goals, as outlined in the QI Work Plan, and identification of opportunities for improvement
- Trending of measures to assess performance in the quality and safety of clinical care and quality of service, including aggregate data on utilization
- An assessment of the accomplishments from the previous year, as well as identification of the barriers encountered in implementing the annual plan through root cause and barrier analyses, to prepare for new interventions
- An evaluation of QI activities, including QIPs, PIPs, PDSAs and CCIPs
- An evaluation of member satisfaction surveys and initiatives
- A report to the QIC and QAC of a summary of all quality measures and identification of significant trends
- A critical review of the organizational resources involved in the QI Program through the CalOptima strategic planning process
- Recommended changes included in the revised QI Program Description for the subsequent year for QIC, QAC and the Board of Directors' review and approval

KEY BUSINESS PROCESSES, FUNCTIONS, IMPORTANT ASPECTS OF CARE AND SERVICE

CalOptima provides comprehensive acute and preventive care services, which are based on the philosophy of a medical home for each member. The primary care practitioner is this medical home for members who previously found it difficult to access services within their community.

The Institute of Medicine describes the concepts of primary care and community-oriented primary care, which apply to the CalOptima model:

- Primary care, by definition, is accessible, comprehensive, coordinated and continual care delivered by accountable providers of personal health services.

- Community-oriented primary care is the provision of primary care to a defined community, coupled with systematic efforts to identify and address the major health problems of that community.

The important aspects of care and service around which key business processes are designed include:

- Clinical care and service
- Access and availability
- Continuity and coordination of care
- Preventive care, including:
  - Initial Health Assessment
  - Initial Health Education
  - Behavioral Assessment
- Diagnosis, care and treatment of acute and chronic conditions
- Complex case management: For members with multiple and/or complex conditions to obtain access to care and services via the UM and Case Management departments
- Drug utilization
- Health education and promotion
- Over/underutilization
- Disease management

Administrative oversight:

- Delegation oversight
- Member rights and responsibilities
- Organizational ethics
- Effective utilization of resources
- Management of information
- Financial management
- Management of human resources
- Regulatory and contract compliance
- Customer satisfaction
- Fraud and abuse* as it relates to quality of care

* CalOptima has a zero-tolerance policy for fraud and abuse, as required by applicable laws and regulatory contracts. The detection of fraud and abuse is a key function of the CalOptima program.

QUALITY IMPROVEMENT

The QI department is responsible for monitoring quality of care issues and assuring the credentialing standards, policies and procedures are implemented to provide a qualified provider network for our members. The QI department fully aligns with the other areas of the QI team to support the organizational mission, strategic goals and processes to monitor and drive improvements to the quality of care and services, and ensure that care and services are rendered appropriately and safely to all CalOptima members.

QI department activities include:

- Monitor, evaluate and act to improve clinical outcomes for members
- Design, manage and improve work processes, clinical, service, access, member safety and quality-related activities
  - Drive improvement of quality of care received
  - Minimize rework and unnecessary costs
  - Measure the member experience of accessing and getting needed care
  - Empower staff to be more effective
  - Coordinate and communicate organizational information, both department-specific and agencywide
- Evaluate and monitor provider credentials
- Support the maintenance of quality standards across the continuum of care for all lines of business
- Monitor and maintain agencywide practices that support accreditation and meet regulatory requirements

Peer Review Process for Potential Quality Issues

Peer Review is coordinated through the QI department. Medical staff triage potential quality of care issues and conduct reviews of suspected physician and ancillary quality of care issues. All potential quality of care cases are reviewed by a medical director who determines a proposed action, dependent on the severity of the case. The medical director presents these cases to CPRC, which provides the final action(s). The QI department tracks, monitors and trends PQI cases to determine if there is an opportunity to improve care and service. Results of Quality of Care reviews, and tracking and trending of service and access issues, are reported to the CPRC and are also reviewed at the time of recredentialing. Potential quality of care case referrals are sent to the QI department from multiple areas at CalOptima, which include, but are not limited to, prior authorization, concurrent review, case management, legal, compliance, customer service, pharmacy or GARS, as well as from providers and other external sources.

Comprehensive Credentialing Program Standards

The comprehensive credentialing process is designed to provide ongoing verification of the practitioner's ability to render specific care and treatment within limits defined by licensure, education, experience, health status and judgment, thus ensuring the competency of practitioners working within the CalOptima contracted delivery system.

Practitioners are credentialed and recredentialed according to regulatory and accreditation standards (DHCS, CMS and NCQA). The scope of the credentialing program includes all licensed MDs, DOs, DPMs (doctors of podiatric medicine), DCs (doctors of chiropractic medicine), DDSs (doctors of dental surgery), allied health and midlevel practitioners, which include, but are not limited to, non-physician behavioral health practitioners, certified nurse midwives, certified nurse specialists, nurse practitioners, optometrists, physician assistants, registered physical therapists, occupational therapists, speech therapists and audiologists, both in the delegated and CalOptima direct environments. Credentialing and recredentialing activities for CCN are performed at CalOptima and delegated to HNs and other subdelegates for their providers.

Organizational Providers (OPs)

CalOptima performs credentialing and recredentialing of Ops, including, but not limited to, acute care hospitals, home health agencies, skilled nursing facilities, free-standing surgery centers, dialysis centers, etc. The intent of this process is to assess that these entities meet standards for quality of care and are in good standing with state and federal regulatory agencies.

Use of QI Activities in the Recredentialing Process

Findings from QI activities and other performance monitoring are included in the recredentialing process.

Monitoring for Sanctions and Complaints

CalOptima has adopted policies and procedures for ongoing monitoring of sanctions, which include, but are not limited to, state or federal sanctions, restrictions on licensure or limitations on scope of practice, Medicare and Medicaid sanctions, potential quality concerns, and member complaints between recredentialing periods.

Facility Site Review, Medical Record and Physical Accessibility Review Survey

CalOptima does not delegate PCP site and medical records review to contracted HMOs, PHCs and SRGs. CalOptima does, however, delegate this function to designated health plans in accordance with standards set forth by APL 20-006. CalOptima assumes responsibility and conducts and coordinates facility site review (FSR) and medical record review (MRR) for delegated HNs. CalOptima retains coordination, maintenance and oversight of the FSR/MRR process. CalOptima collaborates with the SRGs to coordinate the FSR/MRR process, minimize the duplication of site reviews and support consistency in PCP site reviews for shared PCPs.

CalOptima completes initial site reviews and subsequent periodic site reviews comprised of the FSR, MRR and Physical Accessibility Review Survey (PARS) on all PCP sites that intend to participate in their provider networks regardless of the status of a PCP site's other accreditations and certifications.

Site reviews are conducted as part of the initial credentialing process. All PCP sites must undergo an initial site review and receive a minimum passing score of 80% on the FSR Survey Tool. This requirement is waived for precontracted provider sites with documented proof that another local managed care plan completed a site review with a passing score within the past three years. This is in accordance with APL 20-006 and CalOptima policies. An Initial Medical Record Review shall be completed within 90 calendar days from the date that members are first assigned to the provider. An additional extension of 90 calendar days may be allowed only if the provider does not have enough assigned members to complete review of the required number of medical records. Subsequent site reviews consisting of an FSR, MRR and PARS are completed no later than three years after the initial reviews. CalOptima may review sites more frequently per local collaborative decisions or when deemed necessary based on monitoring, evaluation or corrective action plan (CAP) follow-up issues.

Physical Accessibility Review Survey for Seniors and Persons With Disabilities (SPD)

CalOptima conducts an additional DHCS-required physical accessibility review for Americans with Disabilities Act (ADA) compliance for SPD members, which includes access evaluation criteria to determine compliance with ADA requirements.

- Parking
- Building interior and exterior
- Participant areas, including the exam room
- Restroom
- Exam room
- Exam table/scale

Medical Record Documentation Standards

The medical record provides legal proof that the member received care. CalOptima requires that contracted delegated HNs make certain that each member's medical record is maintained in an accurate, current, detailed, organized and easily accessible manner. Medical records are reviewed for format, legal protocols, and documented evidence of the provision of preventive care and coordination and continuity of care services. All data should be filed in the medical record in a timely manner (i.e., lab, X-ray, consultation notes, etc.)

The medical record should provide appropriate documentation of the member's medical care in such a way that it facilitates communication, coordination and continuity of care, and promotes efficiency and effectiveness of treatment. All medical records should, at a minimum, include all information required by state and federal laws and regulations, and the requirements of CalOptima's contracts with CMS and DHCS.

The medical record should be protected to ensure that medical information is released only in accordance with applicable federal and state law.

Corrective Action Plan(s) to Improve Quality of Care and Service

When monitoring by either CalOptima's QI department, Audit & Oversight department or other functional areas identifies an opportunity for improvement, the relevant functional areas will determine the appropriate action(s) to be taken to correct the problem. Those activities specific to delegated entities will be conducted at the direction of the Audit & Oversight department as overseen by the Audit & Oversight Committee, reporting to the Compliance Committee. Those activities specific to CalOptima's functional areas will be overseen by the QI department as overseen by and reported to QIC. Actions for either delegates or functional areas may include the following:

- Development of cross-departmental teams using continuous improvement tools (i.e., quality improvement plans or PDSA) to identify root causes, develop and implement solutions, and develop quality control mechanisms to maintain improvements.

- Formal or informal discussion of the data/problem with the involved practitioner, either in the respective committee or by a medical director.

- Further observation and monitoring of performance via the appropriate clinical monitor. (This process shall determine if follow-up action has resolved the original problem.)

- Intensified evaluation/investigation when a trigger for evaluation is attained, or when further study needs to be designed to gather more specific data, i.e., when the current data is insufficient to fully define the problem.

- Changes in policies and procedures when the monitoring and evaluation results may indicate problems that can be corrected by changing policy or procedure.

QUALITY ANALYTICS

The Quality Analytics (QA) department fully aligns with the QI and PHM teams to support the organizational mission, strategic goals, required regulatory quality metrics, programs and processes to monitor and drive improvements to the quality of care and services, and ensure that care and services are rendered appropriately and safely to all CalOptima members.

The QA department activities include design, implementation, and evaluation of processes and programs to:

- Report, monitor and trend outcomes
- Support efforts to improve internal and external customer satisfaction
- Improve organizational quality improvement functions and processes to both internal and external customers
- Collect clear, accurate and appropriate data used to analyze performance of specific quality metrics and measure improvement
- Coordinate and communicate organizational, HN and provider-specific performance on quality metrics, as required
- Participate in various reviews through the QI Program, including, but not limited to, network adequacy, access to care and availability of practitioners
- Facilitate satisfaction surveys for members
- Incentivize HNs and providers to meet quality performance targets and deliver quality care

Data sources available for identifying, monitoring and evaluating opportunities for improvement and intervention effectiveness include, but are not limited to:

- Claims information/activity
- Encounter data
- Utilization data
- Case management reports
- Pharmacy data
- Immunization registry
- Lab data
- CMS Star Ratings data
- Population Needs Assessment
- HEDIS performance
- Member and provider satisfaction surveys

By analyzing data that CalOptima currently receives (i.e., claims data, pharmacy data and encounter data), the data warehouse can identify members for quality improvement and access to care interventions, which will allow us to improve our HEDIS scores and CMS Star Ratings. This information will guide CalOptima and our delegated HNs in identifying gaps in care and metrics requiring improvement.

POPULATION HEALTH MANAGEMENT

CalOptima strives to provide integrated physical health, behavioral health, LTSS, care coordination and complex case management to improve coordination of care between health care departments. This streamlined interaction will ultimately result in optimized member care. CalOptima's PHM strategy outlines programs that will focus on four key strategies:

1. Keeping members healthy
2. Managing members with emerging risks
3. Patient safety or outcomes across settings
4. Managing multiple chronic conditions

This is achieved through functions described below in Health Promotion, Health Management, Care Coordination and Members with Complex Needs, LTSS, Behavioral Health Services and telehealth areas.

CalOptima developed a comprehensive PHM Strategy that includes a plan of action for addressing our culturally diverse member needs across the continuum of care. CalOptima's PHM Strategy aims to ensure the care and services provided to members are delivered in a whole-person-centered, safe, effective, timely, efficient and equitable manner.

The PHM Strategy is based on numerous efforts to assess the health and well-being of CalOptima members. Additionally, CalOptima's annual Population Needs Assessment (requirement for California Medi-Cal Managed Care Plans) will aid the PHM Strategy further in identifying member health status and behaviors, member health education and cultural and linguistic needs, health disparities and gaps in services related to these issues.

The PHM plan of action addresses the unique needs and challenges of specific ethnic communities including economic, social, spiritual and environmental stressors, to improve health outcomes. CalOptima will conduct quality initiatives designed to achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical and non-clinical services that can be expected to have a beneficial effect on health outcomes and member satisfaction. Quality initiatives that are conducted to improve quality of care and health services delivery to members may include QIPs, PIPs, PDSAs and CCIPs. Quality Initiatives for 2022 are tracked in the QI Work Plan and reported to the QIC.

In 2022, the PHM Strategy will include greater focus on addressing health inequities and SDOH. The COVID-19 pandemic brought worldwide attention to health disparities and inequity. PHM identified opportunities to expand outreach and initiate new initiatives focused on SDOH and health equity as follows:

- Back-to-school immunization clinics for school-aged children (Tdap, COVID-19 vaccine, etc.)
- COVID-19 Member Health Rewards for CalOptima members, with special focus on those experiencing homelessness
- Improving COVID-19 vaccine access for homebound members and other high-risk populations
- Mobile diaper banks for families of infants and adolescent members in collaboration with Women, Infants & Children (WIC) and the Community Action Partnership
- Improving access for eligible CalOptima members to CalFresh benefits
- Improving access to breast cancer screenings for Korean and Chinese members via mobile mammography
- Remote monitoring for members with chronic conditions
- Escape The Vape (Great American Smoke Out) annual event that offers vape and tobacco prevention to school-aged children
- Shape Your Life Childhood Obesity Program, with group classes to improve awareness of good nutrition and physical fitness for adolescents
- Member Health Needs Assessment

The PHM team also focuses on improvement projects, such as QIPs, PIPs, CCIPs and PDSAs to improve processes and outcomes for members.

For each QI Project, specific interventions to achieve stated goals and objectives are developed and implemented, as part of the PHM program. Interventions for each project must:

- Be clearly defined and outlined
- Have specific objectives and timelines
- Specify responsible departments and individuals
- Be evaluated for effectiveness
- Be tracked by QIC

For each project, there are specific system interventions that have a reasonable expectation of effecting long-term or permanent performance improvement. System interventions include education efforts, policy changes, development of practice guidelines (with appropriate dissemination and monitoring) and other plan-wide initiatives. In addition, provider- and member-specific interventions, such as reminder notices and informational communication, are developed and implemented.

Improvement Standards

A. Demonstrated Improvement
Each project is expected to demonstrate improvement over baseline measurement on the specific quality measures selected. In subsequent measurements, evidence of significant improvement over the initial performance to the measure(s) must be sustained over time.

B. Sustained Improvement
Sustained improvement is documented through the continued remeasurement of quality measures for at least one year after the improved performance has been achieved.

Once the requirement has been met for both demonstrated and sustained improvement on any given project, there are no other regulatory reporting requirements related to that project. CalOptima may choose to continue the project or pursue another topic.

Documentation of QI Projects

Documentation of all aspects of each QI Project is required. Documentation includes, but is not limited to:

- Project description, including relevance, literature review (as appropriate), source and overall project goal
- Description of target population
- Description of data sources and evaluation of their accuracy and completeness
- Description of sampling methodology and methods for obtaining data
- List of data elements (quality measures). Where data elements are process measures, there must be documentation that the process indication is a valid proxy for the desired clinical outcome
- Baseline data collection and analysis timelines
- Data abstraction tools and guidelines
- Documentation of training for chart abstraction
- Rater-to-standard validation review results
- Measurable objectives for each quality measure
- Description of all interventions including timelines and responsibility
- Description of benchmarks
- Remeasurement sampling, data sources, data collection and analysis timelines
- Evaluation of remeasurement performance on each quality measure

Health Promotion

Health Education provides program development and implementation for agencywide PHM programs. PHM programs provide for the identification, assessment, stratification and implementation of appropriate interventions for members with certain conditions or chronic diseases. Programs and materials use educational strategies and methods appropriate for members. They are designed to achieve behavioral change and are reviewed on an annual basis. Program topics include exercise, nutrition, hyperlipidemia, hypertension, perinatal health, Shape Your Life/weight management, tobacco cessation, asthma, immunizations and well-child visits.

Primary goals of the department are to achieve member wellness and autonomy through advocacy, communication, education, identification of services, resources and service facilitation throughout the continuum of care. Materials are written at the sixth-grade reading level and are culturally and linguistically appropriate.

PHM supports CalOptima members with customized interventions, which may include:

- Healthy lifestyle management techniques and health education programs and services at no charge to members
- Medication education to ensure adherence to appropriate pharmacotherapy treatment plans

- Informational booklets for key conditions
- Referrals to community or external resources
- Execution and coordination of programs with Case Management, QA and HN providers

Managing Members With Emerging Risk

CalOptima staff provide a comprehensive system of caring for members with chronic illnesses. The systemwide, multidisciplinary approach entails the formation of a partnership between the member, the health care practitioner and CalOptima. The PHM program stratifies the population and identifies appropriate interventions based on member needs.

These interventions include coordinating care for members, and providing services, resources and support to members as they learn to care for themselves and their condition. The PHM program supports the California Surgeon General and Proposition 56 requirements for Adverse Childhood Event (ACE) screening, as well as identification of SDOH. It proactively identifies those members in need of closer management, coordination and intervention. CalOptima assumes responsibility for the PHM program for all lines of business; however, members with more acute needs receive coordinated care with delegated entities.

Care Coordination and Case Management

CalOptima is committed to serving the needs of all members and places additional emphasis on the management and coordination of care of the most vulnerable populations and members with complex health needs. Our goal is delivery of effective, quality health care to members with special health care needs, including, but not limited to, physical and developmental disabilities, multiple chronic conditions, and complex behavioral health and social issues through:

Standardized mechanisms for member identification through use of data, including Health Risk Assessment (HRA) or Health Needs Assessment (HNA) for MOC members.

- Multiple avenues for referral to case management and disease management programs or management of transitions of care across the continuum of health care from outpatient or ambulatory to inpatient or institutionalized care, and back to ambulatory.

- Ability of member to opt out.

- Targeted promotion of the use of recommended preventive health care services for members with chronic conditions (e.g., diabetes, asthma) through health education and member incentive programs.

- Use of evidence-based guidelines distributed to providers who are relevant to chronic conditions prevalent in the member population (e.g., COPD, asthma, diabetes, ADHD).

- Comprehensive initial nursing assessment and evaluation of health status, clinical history, medications, functional ability, barriers to care, and adequacy of benefits and resources.

- Development of individualized care plans that include input from the member, caregiver, PCP, specialists, social worker and providers involved in care management, as necessary.

- Coordination of services for members for appropriate levels of care and resources.

- Documentation of all findings.

- Monitoring, reassessing and modifying the plan of care to drive appropriate service quality, timeliness and effectiveness.

- Ongoing assessment of outcomes.

CalOptima's Case Management program includes three care management levels that reflect the acuity of needs: complex case management, care coordination and basic case management. Members within defined MOCs — SPD, WCM, OCC and OC — are risk-stratified upon enrollment using a plan-developed tool. This risk stratification informs the HRA/HNA outreach process. The tool uses information from data sources, such as acute hospital/emergency department utilization, severe and chronic conditions, and pharmacy.

HRA and HNA

The comprehensive risk assessment facilitates care planning and offers actionable items for the ICT. Risk assessments are completed in person, telephonically or by mail and accommodate language preference. The voice of our members is reflected within the risk assessment, which is specific to the assigned model of care. Risk assessments are completed with the initial visit and then on an annual basis.

ICT

An ICT is linked to members to assist in care coordination and services to achieve the individual's health goals. The ICT may occur at the PCP (basic) or the HN level (care coordination or complex), depending on the results of the member's HRA and/or evaluation or changes in health status. The ICT always includes the member (and caregivers or an authorized representative with member approval or appropriate authorization to act on behalf of the member) and PCP. For members with more needs, other disciplines are included, such as a medical director, specialist(s), case manager, behavioral health specialist, pharmacist, social worker, dietitian and/or long-term care manager. The ICT is designed to ensure that members' needs are identified and managed by an appropriately composed team.

The ICT levels are:

- ICT for Low-Risk Members — occurs at the PCP level
  - Team Composition: member, caregiver or authorized representative, PCP, PCP support staff (nurse, etc.)

    - Roles and responsibilities of this team:
      - Basic case management, including advanced care planning
      - Medication reconciliation

        - Identification of member at risk of planned and unplanned transitions
        - Referral and coordination with specialists
        - Development and implementation of an Individual Care Plan (ICP)
        - Communication with members or their representatives, vendors and medical group
        - Review and update the ICP at least annually, and when there is a change in health status
        - Referral to the primary ICT, as needed

- ICT for Moderate- to High-Risk Members — occurs at the HN, or at CalOptima for CCN members.
    - Team Composition: member, caregiver or authorized representative, HN medical director, PCP and/or specialist, ambulatory case manager, hospitalist, hospital case manager and/or discharge planners, HN UM staff, behavioral health specialist and social worker

        - Roles and responsibilities of this team:
            - Identification and management of planned transitions
            - Care coordination or complex case management
            - Case management of high-risk members
            - Coordination of ICPs for high-risk members
            - Facilitating communication among member, PCP, specialists and vendors
            - Meeting as frequently as is necessary to coordinate care and stabilize member's medical condition

ICP

The ICP is developed through the ICT process. The ICP is a member-centric plan of care with prioritization of goals and target dates. Attention is paid to needs identified in the risk assessment (HRA/HNA) and by the ICT. Barriers to meeting treatment goals are addressed. Interventions reflect care manager or member activities required to meet stated goals. The ICP has an established plan for monitoring outcomes and ongoing follow-up per case management level. The ICP is updated annually and with change in condition.

MOC: Dual Eligible Special Needs Plan (D-SNP)/OC and OCC

The goal of D-SNPs is to provide health care and services to those who can benefit the most from the special expertise of CalOptima providers and focused care management. Care management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet the comprehensive medical, behavioral health and psychosocial needs of an individual and the individual's family, while promoting quality and cost-effective outcomes.

The goal of care management is to help members regain optimum health or improved functional capability, cost-effectively and in the right setting. It involves comprehensive assessment of the member's condition, determining benefits and resources, and developing and implementing a care management plan that includes performance goals, monitoring and follow up.

CalOptima's D-SNP care management program includes, but is not limited to:

- Complex case management program for a subset of members whose critical event or diagnosis requires extensive use of resources, and who need help navigating the system to facilitate appropriate delivery of care and services.

- Transitional case management program focused on evaluating and coordinating transition needs for members who may be at risk of rehospitalization.

- High-risk and high-utilization program for members who frequently use emergency department services or have frequent hospitalizations, and at-high-risk individuals.

- Hospital case management program to coordinate care for members during an inpatient admission and discharge planning.

Care management program focuses on member-specific activities and the coordination of services identified in members' care plans. Care management performs these activities and coordinates services for members to optimize their health status and quality of life.

Seniors and Persons with Disability (SPD)

The goal of case management for SPD members is to facilitate the coordination of care and access to services in a vulnerable population that demonstrates higher utilization and higher risk of requiring complex health care services. The model involves risk stratification and HRA that contributes to the ICT and ICP development.

Whole Child Model (WCM)

The goal of case management for WCM is a single integrated system of care that provides coordination for CCS-eligible and non-CCS-eligible conditions. CalOptima coordinates the full scope of health care needs inclusive of preventive care, specialty health, mental health, education and training. WCM ensures that each CCS-eligible member receives case management, care coordination, provider referral and/or service authorization from a CCS paneled provider; this depends upon the member's designation as high or low risk. The model uses risk stratification and an HNA that informs the ICT and ICP development.

CalAIM's Enhanced Care Management (ECM)

Effective January 1, 2022, ECM is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of members with the most complex medical and social needs. These members are among the most vulnerable and highest-need Medi-Cal managed care members. ECM reflects a systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch and person-centered. The goal of ECM is to coordinate all primary, acute, behavioral, developmental, oral, social and long-term needs for members. Eligible members may participate in ECM and/or Community Supports through CalAIM.

Long-Term Services and Supports

CalOptima ensures LTSS are available to members with health care needs that meet program eligibility criteria and guidelines. LTSS include both institutional and community-based services. The LTSS department monitors and reviews the quality and outcomes of services provided to members in both settings.

Nursing Facility Services for Long-Term Care:

- CalOptima LTSS is responsible for the clinical review and medical necessity determination for members receiving long-term Nursing Facility Level A, Nursing Facility Level B and Subacute levels of care. CalOptima LTSS monitors the levels of overall program utilization as well as care setting transitions for members in the program.

Home- and Community-Based Services:

- CBAS: An outpatient, facility-based program that offers health and social services to seniors and people with disabilities. CalOptima LTSS monitors the levels of member access to, utilization of and satisfaction with the program, as well as its role in diverting members from institutionalization.
- MSSP: Intensive home- and community-based care coordination of a wide range of services and equipment to support members in their home and avoid the need for institutionalization. CalOptima LTSS monitors the level of member access to the program as well as its role in diverting members from institutionalization.

Behavioral Health Integration Services

Medi-Cal

CalOptima is responsible for providing outpatient mental health services to members with mild to moderate impairment of mental, emotional or behavioral functioning, resulting from a mental health disorder, as defined in the current diagnostic and statistical manual of mental disorders. Mental health services include, but are not limited to, individual and group psychotherapy, psychology, psychiatric consultation, medication management and psychological testing, when clinically indicated to evaluate a mental health condition.

In addition, CalOptima covers behavioral health treatment (BHT) for members 20 years of age and younger who meet medical necessity criteria. BHT services are provided under a specific behavioral treatment plan that has measurable goals over a specific time frame. CalOptima provides direct oversight, review and authorization of BHT services.

CalOptima offers Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT) services at the PCP setting to members 11 years and older, including pregnant women. When a screening is positive, providers conduct a brief assessment. Brief misuse counseling is offered when unhealthy alcohol or substance use is detected. Appropriate referral for additional evaluation and treatment, including medications for addiction treatment, is offered to members whose brief assessment demonstrates probable alcohol use disorder (AUD) or substance use disorder (SUD).

CalOptima members can access mental health services directly, without a physician referral, by contacting the CalOptima Behavioral Health Line at 855-877-3885. A CalOptima representative will conduct a brief mental health telephonic screening to make an initial determination of the member's impairment level. If the member has mild to moderate impairments, the member will be referred to behavioral health practitioners within the CalOptima provider network. If the member has moderate to severe impairments, the member will be referred to specialty mental health services through the Orange County Mental Health Plan.

CalOptima ensures members with coexisting medical and mental health care needs have adequate coordination and continuity of care. Communication with both the medical and mental health specialists occurs as needed to enhance continuity by ensuring members receive timely and appropriate access.

CalOptima directly manages all administrative functions of the Medi-Cal mental health benefits, including UM, claims, credentialing the provider network, member services and quality improvement.

CalOptima is participating in two of DHCS' incentive programs focused on improving behavioral health care and outcomes. First, the Behavioral Health Integration Incentive Program (BHIIP) is designed to improve physical and behavioral health outcomes, care delivery efficiency and member experience. CalOptima is providing program oversight, including readiness, milestones tracking, reporting and incentive reimbursement for the seven provider groups approved to participate in 12 projects. The second incentive program is the Student Behavioral Health Incentive Program (SBHIP), part of a state effort to prioritize behavioral health services for youth ages 0–25. The new program is intended to establish and strengthen partnerships and collaboration with school districts, county behavioral health and CalOptima by developing infrastructure to improve access and increase the number of transitional kindergarten through 12th-grade students receiving early interventions and preventive BH services.

OC and OCC

In 2022, OC and OCC behavioral health continues to be fully integrated within CalOptima internal operations. OC and OCC members can access mental health services by calling the CalOptima Behavioral Health Line. Members will be connected to a CalOptima representative for behavioral health assistance.

CalOptima offers Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT) services at the PCP setting to members 11 years and older, including pregnant women. When a screening is positive, providers conduct a brief assessment. Brief misuse counseling is offered when unhealthy alcohol or substance use is detected. Appropriate referral for additional evaluation and treatment, including medications for addiction treatment, is offered to members whose brief assessment demonstrates probable alcohol use disorder (AUD) or substance use disorder (SUD).

Utilization Management

Coverage for health care services, treatment and supplies in all lines of business is based on the terms of the plan, member eligibility at the time of service and subject to medical necessity. Contracts specify that medically necessary services are those that are established as safe and effective, consistent with symptoms and diagnoses, and furnished in accordance with generally accepted professional standards to treat an illness, disease or injury consistent with CalOptima medical policy and not furnished primarily for the convenience of the member, attending physician or other provider.

Use of evidence-based, peer reviewed, industry-recognized criteria ensures that medical decisions are not influenced by fiscal and administrative management considerations. As described in the 2022 UM Program, all review staff are trained and audited in these principles. Licensed clinical staff review and approve requested services based on medical necessity, utilizing evidence-based review criteria. Requests not meeting medical necessity criteria are reviewed by a physician reviewer or other qualified reviewer.

Further details of the UM Program, activities and measurements can be found in the 2022 UM Program Description.

Safety Program

Member safety is very important to CalOptima; it aligns with CalOptima's mission statement: *To provide members with access to quality health care services delivered in a cost-effective and compassionate manner*. By encouraging members and families to play an active role in making their care safe, medical errors will be reduced. Active, involved and informed members and families are vital members of the health care team.

Member safety is integrated into all components of enrollment and health care delivery and is a significant part of our quality and risk management functions. Our member safety endeavors are clearly articulated both internally and externally and include strategic efforts.

This safety program is based on a member-specific needs assessment, and includes the following areas:

- Identification and prioritization of member safety-related risks for all CalOptima members, regardless of line of business and contracted health care delivery organizations
- Operational objectives, roles and responsibilities, and targets based on risk assessment
- Health education and promotion
- Over/under utilization monitoring
- Medication management
- PHM
- Operational aspects of care and service

To ensure member safety, activities for prevention, monitoring and evaluation include:

- Providing education and communication through the Group Needs Assessment to consider the member's language comprehension, culture and diverse needs
- Distributing member information that improves their knowledge about clinical safety in their own care (such as member brochures that outline member concerns or questions that they should address with their practitioners for their care)

Collaborating with HNs and practitioners in performing the following activities:

- Improving medical record documentation and legibility, establishing timely follow up for lab results, addressing and distributing data on adverse outcomes or polypharmacy issues by the P&T, and maintaining continuous quality improvement with pharmaceutical management practices to require safeguards to enhance safety

- Alerting the pharmacy to potential drug interactions and/or duplicate therapies, and discussing these potential problems with the prescribing physician(s), which helps ensure the appropriate drug is being delivered

- Improving continuity and coordination between sites of care, such as hospitals and skilled nursing facilities, to assure timely and accurate communication

- Using FSRs, Physical Accessibility Review Survey (PARS) and medical record review results from providers and health care delivery organization at the time of credentialing to improve safe practices, and incorporate ADA and SPD site reviews into the general FSR process

- Tracking and trending of adverse event reporting to identify system issues that contribute to poor safety

Elements of the safety program address the environment of care and the safety of members, staff and others in a variety of settings. The focus of the program is to identify and remediate potential and actual safety issues, and to monitor ongoing staff education and training, including:

- Ambulatory setting
  - Adherence to ADA standards, including provisions for access and assistance in procuring appropriate equipment, such as electric exam tables
  - Annual blood-borne pathogen and hazardous material training
  - Preventative maintenance contracts to promote keeping equipment in good working order
  - Fire, disaster and evacuation plan testing and annual training

- Institutional settings, including CBAS, SNF and MSSP settings
  - Falls and other prevention programs
  - Identification and corrective action implemented to address postoperative complications
  - Sentinel events, critical incident identification, appropriate investigation and remedial action
  - Administration of flu and pneumonia vaccines
  - COVID-19 infection prevention and protective equipment

    - MRSA prevention program – Shared Healthcare Intervention to Eliminate Life-Threatening Dissemination of Multi-drug Resistant Organisms (SHIELD)

- Administrative offices
    - Fire, disaster and evacuation plan testing and annual training

CULTURAL & LINGUISTIC SERVICES

As a health care organization in the diverse community of Orange County, CalOptima strongly believes in the importance of providing culturally and linguistically appropriate services to members. To ensure effective communication regarding treatment, diagnosis, medical history and health education, CalOptima has developed a program that integrates culturally and linguistically appropriate services at all levels of the operation. Services include, but are not limited to, face-to-face interpreter services, including American Sign Language, at key points of contact; 24-hour access to telephonic interpreter services; and member information materials translated into CalOptima's threshold languages and in alternate formats, such as braille, large-print or audio.

The seven most common languages spoken for all CalOptima programs are: English, 59%; Spanish, 26%; Vietnamese, 10%; Farsi, 1%; Korean, 1%; Chinese, less than 1%; and Arabic, less than 1%. CalOptima provides member materials as follows:

- Medi-Cal member materials are in seven languages: English, Spanish, Vietnamese, Farsi, Korean, Chinese and Arabic
- OC member materials are in three languages: English, Spanish and Vietnamese
- OCC member materials are in seven languages: English, Spanish, Vietnamese, Farsi, Korean, Chinese and Arabic
- PACE participant materials are provided in four languages: English, Spanish, Vietnamese and Korean

CalOptima is committed to member-centric care that recognizes the beliefs, traditions, customs and individual differences of our diverse population. Beginning with identification of needs through a Group Needs Assessment, programs are developed to address the specific education, treatment and cultural norms of the population impacting the overall wellness of the community we serve. Identified needs and planned interventions involve member input and are vetted through the MAC and PAC prior to full implementation.

Objectives for serving a culturally and linguistically diverse membership include:

- Reduce health care disparities in clinical areas
- Improve cultural competency in materials and communications
- Improve network adequacy to meet the needs of underserved groups
- Improve other areas of need as appropriate

Serving a culturally and linguistically diverse membership includes:

- Analyzing significant health care disparities in clinical areas to ensure health equity
- Using practitioner and provider medical record reviews to understand the differences in care provided and outcomes achieved

- Considering outcomes of member grievances and complaints
- Conducting member-focused interventions with culturally competent outreach materials that focus on race-, ethnic-, language- or gender-specific risks
- Conducting member-focused groups or key informant interviews with cultural or linguistic members to determine how to meet their needs
- Identifying and reducing a specific health care disparity affecting a cultural, racial or gender group.
- Providing information, training and tools to staff and practitioners to support culturally competent communication

DELEGATED AND NON-DELEGATED ACTIVITIES

CalOptima delegates certain functions and/or processes to delegated HNs that are required to meet all contractual, statutory and regulatory requirements, as well as accreditation standards, CalOptima policies and other guidelines applicable to the delegated functions.

Delegation Oversight

Participating entities are required to meet CalOptima's QI standards and to participate in CalOptima's QI Program. CalOptima has a comprehensive interdisciplinary team that is assembled for evaluating any new potential delegate's ability to perform its contractual scope of responsibilities. A Readiness Assessment is conducted by the Audit & Oversight department and overseen by the Audit & Oversight Committee, reporting to the Compliance Committee.

NON-DELEGATED ACTIVITIES

The following activities are not delegated, and remain the responsibility of CalOptima:

- QI, as delineated in the Contract for Health Care Services
- QI Program for all lines of business (delegated HNs must comply with all quality-related operational, regulatory and accreditation standards)
- Behavioral Health for Medi-Cal, OC and OCC
- PHM Program, previously referred to as Disease Management or Chronic Care Improvement Program
- Health education (as applicable)
- Grievance and appeals process for all lines of business, and peer review process on specific, referred cases
- Potential Quality Issue investigations
- Development of systemwide measures, thresholds and standards
- Satisfaction surveys of members, practitioners and providers
- Survey for Annual Access and Availability
- Access and availability oversight and monitoring
- Second-level review of provider grievances
- Development of credentialing and recredentialing standards for both practitioners and OPs
- Credentialing and recredentialing of OPs
- Development of UM and Case Management standards
- Development of QI standards

- Management of Perinatal Support Services (PSS)
- Risk management
- Pharmacy and drug utilization review as it relates to quality of care
- Interfacing with state and federal agencies, medical boards, insurance companies, and other managed care entities and health care organizations

Further details of the delegated and non-delegated activities can be found in the 2022 Delegation Grid.

See Appendix B — 2022 Delegation Grid

IN SUMMARY

As stated previously, CalOptima cannot achieve our mission and our vision alone. We must work together with providers, community health centers, county agencies, state and federal agencies, and other community stakeholders to provide quality health care to members. Together, we can be innovative in developing solutions that meet our diverse members' health care needs. We are truly "Better. Together."

APPENDIX A — 2022 QI WORK PLAN

Appendix B — 2022 Delegation Grid

I. PROGRAM OVERSIGHT

A. 2022 QI Annual Oversight of Program and Work Plan
B. 2021 QI Program Evaluation
C. 2022 UM Program
D. 2021 UM Program Evaluation
E. Population Health Management Strategy
F. Credentialing Peer Review Committee (CPRC) Oversight
G. Grievance and Appeals Resolution Services (GARS) Committee
H. Member Experience (MEMX) Committee Oversight
I. Utilization Management Committee (UMC) Oversight
J. Whole Child Model - Clinical Advisory Committee (WCM CAC)
K. Quality Withold for OCC
L. New Quality Program Updates (Health Network Quality Rating, MCAS, P4V, OC P4V, Data Mining/Bridge efforts)
M. Improvement Projects (All LOB)PIPs
N. Improvement Projects (All LOB)QIPs
O. Improvement Projects (All LOB)CCIP's
P. PPME/QIPE: HRA's
Q. BHI Incentive Program (DHCS - under prop 56 funding) and ABA P4V
R. Homeless Health Initiatives (HHI): Homeless Response Team (HRT)
S. CalAIM
T. Health Equity
U. DHCS Comprehensive Quality Strategy
V. Student Behavioral Health Incentive Program (SBHIP)

II. QUALITY OF CLINICAL CARE- Adult Wellness

A. Cancer Screenings: Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL), Breast Cancer Screening (BCS)
B. COVID-19 Vaccination and Communication Strategy

III. QUALITY OF CLINICAL CARE- Behavioral Health

A. Follow-up After Hospitalization for Mental illness within 7 and 30 days of discharge (FUH).

INITIAL WORK PLAN AND APPROVAL:

Submitted and approved by QIC: Date:

Submitted and approved by QAC: Date:

Quality Improvement Committee Chairperson:

Richard Pitts, D.O., Ph.D Date:

Board of Directors' Quality Assurance Committee Chairperson:

Trieu Thanh Tran, M.D. Date:

B. Follow-up Care for Children with Prescribed ADHD Medication (ADD): Continuation Phase. Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.

C. Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD)(Medicaid only)

D. Follow-Up After Emergency Department Visit for Mental Illness (FUM)

IV. QUALITY OF CLINICAL CARE- Chronic Conditions

A. Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): HbA1c Poor Control (this measure evaluates % of members with poor A1C control-lower rate is better)

B. Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): Eye Exam

C. Implement multi-disciplinary approach to improving diabetes care for CCN Members Pilot

V. QUALITY OF CLINICAL CARE- Maternal Child Health

A. Prenatal and Postpartum Care Services (PPC): Timeliness of Prenatal Care and Postpartum Care (PHM Strategy).

VI. QUALITY OF CLINICAL CARE- Pediatric/Adolescent Wellness

A. Pediatric Well-Care Visits and Immunizations - Includes measures such as W30 and IMA, Child and Adolescent Well-Care Visits and Immunizations - Includes measures such as WCV and IMA

B. Blood Lead Screening (BLS) (LSC)

VII. QUALITY OF SERVICE- Access

A. Improve Access: Reducing gaps in provider network
B. Improve Access: Expanding Network of Providers Accepting New Patients
C. Improve Access: Timely Access (Appointment Availability)
D. Improve Access: Telephone Access
E. Improving Access: Subcontracted Network Certification

VIII. SAFETY OF CLINICAL CARE

A. Plan All-Cause Readmissions (PCR) - MCAS Measure. OCC Quality Withhold measure.
B. Post-Acute Infection Prevention Quality Incentive (PIPQI)
C. Orange County COVID Nursing Home Prevention Program.

2022 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Health Equity and/or SDOH	Con't Monitoring from 2021	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
I. PROGRAM OVERSIGHT									
2022 QI Annual Oversight of Program and Work Plan	Obtain Board Approval of 2022 QI Program and Workplan	QI Program and QI Work Plan will be adopted on an annual basis; QI Program Description-QIC-BOD; QI Work Plan-QIC-QAC	Annual Adoption by April 2022	Marsha Choo		X			
2021 QI Program Evaluation	Complete Evaluation 2021 QI Program	QI Program and QI Work Plan will be evaluated for effectiveness on an annual basis	Annual Evaluation by April 2022	Marsha Choo		X			
2022 UM Program	Obtain Board Approval of 2022 UM Program	UM Program will be adopted on an annual basis.	Annual Adoption by April 2022	Mike Shook		X			
2021 UM Program Evaluation	Complete Evaluation of 2021 UM Program	UM Program and UM Work Plan will be evaluated for effectiveness on an annual basis.	Annual Evaluation by April 2022	Mike Shook		X			
Population Health Management Strategy	Implement PHM strategy	Review and adopt on an annual basis.	Annual Review and Adoption	Marie Jeannis/Kelly Giardina		X			
Credentialing Peer Review Committee (CPRC) Oversight - Conduct Peer Review of Provider Network by reviewing Credentialing Files, Quality of Care cases, and Facility Site Review, to ensure quality of care delivered to members		Review of Initial and Recredentialing applications approved and denied; Facility Site Review (including Physical Accessibility Reviews); Quality of Care cases leveled by committee.	Quarterly Adoption of Report	Marsha Choo/Laura Guest		X			
Grievance and Appeals Resolution Services (GARS) Committee - Conduct oversight of Grievances and Appeals to resolve complaints and appeals for members and providers in a timely manner.		The GARS Committee oversees the Grievances, Appeals and Resolution of complaints by members and providers for CalOptima's network and the delegated health netwoks. Trends and results are presented to the committee quarterly.	Quarterly Adoption of Report	Tyronda Moses		X			
Member Experience (MEMX) Committee Oversight - Oversight of Member Experience activities to improve quality of service and member experience to achieve the 2021 QI Goal of improving CAHPS and Access to Care.		The MEMX Subcommittee assesses the annual results of CalOptima's CAHPS surveys, monitor the provider network including access & availability (CCN & the HNs), review customer service metrics and evaluate complaints, grievances, appeals, authorizations and referrals for the "pain points" in health care that impact our members.	Quarterly Adoption of Report	Kelly Rex-Kimmet/Marsha Choo		X			
Utilization Management Committee (UMC) Oversight - Conduct Internal and External oversight of UM Activities to ensure over and under utilization patters do not adversely impact member's care.		UMC meets quarterly; monitors medical necessity, cost-effectiveness of care and services, reviewed utilization patterns, monitored over/under-utilization, and reviewed inter-rater reliability results. P&T and BMSC reports to the UMC, and minutes are submitted to UMC quarterly.	Quarterly Adoption of Report	Mike Shook		X			
Whole Child Model - Clinical Advisory Committee (WCM CAC)- Conduct Clinical Oversight for WCM and provide clinical advice for issues related to implementation.		Meet quarterly, provide clinical advice regarding Whole Child Model operations to Medical Affairs.	Quarterly Adoption of Report	T.T. Nguyen, MD		X			
Quality Withhold for OCC	Earn **75**% of Quality Withhold Dollars back for OneCare Connect in OCC QW program end of MY 2021	Monitor and report to QIC	Annual Assessment	Sandeep Mital		X			

2022 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Health Equity and/or SDOH	Con't Monitoring from 2021	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
New Quality Program Updates (Health Network Quality Rating, MCAS, P4V, **OC P4V,** Data Mining/Bridge efforts)	Achieve 50th percentile on all MCAS measures in 2021	Report of new quality program updates including but not limited to Health Network Quality Rating, MCAS reports and P4V. Data Mining/Bridge efforts include Office Ally EMR, CAIR Registry Data, efforts to immunization registry (CAIR) and lab data gaps Activities requiring intervention are listed below in the Quality of Clinical Care measures. **[NEW] Development of the OC P4V program for MY2023**	Quarterly Report or As needed	Kelly Rex-Kimmet/ Paul Jiang/Sandeep Mital		X			
Improvement Projects (All LOB) PIPs	Meet and exceed goals set forth on all improvement projects	Conduct quarterly/Annual oversight of specific goals All LOB PIPs **MC PIPs:** 1) Improving Breast Cancer Screening (BCS) rates for Korean and Chinese CalOptima Medi-Cal Members.(March 1, 2020-December 31, 2022) 2) Improving Well-Care Visits for Children in Their First 30 Months of Life (W30) for CalOptima Medi-Cal Members (March 1, 2020-December 31, 2022)	Quarterly/Annual Assessment	Helen Syn	Health Equity	X			
Improvement Projects (All LOB) QIPs	Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals)	Conduct quarterly/Annual oversight of specific goals All LOB QIPs **MC QIP:** 1) COVID QIP Phase 2 - a. Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (SSD) b. CCS - Increase the number of Medi-Cal members ages 21-64 who complete cervical cancer screening. c. CIS Combo 10 - Increase immunization rates of Medi-Cal members turning 2 years old. 2) Improving Statin Use for People with Diabetes (SPD)	Quarterly/Annual Assessment	Natalie Zavala/Helen Syn	Health Equity	X			
Improvement Projects (All LOB) CCIP's	Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals)	Conduct quarterly/Annual oversight of specific goals on **All LOB CCIPs** 1) OC and OCC CCIP: Improving CDC measure, HbA1C good control <8% - Targeted outreach calls to those with emerging risk >8% (2019 - 2022) 2) OCC QIP: Improving Statin Use for People with Diabetes (SPD) Oversight (review of MOC ICP/ICT Bundles) 2019-2022	Quarterly/Annual Assessment	Helen Syn		X			
PPME/QIPE: HRA's	Goal 95% timely completion on all HRA HN MOC oversight 90% CA MMP 1.5 ICP High/Low risk Goal is 75% CA MMP 1.6 Care Goal Discussion 95% MMP 3.2 ICP completion 90 days 85%	Conduct quarterly/Annual oversight of specific goals **OC and OCC** PPME and QIPEs 1) PME (OC): HRA's, HN MOC Oversight(Review of MOC ICP/ICT bundles) 2) QIPE (OCC): HRA's, ICP High/Low Risk, ICP Completed within 90 days, HN MOC 3) LTSS HRA OCC: Monitor for timeliness on outreach for completion.	Quarterly/Annual Assessment	Sloane Petrillo/S. Hickman		X			
BHI Incentive Program (DHCS - under prop 56 funding) and ABA P4V	Achieve program milestones quarterly and annual performance goals	1) Monitor the 12 projects approved by DHCS for the BHI Incentive Program. Program launched in January 2021. CalOptima is responsible for program oversight (i.e., milestones tracking, reporting and incentive reimbursement). Quarterly program update at QIC. 2) Monitor the ABA P4V program's performance metrics -% of supervision hours completed by BCBA /BMC and % of 1:1 hours utilized vs. authorized. Submit results quarterly to the program's eligible contracted providers. Program launched January 2021 and approved to continue through January 2022.	Quarterly Adoption of Report	Natalie Zavala/Sheri Hopson		X			
Homeless Health Initiatives (HHI): Homeless Response Team (HRT)	Increase access to Care for individuals experiencing homelessness.	1) Regular planned visits to shelters, hot spots and recuparative care facilities- to resume post-COVID-19 addition of virtual outreach visits to shelters. 2)Primary point of contact for coordinating care with collaborating partners and HNs 3) Serve as a resource in pre-enforcement engagements, as needed. -to resume post-COVID-19	Quarterly Report	Katie Balderas/Sloane Petrillo	SDOH	X			

2022 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Health Equity and/or SDOH	Con't Monitoring from 2021	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
CalAIM	Improve Health & Access to care for enrolled members	1) Complete transition of all enrolled HHP members to CalAIM ECM Q1 2022 2) Complete transition of all enrolled WPC members to CalAIM ECM Q1 2022 3) Establish DHCS reporting process 4) Establish oversight strategy for the CalAIM program	Quarterly Report	Sloane Petrillo/Natalie Zavala	SDOH	X			
Health Equity	Adapt Institute for Healthcare Improvement Health Equity Framework	1) Make health equity a strategic priority 2) Develop structure and process to support health equity work 3) Deploy specific strategies to address the multiple determinants of health on which health care organizations can have direct impact 4) Develop partnerships with community organizations to improve health and equity 5) Ensure COVID-19 vaccination and communication strategy incorporate health equity.	Quarterly Report	Katie Balderas/Marie Jeannis	Health Equity	x			
DHCS Comprehensive Quality Strategy	Develop CalOptima quality strategy in alignment with the final DHCS comprehensive quality strategy.	[NEW} to 2022 QI Work Plan 1) Work with DHCS to define the final 2022 Comprehensive Quality Strategy. 2) Collaborate with Internal and external stakeholders in the development quality strategy	12/31/2022	Marie Jeannis/Marsha Choo	Health Equity				
Student Behavioral Health Incentive Program (SBHIP)	Achieve program implementation period deliverables	[NEW} to 2022 QI Work Plan SBHIP is part of the Administration and State Legislature effort to prioritize behavioral health services for youth ages 0-25. The new program is intended to establish and strengthen partnerships and collaboration with school districts, county BH and CalOptima by developing infrastructure to improve access and increase the number of TK-12 grade students receiving preventative, early interventions and BH services.	12/31/2022	Natalie Zavala	Health Equity				
II. QUALITY OF CLINICAL CARE- Adult Wellness									
Cancer Screenings: Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL), Breast Cancer Screening (BCS)	HEDIS MY2021 Goal: CCS: MC 59.12% BCS: MC 61.24% OCC 69% OC 69% COL: OCC 71% OC 62% Based on HEDIS MY2020 NCQA Quality Compass Benchmarks, 50th percentile (released September 2021): CCS: MC 59.12% BCS: MC 53.93%	1) Transition to the Member Health Reward vendor to continue rewards established for CCS, BCS and COL programs. Track member health reward impact on HEDIS rates for cancer screening measures. 2) Targeted member engagement and outreach campaigns to promote cancer screenings in coordination with health network partners. 3) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. 4) Community and Mobile Cancer Screening Events with community partners and agencies. eg. Mobile Mammography Events.	12/31/2022	Helen Syn	Health Equity	X			
COVID-19 Vaccination and Communication Strategy	Vaccine rate of 80% or more of CalOptima members (12 and over).	1) Efforts to support APL for COVID Vaccination from DHS. 2) Continue COVID Vaccination member health reward fulfillment process for all eligible age groups including Kaiser population and homeless population. 3) Implement the COVID QIP Interventions: Listed in Improvement Projects Section. 4) Continue Communication Strategy for COVID vaccine that address members based on zip codes, ethnicity, and pre-existing risk conditions.	12/31/2022	Helen Syn		X			

2022 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Health Equity and/or SDOH	Con't Monitoring from 2021	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
III. QUALITY OF CLINICAL CARE- Behavioral Health									
Follow-up After Hospitalization for Mental illness within 7 and 30 days of discharge (FUH).	**HEDIS MY2021 Goal:** FUH 30-Days: MC: NA; OC: NA; OCC: 56% (Quality Withhold measure) 7-Days: MC: NA; OC:NA;OCC:34.67%	1) Conduct additional hospital visits to educate discharge planning staff on FUH requirements and address any questions or concerns. 2) Continue to conduct post discharge member outreach to ensure members are able to attend follow up appointment, and identify and address potential barriers. 3) Incorporate successful interventions identified by the BHI Incentive Program project to improve follow-up after hospitalization.	12/31/2022	Natalie Zavala		X			
Follow-up Care for Children with Prescribed ADHD Medication (ADD): Continuation Phase. Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	**HEDIS MY2021 Goal:** MC - Init Phase - 44.51% MC -Cont Phase - 55.96%	1) Continue the non-compliant providers letter activity. 2) Participate in educational events on importance of attending follow-up visits. 3) Continue member outreach to improve appointment scheduling by identifying and addressing potential barriers for not attending visits.	12/31/2022	Natalie Zavala		X			
Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD) (Medicaid only)	HEDIS 2021 Goal: MC 73.69% OC (Medicaid only) OCC (Medicaid only)	[NEW} to 2022 QI Work Plan 1) Identify members in need of diabetes screening test. 2) Conduct outreach to prescribing provider to remind of best practice and provide list of members still in need of screening. 3) Remind prescribing providers to contact members' primary care physician (PCP) with lab results by providing name and contact information to promote coordination of care.	12/31/2022	Natalie Zavala					
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	HEDIS Goal: MC 30-Day: 53.54%; 7 day: 38.55% OC (Medicaid only) OCC (Medicaid only)	[NEW] to 2022 QI Work Plan 1) Create and distribute provider and member educational materials on the importance of follow-up visits. 2) Collaborate with health networks to identify and address potential barriers.	12/31/2022	Natalie Zavala					
IV. QUALITY OF CLINICAL CARE- Chronic Conditions									
Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): HbA1c Poor Control (this measure evaluates % of members with poor A1C control-lower rate is better)	**MY2021** HEDIS Goals: MC: 34.06%; OC: 19% OCC: 19%	1) Transition to the Member Health Reward vendor to continue rewards established for A1c Testing. Implement new member health rewards targeting CCN members with diabetes with poor control. Track member health reward impact on HEDIS rates for CDC measures. 2) Targeted member engagement and outreach campaigns to promote CDC compliance in coordination with health network partners. 3) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. 4) Prop 56 provider value based payments for diabetes care measures	12/31/2022	Helen Syn		X			
Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): Eye Exam	MY2020 HEDIS Goals:: MC 63.2% OC: 71%; OCC: 79%	1) Transition to the Member Health Reward vendor to continue rewards established for Eye Exams. 2) Targeted member engagement and outreach campaigns to promote CDC compliance in coordination with health network partners. 3) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. 4) Prop 56 provider value based payments for diabetes care measures	12/31/2022	Helen Syn		X			

2022 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Health Equity and/or SDOH	Con't Monitoring from 2021	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
Implement multi-disciplinary approach to improving diabetes care for CCN Members Pilot	1) lower HbA1c level to avoid complications 2) reduce emergency department (ED) visits 3) reduce hospitalization rates 4) reduce costs for diabetic medications 5) improve member and provider satisfaction; and 6) optimize diabetes medication management during the transition to Medi-Cal Rx.	There are four parts to this multidispclinary approach: 1) Pharmacist Involvement and Intervention- Nicki G. • CalOptima Pharmacist's role will include individual member outreach and provider consultations for members enrolled in the pilot program. CalOptima pharmacists will promote proper medication utilization, provide medication adherence counseling, and support behavior changes needed for diabet c members with a multidisciplinary team approach, including collaboration with PCPs and health coaches/registered dieticians/case managers. 2) Health Coach/Registered Dietician Intervention - Jocelyn J. • CalOptima Health Coaches will provide CCN-focused interventions such as assessment/care plannin motivational interviewing, member education materials, referral to other community resources based on needs. Health Coaches/Registered Dieticians would also participate in Interdisciplinary Care Team (IC meetings, as applicable, and connect members to case management if other acute needs are identified during an intervention. 3) Member Health Rewards - Helen Syn • CalOptima would like to support member engagement and compliance by providing members with health rewards (non- monetary incentives). 4) Provider Incentives - TBD • In order to have successful provider buy-ins, CalOptima proposes providing incentives for their dedicated participation in this multidisciplinary DM program. Providers are eligible for incentives when they participate in the program to manage a member with known or potentially poorly controlled diabetes and meet the eligibility criteria for participation year.	12/31/2024	Nicki Ghazanfarpour /Helen Syn/ Jocelyn Johnson		X			
V. QUALITY OF CLINICAL CARE- Maternal Child Health									
Prenatal and Postpartum Care Services (PPC): Timeliness of Prenatal Care and Postpartum Care (PHM Strategy).	HEDIS MY2021 Goal: Postpartum: 79.56% Prenatal: 90.75% Based on HEDIS MY2020 NCQA Quality Compass Benchmarks (released September 2021)	1)Transition to the Member Health Reward vendor to continue rewards established for Postpartum care. 2) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, events, and other modes. 3) Continue expansion of Bright steps comprehensive maternal health program through community partnerships, provider/ health network partnerships, and member engagement. Examples: WIC Coordination, Diaper Bank Events 4) Implement Collaborative Member Engagement Event with OC CAP Diaper Bank and other community-based partners 5) Prop 56 provider value based performance incentives for prenatal and postpartum care visits	12/31/2022	Ann Mino/Helen Syn	Health Equity	X			
VI. QUALITY OF CLINICAL CARE- Pediatric/Adolescent Wellness									
Pediatric Well-Care Visits and Immunizations - Includes measures such as W30 and IMA, Child and Adolescent Well-Care Visits and Immunizations - Includes measures such as WCV and IMA	HEDIS **MY2021** Goal CIS-Combo 10: 49.58% IMA-Combo 2: 50.61% W30-First 15 Months: 54.92% W30-15 to 30 Months: 74.42% WCV (Total): 53.83% Based on HEDIS MY2020 NCQA Quality Compass Benchmarks (released September 2021)	1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Expand member engagement strategy to include multi-modal approach as deemed most strategic via: texting, robocalls, social media, website, direct mailing, member newsletter, and other modes. 3) EPSDT DHCS promotional campaign emphasizing immunizations and well care EPSDT visits 4) Implement Community events to promote well-care visits and immunizations for children and adolescents; and track the number of participants and impact on rates. Examples: Back-to-School Immunization Clinics 5) Prop 56 provider value based payments for relevant child and adolescent measures	12/31/2022	Helen Syn	Health Equity	X			

2022 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Health Equity and/or SDOH	Con't Monitoring from 2021	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
Blood Lead Screening (BLS) (LSC)	1) Comply with APL requirements as stated 2) Send quarterly reports to CalOptima contracted PCPs timely 3) **HEDIS MY2021 Goal (3 Year Goal)**: Lead Screening 50th percentile 71.53%	1) Continue providing quarterly report to CalOptima contracted PCPs identifying children with gaps in blood lead screening recommended schedule. 2)Targeted member engagement and outreach campaigns to promote blood lead screenings in coordination with health network partners 3) Prop 56 provider value based payments for Blood Lead Screening	12/31/2022	Helen Syn		X			
VII. QUALITY OF SERVICE- Access									
Improve Access: Reducing gaps in provider network	Reduce the rate of OON requests for these top 3 specialties by 10%	1) Actively recruit specialties with the most out-of-network (OON) requests for CCN (General Surgery, Ophthalmology and Orthopedic Surgery)	12/31/2022	Michelle Laughlin/Jennifer Bamberg/Maggie Hart		X			
Improve Access: Expanding Network of Providers Accepting New Patients	Increase the number of providers accepting new patients: PCPs from 60.3% to 65.3% Specialists from 56.7% to 61.7%	[NEW] to 2022 QI Work Plan 1) Targeted outreach campaign to open their panels 2) Business consideration to require providers to participate in all programs.	12/31/2022	Marsha Choo/Jennifer Bamberg					
Improve Access: Timely Access (Appointment Availability)	Improve Timely Access compliance with Appointment Wait Times: Routine PCP from 76.2% to 80% MPL Urgent PCP from 68.4% to 73.4% Routine SPEC from 67.7% to 72.7% Urgent SPEC from 56.1% to 61.1%	1) Communication and corrective action to providers not meeting timely access standards 2) Communication and PDSAs to HNs not meeting timely access standards 3) See Virtual Care Strategies	12/31/2022	Marsha Choo/Jennifer Bamberg		X			
Improve Access: Telephone Access	Reduce the rate of **No Live Contacts After 3 Attempts** from 29.9% to 26.9% (or 10% of the performance gap)	1) Improve provider data in FACETs (i.e. Provider Directory Attestations, DHCS Quarterly and Monthly Provider Data Audits) 2) Individual Provider Outreach and Education (Timely Access Survey)	12/31/2022	Marsha Choo/Jennifer Bamberg		X			
Improving Access: Subcontracted Network Certification	Certifiy all HNs for network adequacy	[NEW] 2022 QI Work Plan 1) Mandatory Provider Types 2) Provider to Member Ratios 3) Time/Distance 4) Timely Access If 1-3 are not met, HN to identify a provider to fill the gap. If 4 not met, HN to be issued a PDSA.	7/31/2022	Marsha Choo/Jennifer Bamberg					

2022 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	Health Equity and/or SDOH	Con't Monitoring from 2021	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
VIII. SAFETY OF CLINICAL CARE									
Plan All-Cause Readmissions (PCR) - MCAS Measure. OCC Quality Withhold measure.	**HEDIS MY2021** Goal: MC - NA OC 8%; OCC 1.0 (O/E Ratio)	1) Update the existing CORE report(RR0012) to include Medical LOB, Members with First Follow-up Visit within 30 days Discharge (CA 1.11) 2) Improve PCP Visit Access 3) Continue to engage work group to address barriers, thereby achieving inctreased post hospitalization visits with PCP Continue to discuss barriers with internal team to improve members having a follow up PCP visit at time of discharge. Currently developing a communication strategy to hospitals and members regardign the importance of having a post dischage visit with the members PCP.	12/31/2022	Mike Shook		X			
Post-Acute Infection Prevention Quality Incentive (PIPQI)	1) To reduce the number of nosocomial infections for LTC members. 2) To reduce the number of acute care hospitalizations related to infections for LTC members.	1) Nurses will be visiting each facilitiy/ out reach minimally once a week. 2) Facility Staff bathe residents in Chlorhexidine (CHG) antiseptic soap for routine bathing and showering. And administer Iodofor (nasal swabs) per PIPQI Protocols. 3) CalOptima will pay participating facilities via reimbursement for product purchasing and quarterly quality incentive payments. 4) CalOptima will market and expand the PIPQI Program into additional CalOptima Contracted Nursing facilities providing onboarding training, new branding and educational materials.	12/31/2022	Michelle Findlater/Scott Robinson		X			
Orange County COVID Nursing Home Prevention Program.	Conduct in-person training of 12 CalOptima contracted nursing facilities in collaboration with UCI to reduce the spread of COVID/Infections in nursing facilities; toolkit, consultative services and webinars provided to all Orange County nursing homes free of charge	Program includes intense in-person training of contracted nursing facilities provided by UCI, along with consultative sessions, comprehensive toolkit, weekly educational emails, and training webinars provided free to all CalOptima Orange County contracted nursing facilities. Program funding through May 2022. Planned activities include: 1) Provide expertise on infection prevention for COVID-19/SARS-CoV-2 2) Provide guidance, protocols for preventing spread of COVID 3) Support training on how to stock and use protective gear 4) Develop high compliance processes for protection of staff and residents. 5) Make toolkit available for free at www.ucihealth.org/stopcovid 6) Provide COVID prevention helpline to offer guidance and information to nursing home staff 7) Conduct point prevalence sweeps of residents for multi-drug organisms	5/31/2022	Cathy Osborn/**Scott Robinson**		X			

APPENDIX B- 2022 QI Delegation Grid

2022 QI Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
1.1.1	QI1A: QI Program Structure	X		X	
1.1.2	QI1B: Annual Work Plan	X		X	
1.1.3	QI1C: Annual Evaluation	X		X	
1.1.4	QI1D: QI Committee Responsibilities	X		X	
New	QI1E: Promoting Organizational Diversity, Equity and Inclusion	X		X	[NEW] Effective 7/1/2022, 2022 HP Standards
1.2.1	QI2A: Practitioner Contracts	X		X	
1.2.2	QI2B: Provider Contracts	X		X	Not Required for Renewal Survey
1.3.1	QI3A: Identifying Opportunities-Continuity & Coordination of Care of Medical Care (C&C)	X		X	
1.3.2	QI3B: Acting on Opportunities-Continuity & Coordination of Care of Medical Care (C&C)	X		X	
1.3.3	QI3C: Measuring Effectiveness-Continuity & Coordination of Care of Medical Care (C&C)	X		X	
1.3.4	QI3D: Transition to other Care-Continuity & Coordination of Care of Medical Care (C&C)	X		X	
1.4.1	QI4A: Data Collection- C&C Between Medical Care and Behavioral Health	X		X	

APPENDIX B- 2022 QI Delegation Grid

2022 QI Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
1.4.2	QI4B: Collaborative Activities- C&C Between Medical Care and Behavioral Health	X		X	
1.4.3	QI4C: Measuring Effectiveness- C&C Between Medical Care and Behavioral Health	X		X	
1.5.1	QI5A: Delegation Agreement	X			May not be Delegated
1.5.2	QI5B: Predelegation Evaluation	X			May not be Delegated
1.5.3	QI5C: Review of QI Program	X			May not be Delegated
1.5.4	QI5D: Opportunuties for Improvement	X			May not be Delegated
2.1.1	PHM1A: Strategy Description-PHM	X		X	
2.1.2	PHM1B: Informing Members-PHM	X		X	
2.2.1	PHM2A: Data Integration-PHM	X		X	
2.2.2	PHM2B: Population Assessment-PHM	X		X	
2.2.3	PHM2C: Activities and Resources-PHM	X		X	
2.2.4	PHM2D: Segmentation-PHM	X		X	

APPENDIX B- 2022 QI Delegation Grid

2022 QI Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
2.3.1	PHM3A: Practitioner or Provider Support	X		X	
2.3.2	PHM3B: Value-Based Payment Arrangement	X			May not be Delegated
2.4.1	PHM4A: Frequency of HA Completion	X		X	
2.4.2	PHM4B: Topics of Self- Management Tools	X		X	
2.5.1	PHM5A: Access to Case Management-CCM	X	X	X	
2.5.2	PHM5B: Case Management Systems-CCM	X	X	X	
2.5.3	PHM5C: Case Management Process-CCM	X	X	X	Not Required for Renewal Survey
2.5.4	PHM5D: Initial Assessment-CCM	X	X	X	
2.5.5	PHM5E: Case Management- Ongoing Management-CCM	X	X	X	
2.6.1	PHM6A: Measuring Effectiveness-PHM	X		X	
2.6.2	PHM6B: Improvement and Action -PHM	X		X	
2.7.1	PHM7A: Delegation Agreement	X			May not be Delegated

APPENDIX B- 2022 QI Delegation Grid

2022 QI Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
2.7.2	PHM7B: Predelegation Evaluation	X			May not be Delegated
2.7.3	PHM7C: Review of PHM Program	X			May not be Delegated
2.7.4	PHM7D: Opportunities for Improvement	X			May not be Delegated
3.1.1	NET1A: Cultural Needs and Preferences	X		X	
3.1.2	NET1B: Practitioners Providing Primary Care	X		X	
3.1.3	NET1C: Practitioners Providing Specialty Care	X		X	
3.1.4	NET1D: Practitioners Providing Behavioral Health (BH)	X		X	
3.2.1	NET2A: Access to Primary Care	X		X	
3.2.2	NET2B: Access to BH	X		X	
3.2.3	NET2C: Access to Specialty Care	X		X	
3.3.1	NET3A: Assessment of Member Experience Accessing the Network	X		X	
3.3.2	NET3B: Opportunities to Improve Access to Non-behavioral Healthcare Services	X		X	

APPENDIX B- 2022 QI Delegation Grid

2022 QI Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
3.3.3	NET3C: Opportunities to Improve Access to BH Services	X		X	
3.4.1	NET4A: Notification of Termination	X	X	X	
3.4.2	NET4B: Continued Access to Practitioners	X	X	X	
3.5.1	NET5A: Physician Directory Data	X		X	
3.5.2	NET5B: Physician Directory Updates	X		X	
3.5.3	NET5C: Assessment of Physician Directory Accuracy	X		X	
3.5.4	NET5D: Identifying and Acting on Opportunities	X		X	
3.5.5	NET5E: Searchable Physician Web-Based Directory	X		X	
3.5.6	NET5F: Hospital Directory Data	X		X	
3.5.7	NET5G: Hospital Directory Updates	X		X	
3.5.8	NET5H: Searchable Hospital Web-Based Directory	X		X	
3.5.9	NET5I: Usability Testing	X		X	

APPENDIX B- 2022 QI Delegation Grid

2022 QI Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
3.5.10	NET5J: Availability of Directories	X		X	
3.6.1	NET6A: Delegation Agreement	X			May not be Delegated
3.6.2	NET6B:Pre-Delegation Evaluation	X			May not be Delegated
3.6.3	NET6C: Review of Delegated Activities	X			May not be Delegated
3.6.4	NET6D: Opportunities for Improvement	X			May not be Delegated
4.1.1	UM1A: Written Program Description	X	X	X	
4.1.2	UM1B: Annual Evaluation	X	X	X	
4.2.1	UM2A: UM Criteria	X	X	X	
4.2.2	UM2B: Availability of Criteria	X	X	X	Not Required for Renewal Survey
4.2.3	UM2C: Consistency in Applying Criteria	X	X	X	
4.3.1	UM3A: Access to Staff	X	X	X	
4.4.1	UM4A: Licensed Health Professionals	X	X	X	

APPENDIX B- 2022 QI Delegation Grid

2022 QI Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
4.4.2	UM4B: Use of Practitioners for UM Decisions	X	X	X	
4.4.3	UM4C: Practitioner Review of Non-Behavioral Healthcare Denials	X	X	X	
4.4.4	UM4D: Practitioner Review of BH Denials	X		X	
4.4.5	UM4E: Practitioner Review of Pharmacy Denials	X		X	
4.4.6	UM4F: Use of Board-Certified Consultants	X	X	X	
4.5.1	UM5A: Notification of Non-Behavioral Decisions	X	X	X	
4.5.2	UM5B: Notification of Behavioral Healthcare Decisions	X		X	
4.5.3	UM5C: Notification of Pharmacy Decisions	X		X	
4.5.4	UM5D: UM Timeliness Report	X		X	
4.5.5	UM5E: Interim- Policies and Procedures				NA (Interim Surveys only)
4.6.1	UM6A: Relevant Information for Non-Behavioral Decisions	X	X	X	
4.6.2	UM6B: Relevant Information for BH Decisions	X		X	

APPENDIX B- 2022 QI Delegation Grid

2022 QI Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
4.6.3	UM6C: Relevant Information for Pharmacy Decisions	X		X	
4.7.1	UM7A: Discussing a Denial with a Reviewer	X	X	X	
4.7.2	UM7B: Written Notification of Non-Behavioral Healthcare Denials	X	X	X	
4.7.3	UM7C: Non-Behavioral Notice of Appeal Rights/Process	X	X	X	
4.7.4	UM7D: Discussing a BH Denial with a Reviewer	X		X	
4.7.5	UM7E: Written Notification of BH Denials	X		X	
4.7.6	UM7F: BH Notice of Appeal Rights/Process	X		X	
4.7.7	UM7G: Discussing a Pharmacy Denial with a Reviewer	X		X	
4.7.8	UM7H: Written Notification of Pharmacy Denials	X		X	
4.7.9	UM7I: Pharmacy Notice of Appeal Rights/Process	X		X	
4.8.1	UM8A: Internal Appeals (Policies and Procedures)	X		X	
4.9.1	UM9A: Pre-service and Post-service Appeals	X		X	

APPENDIX B- 2022 QI Delegation Grid

2022 QI Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
4.9.2	UM9B: Timeliness of the Appeal Process	X		X	
4.9.3	UM9C: Appeal Reviewers	X		X	
4.9.4	UM9D: Notification of Appeal Decision/Rights	X		X	
4.9.5	UM9E: Final Internal and External Decision Rights				For Medi-Cal or OC/OCC this function or activity is not Applicable
4.9.6	UM9F: Appeals Overturned by the IRO				For Medi-Cal or OC/OCC this function or activity is not Applicable
4.9.7	Provider Level 1 UM Appeals	X	X	X	
4.9.8	Provider Level 2 UM Appeals	X			
4.10.1	UM10A: Written Process	X			For Medi-Cal, this function or activity is no applicable. For OC/OCC, this function or activity is retained by CalOptima and is not delegated to the Delegate.
4.10.2	UM10B: Description of the evaluation Process	X			For Medi-Cal, this function or activity is no applicable. For OC/OCC, this function or activity is retained by CalOptima and is not delegated to the Delegate.
~~4.11.1~~	~~UM11A: Pharmaceutical Management Procedures (Policies and Procedures)~~	~~X~~		~~X~~	Effective 1/1/2022, Pharmacy Benefit Management will be carved out.
~~4.11.2~~	~~UM11B: Pharmaceutical Restrictions/Preferences~~	~~X~~		~~X~~	Effective 1/1/2022, Pharmacy Benefit Management will be carved out.

APPENDIX B- 2022 QI Delegation Grid

2022 QI Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
~~4.11.3~~	~~UM11C: Pharmaceutical Patient Safety Issues~~	~~X~~		~~X~~	Effective 1/1/2022, Pharmacy Benefit Management will be carved out.
~~4.11.4~~	~~UM11D: Reviewing and Updating Procedures~~	~~X~~		~~X~~	Effective 1/1/2022, Pharmacy Benefit Management will be carved out.
~~4.11.5~~	~~UM11E: Considering Exceptions~~	~~X~~		~~X~~	Effective 1/1/2022, Pharmacy Benefit Management will be carved out.
4.12.1	UM12A: UM Denial System Controls	X	X	X	
New	UM12B: UM Denials System Controls Oversight	X	X	X	[NEW] Effective 7/1/2022, 2022 HP Standards
4.12.2	UM12C: UM Appeal System Controls	X		X	
New	UM12D: UM Appeals System Controls Oversight	X		X	[NEW] Effective 7/1/2022, 2022 HP Standards
4.13.1	UM13A: Delegation agreement	X			May not be Delegated
4.13.2	UM13B: Predelegation Evaluation	X			May not be Delegated
4.13.3	UM13C: Review of the UM Program	X			May not be Delegated
4.13.4	UM13D: Opportunities for Improvement	X			May not be Delegated
4.14.1	Second Opinion	X	X	X	

APPENDIX B- 2022 QI Delegation Grid

2022 QI Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
5.1.1	CR1A: Practitioner Credentialing Guidelines	X	X	X	
5.1.2	CR1B: Practitioner Rights	X	X	X	
5.1.3	CR1C: Credentialing System Controls	X	X	X	
New	CR1D: Credentialing System Controls Oversight	X	X	X	[NEW] Effective 7/1/2022, 2022 HP Standards
5.2.1	CR2A: Credentialing Committee	X	X	X	
5.3.1	CR3A: Verification of Credentials	X	X	X	
5.3.2	CR3B: Sanction Information	X	X	X	
5.3.3	CR3C: Credentialing Application	X	X	X	
5.4.1	CR4A: Recredentialing Cycle Length	X	X	X	
5.5.1	CR5A: Ongoing Monitoring and Interventions	X	X	X	
5.6.1	CR6A: Actions Against Practitioners	X	X	X	Not Required for Renewal Survey
5.7.1	CR7A: Review and Approval of Provider	X	X	X	Not Required for Renewal Survey

APPENDIX B- 2022 QI Delegation Grid

2022 QI Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
5.7.2	CR7B: Medical Providers	X	X	X	Not Required for Renewal Survey
5.7.3	CR7C: Behavioral Health Providers				For Medi-Cal, this standard is not applicalbe because behavioral health facilities are carved out to the HCA. For OC/OCC, this function or activities is retained by CalOptima and is not delegated to the Delegate.
5.7.4	CR7D: Assessing Medical Providers	X	X	X	
5.7.5	CR7E: Assessing Behavioral Healthcare Providers	X			For Medi-Cal, this standard is not applicable because behavioral health facilities are carved out to the HCA. For OC/OCC, this function or activities is retained by CalOptima and is not delegated to the Delegate.
5.8.1	CR8A: Delegation Agreement	X			May not be Delegated
5.8.2	CR8B: Predelegation Evaluation	X			May not be Delegated
5.8.3	CR8C: Review of Delegate's Credentilaing Activities	X			May not be Delegated
5.8.4	CR8D: Opportunities for Improvement	X			May not be Delegated
6.1.1	ME1A: Rights and Responsibility Statement	X			May not be Delegated
6.1.2	ME1B: Distribution of Rights Statement	X		X	

APPENDIX B- 2022 QI Delegation Grid

2022 QI Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
6.2.1	ME2A: Subscriber Information	X			May not be Delegated
6.2.2	ME2B: Interpreter Services	X		X	
6.3.1	ME3A: Materials and Presentations	X			For Medi-Cal , this function or activity is not applicable. For OC/OCC, this function or activity is retained by CalOptima and is not delegated to the Delegate
6.3.2	ME3B: Communication with Prospective Members	X			For Medi-Cal , this function or activity is not applicable. For OC/OCC, this function or activity is retained by CalOptima and is not delegated to the Delegate
6.3.3	ME3C: Assessing Member Understanding	X			For Medi-Cal , this function or activity is no applicable. For OC/OCC, this function or activity is retained by CalOptima and is not delegated to the Delegate
6.4.1	ME4A: Functionality: Website	X			Not Required for Renewal Survey
6.4.2	ME4B: Functionality: Telephone Requests	X			Not Required for Renewal Survey
6.5.1	ME5A: Pharmacy Benefit Information: Website	X		X	Not Required for Renewal Survey
6.5.2	ME5B: Pharmacy Benefit Information: Telephone	X		X	Not Required for Renewal Survey
6.5.3	ME5C: QI Process on Accuracy of Information	X		X	

APPENDIX B- 2022 QI Delegation Grid

2022 QI Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
6.5.4	ME5D: Pharmacy Benefit Updates	X		X	
6.6.1	ME6A: Functionality: Web Site	X		X	
6.6.2	ME6B: Functionality: Telephone	X		X	
6.6.3	ME6C: Quality and Accuracy of Information	X		X	
6.6.4	ME6D: E-Mail Response Evaluation	X		X	
6.7.1	ME7A: Policies and Procedures for Complaints	X		X	
6.7.2	ME7B: Policies and Procedures for Appeals	X		X	
6.7.3	ME7C: Annual Assessment- Nonbehavioral Healthcare Complaints and Appeals	X		X	
6.7.4	ME7D: Opportunities for Improvement-Non-behavioral Opportunities for Improvement	X			May not be Delegated
6.7.5	ME7E: Annual Assessment of BH and Services-Member Experience	X		X	
6.7.6	ME7F: BH Opportunities for Improvement-Behavioral Healthcare Opportunities for Improvement	X			
6.8.1	ME8A: Delegation Agreement	X			May not be Delegated

APPENDIX B- 2022 QI Delegation Grid

2022 QI Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
6.8.2	ME8B: Predelegation Evaluation	X			May not be Delegated
6.8.3	ME8C: Review of Performance	X			May not be Delegated
6.8.4	ME8D: Opportunities for Improvement	X			May not be Delegated
7.1.1	Claims Processing Exclusion and Preclusion Monitoring	X	X	X	
7.1.2	Claims Forwarding	X	X	X	
7.1.3	Interest Payment of Emergency Services Claims	X	X	X	
7.1.4	Timeliness of Claims Processing	X	X	X	
7.1.5	Claims Processing and Coordination of Benefits	X	X	X	
7.1.6	Claims Processing and Provider Dispute Resolution (PDR) related to Claims Payment Decisions- Level 1	X	X	X	
7.1.7	Provider Dispute Resolution related to Claims Payment Decisions- Level 2	X			
7.1.8	Third Party Liability (TPL)	X	X	X	
8.1.1	Provider Complaint Processing	X			

APPENDIX B- 2022 QI Delegation Grid

2022 QI Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
9.1.1	MED1H: Notification of Termination of a Practitioner or Practice Group	X		X	
9.2.1	MED2A: Adoption of Practice Guidelines	X		X	
9.2.2	MED2B: Distributions of Practice Guidelines	X		X	
9.3.1	MED3B: Site Visits and Ongoing Monitoring	X		X	
9.4.1	MED5A: Coordination Health Care Services for Members	X	X	X	
9.4.2	MED5B: Maintaining and Sharing Member Health Records	X		X	
9.5.1	MED8D: Informing Members About the QI Program	X		X	
9.6.1	MED9D: Affirmative Statement about Incentives	X		X	
9.7.1	MED12D: Providing Information to Medicaid Members in the Practitioner Directory	X		X	
9.7.2	MED12F: Providing Information to Medicaid Members in Denial Notifications	X		X	
9.7.3	MED12G: Providing Information to Members in Appeal and Grievance Notifications	X		X	
9.7.4	MED12H: Interpreter Services for Medicaid Members	X		X	

APPENDIX B- 2022 QI Delegation Grid

2022 QI Delegation Grid

Delegation Agreement Reference	Domain/ Element Name	CalOptima Responsibility	Delegated to Health Network	Delegated to Kaiser	Comments
9.7.5	MED12I: Usability Testing of Member Materials	X		X	
9.8.1	MED13B: Offering Special Communication Assistance	X		X	
9.9.1	MED14A: Directory Data	X		X	
9.9.2	MED14B: Pharmacy Directory Data	X		X	
9.9.3	MED14C: Behavorial Healthcare Directory Data	X		X	
9.9.4	MED14D: Long-Term Services and Supports Provider Directory Data	X		X	
9.10.1	MED15A: Delegation Agreement	X			May not be Delegated
9.10.2	MED15B: Provisions for PHI	X			May not be Delegated
9.10.3	MED15C: Predelegation Evaluation	X			May not be Delegated
9.10.4	MED15D: Review of Delegates MED Activities	X			May not be Delegated
9.10.5	MED15E: Opportunities for Improvement	X			May not be Delegated
Note: NCQA Delegated Elements are based on 2021 HP Standards. QI1E, UM12B,UM12D, CR1D are new to 2022 HP Standards (will be added new Delegation Agreements in 2022)					

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Better. Together.

2021 Quality Improvement (QI) Evaluation, 2022 QI Program and Work Plan

Quality Assurance Committee
March 9, 2022

Marie Jeannis, RN, MSN, CCM, Executive Director, Quality & PHM
Marsha Choo, Interim Director, Quality Improvement

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QI Program, Workplan and Evaluation

- Annually, CalOptima evaluates the effectiveness of the QI Program:
  - Achievements from the previous year
  - Program structure
  - Responsibility of initiatives
  - Identification of new initiatives
- Based upon the evaluation of the previous year, the QI Program is revised and updated for the following year.
- The QI Workplan provides the detail of how CalOptima will design, implement and measure the initiatives outlined in the QI Program.
- In 2022, QI Workplan has been updated to flag activities related to health equity

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2021 QI Program Achievements

Date	Awards and Recognition
July 2021	Achieved NCQA[1] Accreditation through 2024
September 2021	Received 4 out of 5 in NCQA's Medicaid Health Plan rating
September 2021	Received mPulse award for Achieving Health Equity related to health care innovation
September 2021	Received Orange County Chapter of the Public Relations Society of America's Award of Excellence for COVID-19 response
October 2021	CalOptima PACE program recognized by Assemblywoman Cottie Petrie-Norris for use of telehealth technology
November 2021	Received DHCS[2] 2021 Consumer Satisfaction Award – Adult (for large scale health plan)

NCQA[1] - National Committee for Quality Assurance
DHCS[2] – Department of Health Care Services

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2022 QI Program Recommendations

- Incorporate SDOH[1] and health equity in targeted quality initiatives.
- Collaborate with external stakeholders and partners in the comprehensive assessment of our members.
- Develop robust community-based interventions using analytical tools, such as geomapping.
- Strategize and streamline member outreach by using multiple modes of communication
- Expand collaboration on quality initiatives with health networks.
- Implement ECM[2] and Community Supports as part of CalAIM[3].
- Increase emphasis on preventive measures and screenings that may have been neglected during the pandemic.
- Align QI Program with DHCS 2022 Comprehensive Quality Strategy

SDOH[1] – Social Determinants of Health
ECM[2] - Enhanced Care Management
CalAIM[3] - California Advancing and Innovating Medi-Cal

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2022 QI Goals and Initiatives

- Goals:
  - Develop and implement a comprehensive Health Equity framework
  - Ensure member's safety during COVID-19 pandemic
  - Improve member quality of care and experience
  - Engage providers through the provision of new pay for value (P4V) program
- Outreach and engagement activities:
  - CalFresh Outreach Strategy
  - COVID- 19 Vaccination events for new age groups and boosters
  - Mobile Mammography Clinics
  - Orange County Diaper Bank events
  - Back to School Wellness Adolescent Health Immunization Clinic
  - Great American Smokeout per American Cancer Society
  - Diabetes Care Program

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2022 QI Program Appendix

- Appendix A – 2022 QI Workplan
  - Additions to workplan in red font
- Appendix B – Delegation Grid
  - CalOptima Responsibilities
  - Activities Delegated to Health Networks
  - Activities Delegated to Kaiser

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Our Mission

To provide members with access to quality health care services delivered in a cost-effective and compassionate manner

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CalOptima Board Action Agenda Referral

Action To Be Taken April 7, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

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

Contacts

Richard Pitts, D.O., Ph.D., Chief Medical Officer, Medical Management, (714) 246-8491
Monica Macias, LCSW, PACE Director, (714) 468-1077

Recommended Actions

- Receive and File 2021 CalOptima PACE Quality Improvement Plan Evaluation, and
- Approval of the 2022 PACE Quality Improvement Plan

Background

PACE is viewed as a natural extension of CalOptima's commitment to integration of acute and long-term care services for its members. This program provides the link between our healthy, elderly seniors with those seniors who need costly long-term nursing home care. PACE is a unique model of managed care service delivery in which the PACE organization is a combination of the health plan and the provider who provides direct service delivery. As of December 31, 2021, CalOptima PACE has 421 members enrolled. Independent evaluations of PACE have consistently shown that it is a highly effective program for its target population that delivers high quality outcomes and participant satisfaction.

PACE organizations are required to have a written Quality Improvement (QI) Plan that is evaluated annually. The results of the evaluation can directly lead to the revisions made to the following year's QI Plan. The QI Plan reflects the full range of services furnished by CalOptima PACE. The goal of the QI Plan is to improve future performance through effective improvement activities driven by identifying key objective performance measures, tracking them, and reliably reporting them to decision-making and care-giving staff.

The 2021 Program of All-Inclusive Care for the Elderly Quality Improvement Plan Evaluation analyzes the core clinical and service indicators to determine if the 2021 Plan has achieved its key performance goals for the year. In 2022, CalOptima PACE continues to expand participants services and update quality element goals to include vaccinations, improved telehealth options, and continued efforts to ensure comprehensive care. The 2022 PACE Quality Improvement Plan reflects our efforts to continue a high level of quality while also focusing on improving health outcomes and access for our program participants.

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Discussion

In 2021, the continued COVID-19 pandemic held challenges which significantly impacted CalOptima PACE. PACE faced these challenges head-on and continued to provide direct care to hundreds of our county's frail and senior population who are most at risk of contracting the COVID-19 virus. The pandemic led to an increase in the utilization of telehealth as PACE continued HIPPA compliant telehealth solutions this year. Additionally, as a quality element PACE was able to assist 96% of participants in becoming fully vaccinated against COVID-19. Despite COVID-19, the PACE program was still able to meet 25 of the 29 quality work plan goals while also increasing participant satisfaction scores.

CalOptima PACE has updated the 2022 Quality Improvement Work Plan to ensure that it is aligned with health network and strategic organizational changes. This will ensure that all regulatory requirements and NCQA accreditation standards are met in a consistent manner. The 2022 PACE Quality Improvement Plan, created through a collaboration of the PACE Leadership team, refines the PACE Quality elements based on the current population's health needs. The 2022 PACE Quality Improvement Plan challenges the PACE team to strive for improvement in areas of treatment, service, and health outcomes.

In 2022 PACE proposes:

1. To add an element focused on the treatment of Osteoporosis in order to slow down bone loss, lower risk of fracture, and help with pain management.
2. To ensure that our eligible participants receive their COVID-19 vaccine boosters to prevent infection and hospitalization.
3. To continue to strive for Medicare Quality Compass HEDIS 95th percentiles for our diabetic care elements.
4. To assist in providing our participants with completed advanced health care directives.
5. To improve access to telehealth options for our participants to make healthcare services more readily available and convenient.
6. To focus on preventing falls with injury among our participants.
7. To continue to provide excellent service to our participants in areas of transportation, meals, and overall satisfaction with the PACE program.

Rationale for Recommendation

PACE organizations are required to establish a QI program. Through the Code of Federal Regulations (CFR), 42 CFR section 460.130 (a), the Centers for Medicare & Medicaid Services (CMS) requires a PACE organization must develop, implement, maintain, and evaluate an effective, data-driven quality improvement program. As per 42 CFR section 460.132(a) and (b),

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A PACE organization must have a written quality improvement plan that is collaborative and interdisciplinary in nature. The PACE governing body must review the plan annually and revise it, if necessary.

Fiscal Impact

The recommended action to approve the 2022 PACE QI Plan has no additional fiscal impact beyond what was incorporated in the Fiscal Year (FY) 2021-22 Operating Budget. Staff will include updated expenditures for the period of July 1, 2022, through December 31, 2022, in the FY 2022-23 Operating Budget.

Concurrence

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

Attachments

1. 2021 CalOptima PACE QI Program Evaluation
2. 2022 PACE Quality Improvement Program and Work Plan (Redline version)
3. Proposed 2022 Quality Improvement Program and Work Plan (Clean version)
4. PowerPoint Presentation: 2021 PACE QI Work Plan Evaluation, 2022 PACE QI Work Plan

/s/ Michael Hunn *03/31/2022*
Authorized Signature **Date**

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CalOptima Program of All-Inclusive Care for the Elderly

2021

Quality Improvement Plan

Annual Evaluation

SIGNATURE PAGE

PACE Quality Improvement Committee Chairperson:

_____ _____

Richard Helmer, M.D. **Date**
Medical Director, PACE

Board of Directors' Quality Assurance Committee Chairperson:

_____ _____

Trieu Tran, M.D. **Date**

Board of Directors Chairperson:

_____ _____

Andrew Do **Date**
Supervisor, First District

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2021 CalOptima PACE

Quality Improvement (QI) Plan Annual Evaluation

Executive Summary

As the COVID-19 pandemic continued into 2021, unprecedented challenges continue to impact all areas of life. CalOptima PACE faced these challenges head-on and continued to provide direct care to hundreds of our county's frail and senior population who are most at risk of contracting the COVID-19 virus.

When the pandemic was first declared, the scope of delivery of health care services had to instantly adjust to numerous health orders and recommendations from the national, state and county levels. We have continued to closely follow all updated mandates to provide a safe environment for our staff and participants.

PACE along with others in the health care community, received a waiver from the Centers for Medicare & Medicaid Services (CMS), to provide the flexibilities needed to take care of patients during the continued public health emergency. This has improved our ability to provide services beyond the existing walls of the PACE Center and assume a more home-based model, called "PACE without Walls." We continued with our service delivery matrix to provide existing PACE care services including: medical management, nursing services, social services, therapies such as physical, occupational and speech therapies, dietary services and personal care services. Additional "PACE without Walls" services delivered by our transportation team included care packages containing items such as activity books, calendars, and socks. Participants eagerly awaited these care packages and the opportunity to connect with others beyond their home.

The PACE Clinic continued operations and a new triage system was used to accommodate requests from our participants for urgent and same day visits with our medical providers. Understanding the importance of continuing to provide preventive health services, we continued drive-through immunization hours and drive-through COVID-19 testing. In January and February of 2021, the PACE center was able to hold several vaccinations events at PACE in which participants were offered the Moderna vaccine provided in collaboration with Orange County Health Department and Mercy Pharmacy. Additionally, a collaboration between the PACE clinic, the Quality Improvement department and the PACE scheduling team led to additional COVID vaccinations. These events were extremely successful, and we were able to end 2021 with a 96% participant COVID-19 vaccination rate. Additionally, efforts began in Q4 to provide eligible participants with third dose/boosters as recommended.

Understanding the profound importance of maintaining contact with PACE participants, we continued with our previously implemented "wellness calls" to check in on the well-being of our participants. As of the end of 2021, close to 30,000 wellness calls have kept participants connected with PACE since the start of the pandemic.

In July of 2021, after several months without any new reported cases, the PACE center reopened for limited day center services. This reopening was small scale, with only up to 12 participants per day on Mondays through Thursdays, AM shift only. All CDC guidelines were put into place to ensure safety protocols are being followed. Four "pods" were assigned in the day floor area, with two staff members per pod. Participants were chosen by IDT based on who needed the most

support and who was able to follow the CDC guidelines (i.e., wear a mask, stay 6 feet apart). Any participants attending day center services must also be fully vaccinated, which now includes booster doses. Additionally, in Quarter 2 and 3, we were able to provide more face-to face services for participants with their providers, clinic, and rehabilitation staff. Unfortunately, toward the end of Quarter 4 we began to see an uptick in cases of COVID-19 and made the difficult decision to put non-emergent services on hold temporarily until this most recent surge has passed.

Despite the challenges of COVID-19 we continued to enroll new participants and saw our highest enrollment number ever in 2021. When CalOptima PACE opened for operations on October 1, 2013 we had 13 participants. We have seen steady growth in enrollment through the years and at the end of 2021, we had 421 participants enrolled. The multi-cultural background and the diversity of our participant population provides a very vibrant and engaging environment. Out of our 421 participants, the preferred languages are 60% Spanish, 19% English and 17% Vietnamese. Other languages spoken include Arabic, Korean, Tagalog, Chinese, Hindu, Persian and Telugu.

The purpose of the CalOptima PACE QI Plan is to improve the quality of health care for participants, improve on the patient experience, ensure appropriate use of resources, provide oversight to contracted services, communicate all quality and process improvement activities and outcomes, and reduce the potential risk to safety and health of PACE participants through ongoing risk management. This is done via data-driven assessments of the program which in turn drives continuous QI for the entire PACE organization. It is designed and organized to support the mission, values, and goals of CalOptima PACE.

The goals of the CalOptima PACE QI Plan is to improve future performance through effective improvement activities, driven by identifying key objective performance measures, tracking them, and reliably reporting them to decision-making and care-giving staff. The 2021 PACE QI Evaluation helps to identify key areas that offer opportunities for improvement that will be incorporated into the 2022 PACE QI Plan.

SECTION 1: PROGRAM STRUCTURE

The CalOptima PACE QI Plan is developed by the PACE QI Committee (PQIC). It is then reviewed and approved by the CalOptima Board of Directors' Quality Assurance Committee (QAC) and then approved by the CalOptima Board of Directors annually. The 2021 PACE QI Plan was reviewed and approved by the CalOptima Board of Directors on February 25, 2021.

The CalOptima PACE Medical Director has oversight and responsibility for implementation of the PACE QI Plan. The PACE QI manager will ensure timely collection and completeness of data with the support of the PACE QI program specialists. Overall, oversight of the PACE QI is provided by the CalOptima Board of Directors.

The CalOptima PACE QI Plan incorporates continuous QI methodology that focuses on the specific needs of CalOptima's PACE participants.

- It is organized to identify and analyze significant opportunities for improvement in care and service.
- It fosters the development of improvement strategies, along with systematic tracking, to determine whether these strategies result in progress towards established benchmarks or goals.
- It is focused on QI activities carried out on an ongoing basis to ensure that quality of care issues are identified and corrected.

SECTION 2: PACE QAPI PROGRAM

Major Accomplishments

In 2021, CalOptima PACE accomplishments include:

1. Swift response to updates regarding the COVID-19 pandemic, to follow all federal, state, and local guidance.
2. Continued a clinic triage system to provide health care access to participants during the ongoing pandemic.
3. Use of various telehealth modalities that enabled participants to "visit" their providers from their homes.
4. Implemented comprehensive care coordination activities to ensure that participants received the COVID-19 vaccination as well as COVID-19 booster vaccines.
5. Connected with participants through 9946 wellness calls, 40,268 home delivered meals and provision of 3851 care packages throughout 2021.
6. Provided aggressive infection control training to all staff in accordance with CDC, DHCS and CDPH directives.
7. Oversight of PACE contractors to ensure compliance to state and federal COVID-19 vaccination guidelines.
8. Implemented robust staff COVID-19 vaccination compliance, assuring that staff was fully vaccinated by the state ordered deadline of September 30, 2021.
9. Implemented robust participant COVID-19 vaccination initiative, with 96% of participants becoming fully vaccinated by the end of 2021.
10. Formulated and implemented a plan to re-open PACE Day center activities on a limited basis in accordance with infection control guidelines.
11. Established COVID-19 visitor vaccination protocols, which included proof of vaccination for those accessing the PACE Center.
12. Implemented COVID-19 rapid antigen testing for unvaccinated caregivers who accompany participants for PACE services.
13. Continued deployment of staff to work remotely from their homes when possible.
14. Weekly COVID-19 updates to the leadership team and monthly updates during our all-staff meetings.
15. Completed two Quality Initiatives: COVID-19 Vaccine Quality Initiative and Telehealth Engagement Initiative.
16. Met 25 out of 29 Work Plan goals.
17. 91% of participants received their annual influenza vaccine.
18. 94% of participants received the Pneumococcal vaccine.
19. Continued enhanced care coordination program for participants with dialysis.
20. 100% of participants had their medications reconciled within 30 days of hospital discharge.
21. Prompt review by clinical pharmacist of specialty medications ordered by outside specialists.
22. Retrospective reviews of medication utilization were performed daily and monthly. Recommendations were immediately addressed with the PACE provider and/or IDT.
23. Quality of Diabetes Care
    a. 95% of participants with diabetes completed an annual eye exam.

b. 100% of participants with diabetes had nephropathy monitoring.
c. 89% of participants with diabetes had their blood pressure controlled.

24. Utilization:
    a. Only 2.8% participants were placed in long-term care in 2021.
    b. Refined the PACE Emergency Room (ER) Diversion program.
    c. Continued to provide in-house specialists including podiatry and dental for improved access and coordination of care.
    d. Added psychiatrist and nephrologist to list of on-site specialty care providers.
    e. Morning clinical huddles continue to be incorporated into the IDT meetings for all teams.
25. Transportation:
    a. 30,696 one-way trips with an on-time performance of 99%.
26. Participant Satisfaction
    a. 91% overall satisfaction with care received compared to the national average of 88.5%.
    b. 95% said the services they received at PACE improved or maintained their quality of life.
    c. 94% said they would recommend the program to a close friend.
    d. 8 of the 10 participant satisfaction domains scored higher than the national average.
27. 100% of staff competency assessments were completed. Year-round staff trainings were provided covering a broad area of topics included coding, infection control, wound care, emergency responses, grievances, appeals, service delivery requests, and participant rights.

SECTION 3: STRATEGIC GOALS AND OBJECTIVES

Accomplishments

1. The QI program is organized to identify and analyze significant opportunities for improvement in clinical services, care, and utilization. Accomplished and evidenced by:
    a. The ongoing Health Plan Management System (HPMS) and QI individual metric data collection and analysis.
    b. The ongoing PACE QI activities and initiatives.
2. The quality of clinical care and services and patient safety provided by the health care delivery system in all settings, especially as it pertains to the unique needs of the population. Accomplished and evidenced by:
    a. The ongoing HPMS and QI individual metric data collection and analysis.
    b. The ongoing PACE QI initiatives.
    c. The monitoring of member grievances and complaints, and regular review of delegated entities.
    d. The monthly meeting with the transportation vendor.
    e. The daily morning inpatient and nursing facility clinical reviews.
    f. The ongoing infection control activities.
    g. Collaboration with the Compliance department for identification of potential quality issues that may involve fraud, waste, abuse, confidentiality, security, etc.

h. The annual approval of up-to-date Clinical Practice Guidelines and the National PACE Association Preventative Guidelines.
i. The Redesigned PACE Clinic Workflow/Triage to efficiently address participant care issues during the COVID-19 pandemic.
j. Continuation of telehealth platform that enables enhanced access to care during the pandemic.
k. Updated the relative value unit (RVU) measurement to monitor the productivity of clinic staff, including those deployed as teleworkers.

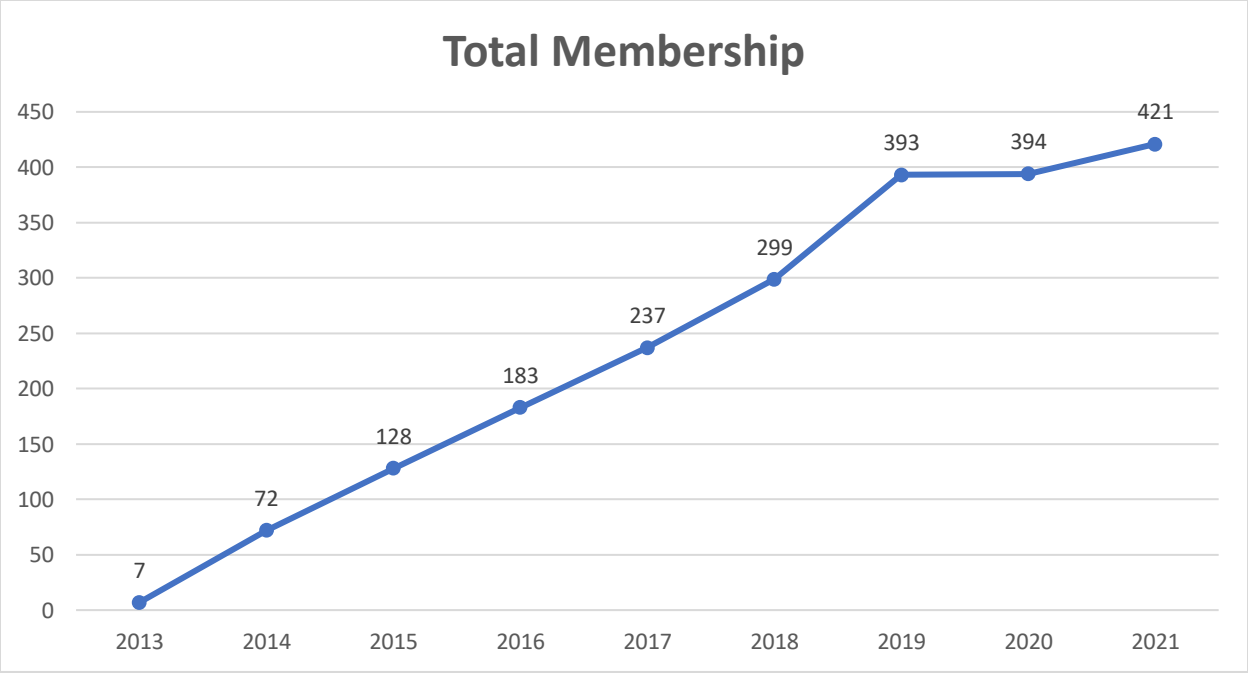
3. The continuity and coordination of care between specialists and primary care practitioners, and between medical and behavioral health practitioners. Accomplished and evidenced by:
    a. The Interdisciplinary Care Team (IDT) meetings at CalOptima PACE.
    b. Continued presence of physicians during IDT meetings.
    c. Addition of preferred specialists who regularly provide services within the PACE clinic.
    d. The coordination of care found in the ER Diversion Program.
4. The accessibility and availability of appropriate clinical care and to a network of providers with experience in providing care to the population. Accomplished and evidenced by:
    a. The number of grievances that have been tracked and trended.
    b. A nurse practitioner that specializes in podiatric procedures, and a dentist at the PACE clinic to see and treat the PACE participants.
    c. Addition of nephrologist and psychiatrist to specialist staff providing on-site care.
5. The qualifications and practice patterns of all individual providers in the Medi-Cal network to deliver quality care and service. Accomplished and evidenced by:
    a. The credentialing and peer review process.
    b. Annual evaluations of all CalOptima PACE employees.
6. Member and provider satisfaction, including the timely resolution of complaints and grievances. Accomplished and evidenced by:
    a. The improvements in the PACE Participant Satisfaction Survey.
    b. The summary of grievance and appeals activities.
    c. The ongoing input from the PACE Member Advisory Committee meetings.
7. Risk prevention and risk management processes. Accomplished and evidenced by:
    a. The QI activities which occur around all Unusual Incidents, including root cause analyses.
    b. Physical therapy driven groups such as Fall Prevention Group, Fallers Anonymous and Matter of Balance groups.
8. Compliance with regulatory agencies and accreditation standards. Accomplished and evidenced by:
    a. The successful submission of data as required by CMS and DHCS.
9. Compliance with clinical practice guidelines and evidence-based medicine. Accomplished and evidenced by:
    a. The adoption of the National PACE Association Preventative Guidelines.
    b. The use of Uptodate.com clinical practice standards.
    c. On-going PACE staff training.

10. Support of the organization's strategic quality and business goals by utilizing resources appropriately, effectively and efficiently. Accomplished and evidenced by:
    a. Tracking, trending, and analyzing utilization management (UM) data monthly.
    b. The provider incentive program.
    c. The coordination of care found in the ER Diversion Program.
    d. The weekly PACE leadership team meetings.
    e. The participation in the CalOptima QI, UM, and Credentialing and Peer Review Committee meetings.
    f. The participation in the CalOptima Board of Directors and the Board of Directors' Quality Assurance Committee meetings.

SECTION 4: SUMMARY OF ACCOMPLISHMENTS, BARRIERS, AND ACTIONS

PACE Membership at a Glance

CalOptima PACE offers a community-based program that provides all necessary medical care coordination and social services support in one location to the frail and elderly within our community. The goal of keeping seniors healthy in their homes and maintaining their independence continues to be our mission eight years later. At the end of 2013, we had seven participants enrolled and now, eight years later, we have 421 active participants.



As illustrated in the first membership graph, PACE has seen a steady enrollment trend over the years. 2018 was a particularly notable year for enrollment, as this was the year we implemented "PACE 2.0" a collaborative PACE-team effort focused on program growth and expansion. The tenets of PACE 2.0 were to create a context for change by developing a process for optimizing enrollment and establishing organizational capacity to promote continued growth. Due to the

COVID-19 pandemic, there was almost no growth noted in 2020. However, despite continued challenges, in 2021 PACE again saw an upward trend in enrollment numbers.

In 2022, our goals for program growth remain intact and strategies are already being put into place to accommodate participants post-pandemic. We continue to plan for aggressive marketing which includes 2022 rebranding efforts as well as print, radio and television media to reach a wider audience throughout Orange County.

2021 Quality Improvement Work Plan — Elements by Category:

Quality of Care and Services

QI21.01 PACE QAPI Plan and Work Plan will be evaluated annually

Received and filed by the CalOptima Board of Directors on February 25, 2021.

QI21.02 PACE QAPI Plan and Work Plan will be reviewed and updated annually

Approved by the CalOptima Board of Directors on February 25, 2021.

QI21.03 Increase Influenza immunization rates for all eligible PACE participants

Goal: Greater than or equal to 94% of eligible participants will have their annual influenza vaccination by December 31, 2021.

Goal: Not Met

Data/Analysis: 91% percent of participants received the influenza vaccination by the year end.

Summary and Key Findings/Opportunities for Improvement:

With a year-end vaccination rate of 91%, we fell short in meeting our goal by three percentage point. This was despite an aggressive flu vaccination campaign which included drive through vaccine clinics at PACE. All participants who have not been vaccinated have had discussions with our providers and have refused. Vaccines were pre-ordered in late spring from our distributer, and

we began to vaccinate participants when vaccines arrived in mid-August. Monthly reports were generated by our QI department identifying those participants who still required the vaccine, and this was shared with the PCP and RN's who personally reached out to the unvaccinated participants. It is important to note that enrollees in the month of December, were part of the statistical data and may not have had the vaccine due to their short involvement in the PACE program.

PACE staff also received their flu vaccine through employee health services, expanding the scope and engagement of the flu vaccine campaign. It is important to note that CalOptima PACE reported zero influenza outbreaks among our participants or staff in 2021. Our 2021/2022 influenza vaccination efforts will continue through Quarter 1 of 2022 where we will continue to reach out to the unvaccinated.

QI21.04 Increase Pneumococcal immunization rates for all eligible PACE participants

Goal: Greater than or equal to 94% of eligible participants will have their PCV23 pneumococcal vaccination by December 31, 2021.

Goal: Met

Data/Analysis: 94% of participants received the pneumococcal vaccination by the year end.

Summary and Key Findings/Opportunities for Improvement:

By the end of 2021, 94% of our participants had received the pneumococcal vaccine, meeting our goal. Much of our success is attributed to the implementation of the following protocols:

a. Standing orders and standardized procedures in vaccine administration. This eliminated the need to wait for a physician order by delegating this responsibility to a registered nurse who has demonstrated the required competency.

b. Utilize the electronic medical record's (EMR) quality analytics, and other data platforms to track missed opportunities for immunization.

c. Continued drive-through vaccination clinics.

d. PACE PCP's reached out to those participants who refused the vaccine.

The PACE QI department provided detailed monthly reports which specified which participants still needed the vaccination. It was then shared with all participant's medical providers. As with previous years, one of our challenges was the complex interval periodicity between the Pneumococcal 13 and Pneumococcal 23 vaccines. It is important to note that enrollees in the month of December were part of the statistical data and may not have had the vaccine due to their short involvement in the PACE program. In 2022, we plan to continue with our successful existing strategies to meet our goals for the pneumococcal vaccine.

QI21.05 Increase COVID-19 immunization rates for all eligible PACE participants

Goal: Greater than or equal to 80% of eligible participants will have their COVID-19 vaccination by December 31, 2021

Goal: **Met**

Data/Analysis: 96% of participant received COVID-19 vaccination by the year end.

Summary and Key Findings/Opportunities for Improvement:

By the end of 2021, 96% of PACE participants received either 1 dose of Janssen or 2 doses of Moderna or Pfizer COVID-19 vaccine. Much of our success is attributed to the implementation of the following efforts:

a. PACE partnered with Mercy Pharmacy to provide vaccine events for participants within the PACE center in January and February of 2021.

b. PACE PCP's reached out to those participants who initially refused the vaccine to provide education and encouragement.

c. PACE participants who were unable to attend the vaccine events at PACE were tracked and assisted by PACE staff with scheduling of vaccine and transportation to and from vaccination sights.

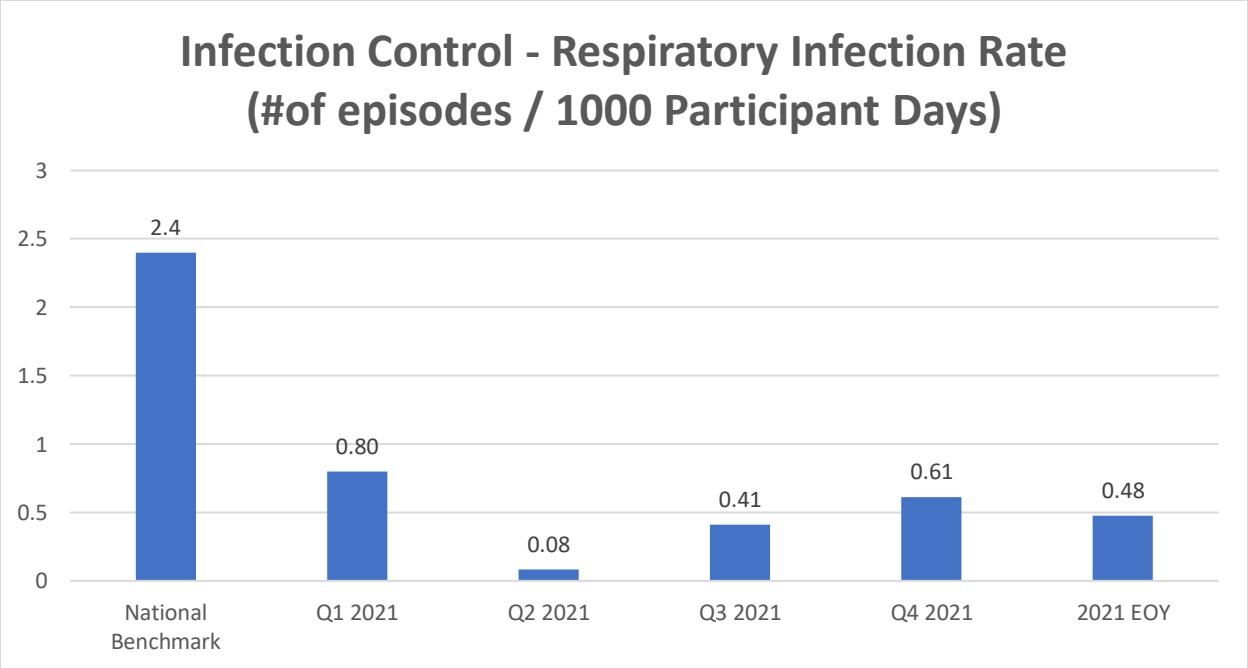
The PACE QI department provided detailed weekly reports which specified which participants still needed the vaccination. These participants were followed up by PCP, QI team and scheduling department to ensure that there were no barriers to vaccination. In 2022, we plan to continue our efforts to ensure that all PACE participants are vaccinated against COVID-19 and have raised our goal to 95% full vaccinated. We will also have a quality initiative to ensure that our participants will be receiving COVID booster shots as well.

QI21.06 Reduce common infectious in PACE participants (Respiratory Infection)

Goal: Maintain common respiratory infection rate less than the following national benchmarks: Respiratory Tract 0.1–2.4 episodes/1000 participant days.

Goal: Met

Data/Analysis: The 2021 rate was 0.48 episodes per 1000 participant days.



Summary and Key Findings/Opportunities for Improvement:

Despite the COVID-19 pandemic, we were able to conclude the year below the national benchmark. As in previous years, we focused heavily on infection control in 2021 with increased

surveillance due to continued COVID-19 pandemic. In 2021, we limited day center on-site activities for participants and continued to enable eligible staff to telework. We screened all individuals accessing the PACE center and continued the mask mandate for all individuals at the center. We ordered and tracked our personal protective equipment (PPE) inventory and continued our enhanced environmental controls such as surface disinfection. We continued our comprehensive infection control training which covered blood borne pathogens, droplet vs. aerosol COVID-19 transmission, handwashing, and proper use of PPE. We continued to follow the guidance of Centers for Disease Control and Prevention (CDC) and the Orange County Health Care Agency and continued conducting drive thru COVID-19 testing for our participants who were symptomatic. All positive COVID-19 participants received daily phone calls from their PCP and ancillary health staff. We also included an aggressive campaign to vaccinate participants with the two pneumococcal vaccines, PCV13 and PPSV23. Other actions taken to minimize the risk of respiratory infections were interventions such as providing home nebulizer machines to participants with COPD, CHF and asthma. Keeping abreast of the trending of the COVID-19 virus and anticipating surges allowed us to plan for the "worst case scenarios" and implement a solid infection control plan and to maintain a safe environment for our participants and staff members. The PACE leadership team has recommended to sunset this element due to consistently meeting the benchmark for the past 3 years.

QI21.07 Increase Physician Orders for Life-Sustaining Treatment (POLST) utilization for PACE participants

Goal: Greater than or equal to 95% of participants who have been enrolled in the PACE program for 6 months will have a POLST completed by December 31st, 2021.

Goal: Not Met

Data/Analysis: 91% of participants enrolled in the PACE program for 6 months had POLST by the end of 2021.

Quarter 2021	Completion Rate
Q1	89%
Q2	90%
Q3	94%
Q4	93%
EOY	**91%**

Summary and Key Findings/Opportunities for Improvement:

We did not meet our goal in 2021. With the continuation of COVID-19 pandemic, the one-on-one encounter necessary for a POLST completion was not feasible. However, end-of-life care which is consistent with the participants wishes are still reviewed with the participant and the PCP during telehealth encounters. End-of-life and palliative care discussions continue to be integrated into our Interdisciplinary Team meetings (IDT) and are documented in the participant's care plan.

In 2022, we plan to continue our efforts to ensure that our participants have a POLST in place. In addition to the PACE Clinical Operations Manager having oversight of this element, the PACE Clinical Medical Director will also be assisting with plans to reach our goal in 2022.

QI21.08 Increase the percent of PACE participants who have an Advance Health Care Directive

Goal: Greater than or equal to 40% of eligible participants will have an Advance Health Care Directive in place by December 31, 2021

Goal: **Met**

Data/Analysis: 43% of participants had an Advance Health Care Directive by December 31, 2021.

Summary and Key Findings/Opportunities for Improvement:

By the end of 2021, 43% of PACE participants had completed an Advance Health Care Directive, meeting our goal. The leadership team has agreed that we will continue support this project as a quality initiative in 2022. The PACE leadership team has completed a plan to increase the number of participants who have Advance Health Care Directives on file. The PACE Center Manager with assistance from the Social Work Department will implement this plan with a goal of ≥ 50% of participants with completed AHCD by the end of 2022.

QI21.09 Ensure all PACE participants have a functional status assessment completed every 6 months by the disciplines required by CMS

Goal: 100% of participants have functional status assessment completed every 6 months by the disciplines required by CMS.

Goal: Met

Data/Analysis: 100% of participants had functional assessment completed every 6 months.

Functional Status Assessment	Q1 2021	Q2 2021	Q3 2021	Q4 2021	EOY
Charts with All Assessments	387	398	409	419	1613
Census at End of Quarter	387	398	409	419	1613
Rate	**100%**	**100%**	**100%**	**100%**	**100%**

Care for Older Adults: Functional Status Assessment				
	2021 Star Rating Measure Cut Points			
MY 2021 PACE	2 Stars	3 Stars	4 Stars	**5 Stars**
100%	55% to 71%	71% to 85%	85% to 93%	**≥ 93%**

Summary and Key Findings/Opportunities for Improvement:

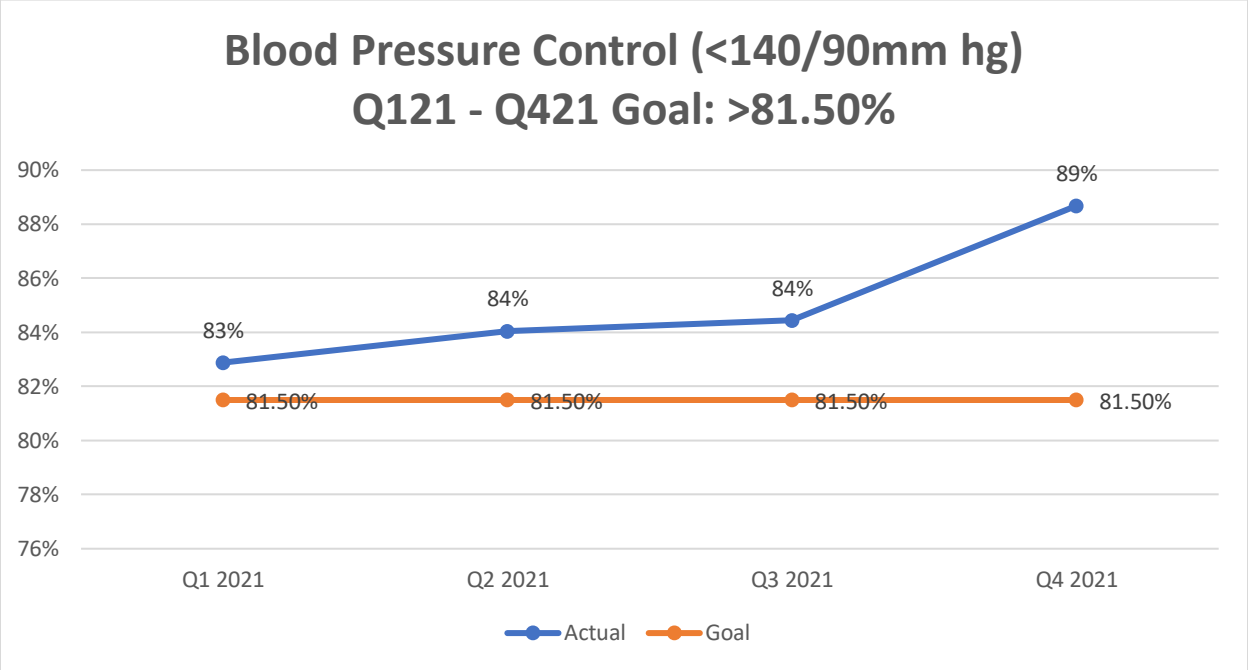
Annual and semi-annual functional assessments are critical in determining a participant's medical, psychosocial, and cognitive status. These assessments assist in identifying risk factors and interventions necessary for optimal outcomes. A key factor in achieving this has been the monthly reports generated by the QI department specifying which participants required the functional assessment. This prompts the IDT disciplines to schedule the appointment, communicate with the family/caregiver regarding the appointment and coordinate transportation for the participant. Our success in this element places us comparable to a 5-Star Medicare rating based on the 2020 Star Rating Measure Cut Points. PACE has maintained this element continuously at 100% and it is a core regulatory requirement that is tracked elsewhere and therefore the leadership team has elected to remove this as a quality measure in 2022.

QI21.10 Increase the percentage of PACE participants with diabetes who have controlled blood pressured (<140/90 mm hg)

Goal: > 81.50% of Diabetics will have a Blood Pressure of <140/90

Goal: Met

Data/Analysis: The 2021 final rate was 89%.



Diabetics with Controlled Blood Pressure					
	2019 Medicare Quality Compass				
MY 2021 PACE	25th Percentile	50th Percentile	75th Percentile	90th Percentile	**95th Percentile**
89%	64.72%	69.53%	76.56%	81.50%	**84.91%**

Diabetes Care: Blood Sugar Controlled				
	2021 Star Rating Measure Cut Points			
MY 2021 PACE	2 Stars	3 Stars	4 Stars	**5 Stars**
89%	37% to 61%	61% to 72%	72% to 85%	**≥ 85%**

Summary and Key Findings/Opportunities for Improvement:

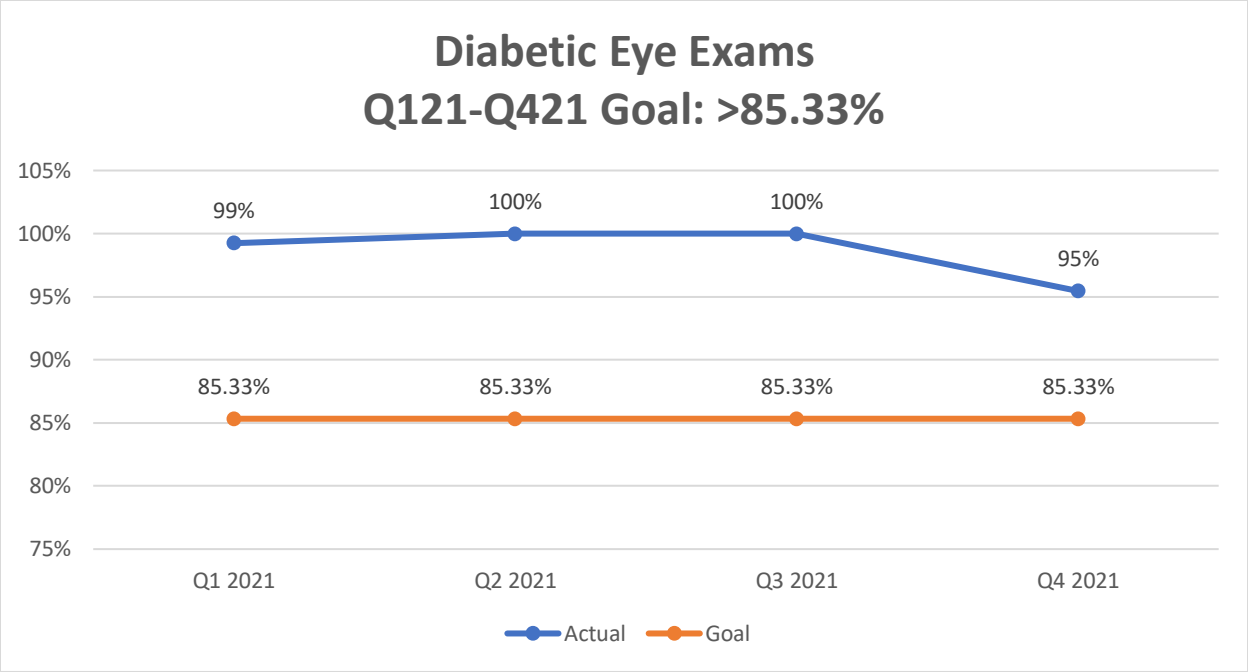
We exceeded our goals in this element and increased our performance by 2 percentage points from 2020. Prompt identification of participants with poor control of their blood pressure and monthly generated reports contributed to the success in this element. Those participants with out-of-range numbers are monitored leading to direct interventions such as medication adjustments. Our in-house pharmacist also provided recommendations for those participants who have difficulty maintaining adequate blood pressure control. These results are comparable to the 2019 Medicare HEDIS Quality Compass 95th percentile and a 5-star Medicare rating based on 2021 Star Cut Points. We will maintain this goal and continue our successful monitoring plan in 2022.

QI21.11 Increase the percentage of PACE participants with diabetes who have had their annual diabetic eye exam completed

Goal: Greater than 85.33% of Diabetics will have an Annual Eye Exam

Goal: Met

Data/Analysis: The 2021 final rate was 95%.



Comprehensive Diabetes Care: Annual Diabetic Eye Exam					
	2019 Medicare Quality Compass				
MY 2021 PACE	25th Percentile	50th Percentile	75th Percentile	90th Percentile	**95th Percentile**
95%	67.75%	75.28%	82.00%	85.33%	**87.10%**

Diabetes Care: Eye Exam					
	2021 Star Cut Points				
MY 2021 PACE	1 Star	2 Stars	3 Stars	4 Stars	**5 Stars**
95%	<63%	63% to 69%	69% to 73%	73% to 78%	**≥ 78%**

Summary and Key Findings/Opportunities for Improvement:

We exceeded our target goal, with 95% of diabetic participants having received an annual eye exam in 2021. With the assistance of monthly reports generated by the PACE QI team, medical providers were alerted to those participants who required eye exams. Those participants were then scheduled for an appointment with their PCP on an annual and semi-annual basis. Contracted ophthalmologists and optometrists are very diligent in their follow-up and provide our medical team with timely specialty reports. These results are comparable to a 5-Star Medicare rating based on the 2021 Star Cut Points and the 2019 Medicare HEDIS Quality Compass 95% percentile. In 2022, the goal will be changed to >82.77% of Diabetics will have an Annual Eye Exam (Comparable to the 2020 MEDICARE Quality Compass HEDIS 95th percentile, exclusions defined in 2022 QI Work Plan).

QI21.12 Increase the percentage of PACE participants with diabetes who receive nephropathy monitoring

Goal: Greater than 98.30% of Diabetics will have Nephropathy Monitoring

Goal: Met

Data/Analysis: The 2021 final rate was 100%.

Comprehensive Diabetes Care: Medical Attention for Nephropathy					
	2019 Medicare Quality Compass				
MY 2021 PACE	25th Percentile	50th Percentile	75th Percentile	90th Percentile	**95th Percentile**
100%	94.19%	95.95%	97.08%	98.30%	**98.78%**

Comprehensive Diabetes Care: Nephropathy Monitoring				
	2021 Star Rating Measure Cut Points			
MY 2021 PACE	2 Stars	3 Stars	4 Stars	**5 Stars**
100%	NA	80% to 95%	95% to 97%	**≥ 97%**

Summary Key Findings/Opportunities for Improvement: In 2021, 100% of our diabetic participants received nephropathy monitoring, matching our success from 2020. The PACE QI department works closely with the medical team in providing data generated reports identifying which participants required nephropathy screening/monitoring. These results are comparable to a 5-Star Medicare rating based on the 2021 Star Cut Points and the 2019 Medicare HEDIS Quality Compass 95th percentile. PACE will maintain this goal in 2022.

QI21.13 Decrease the rate of participant falls at Home or at the PACE day centers

Goal: <6.65 Falls per 1000 member months occurring at the PACE day centers (ACS and Garden Grove PACE)

AND

≥17% of participants will not experience a recurring fall within the same quarter at home.

Goal: Met

Data/Analysis:

The 2021 rate was 0.41 falls per 1000 member months at the PACE day center:

Quarter 2021	# Falls	Member Months	# Falls Per 1000 Members Months
Q1	0	1171	0.00
Q2	1	1191	0.84
Q3	1	1218	0.82
Q4	0	1254	0.00
EOY	**2**	**4834**	**0.41**

80% of participants did not experience a recurring fall at home within the same quarter:

Quarter 2021	Rate
Q1	71%
Q2	87%
Q3	83%
Q4	80%
EOY	**80%**

Summary Key Findings/Opportunities for Improvement:

We met our goal for day center falls during 2021. However, it should be noted that fewer participants were in the PACE Center due to the COVID-19 pandemic, and that no members attended our ACS sites. Additionally we met our goal of having less recurrent falls within the same quarter at home. We examined various elements of each fall, such as where they occurred and the contributing factors. In 2022, will be making modification s to this quality element. “Falls at Home or in the PACE Day Center” will be changed to “Fall at Home Classified as CMS reportable Quality Incidents” as this will more accurately reflect our efforts in ensuring participant safety. We feel that falls with injury are an area of special focus for prevention. Our new goal will be ≤ 207 falls with injury per 1000 participants per year.

QI21.14 Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Dementia + tricyclic antidepressant or anticholinergic agents

Goal: <35.73%

Goal: Met

Data/Analysis: The 2021 rate was 17%.

DDE: Dementia + Tricyclic Antidepressant or Anticholinergic Agents					
	2019 Medicare Quality Compass				
MY 2021 PACE	25th Percentile	50th Percentile	75th Percentile	90th Percentile	**95th Percentile**
17%	44.44 %	40%	35.73%	33.96%	**33.96%**

Summary and Key Findings/Opportunities for Improvement:

In 2021, 17% of our participants who were diagnosed with dementia were prescribed a tricyclic antidepressant or anticholinergic agent. The PACE QI department worked closely with the medical team and generated reports of participants with dementia who were also prescribed the cautionary medications. On a monthly basis our medical providers, clinical pharmacists and data specialists, review in detail all the medications that are considered "red flags" per CMS and Beer's criteria. This is shared with other clinical medical providers and alternative medication options are discussed during provider meetings. Our clinical pharmacist is instrumental in reviewing medications ordered by providers, confirming that there are no contraindications to the drugs and then recommending alternative medication options, thereby preventing adverse outcomes. These results are comparable to the 2019 Medicare HEDIS Quality Compass 95th percentile. Based on 2020 updates to HEDIS guidelines, in 2022 we will be changing our goal from <35.73% to <27.24 (Comparable to the 2020 MEDICARE Quality Compass HEDIS 90th percentile, exclusions defined in 2022 QI Work Plan) and feel confident that we will once again exceed this goal.

QI21.15 Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Chronic Renal Failure + Nonaspirin NSAIDS or Cox2 Selective NSAIDs

Goal: <3.90%

Goal: Met

Data/Analysis: The 2021 rate was 0.0%.

DDE: CKD+ Nonaspirin NSAIDS or Cox2 Selective NSAIDs				
	2019 Medicare Quality Compass			
MY 2021 PACE	50th Percentile	75th Percentile	90th Percentile	**95th Percentile**
0.0%	9.31%	6.36%	3.90%	**2.47%**

Summary and Key Findings/Opportunities for Improvement:

Careful review of participants with chronic kidney disease who are prescribed NSAIDS is an important factor in limiting the progression of kidney disease. Our in-house clinical pharmacist is a vital asset in monitoring potential drug/disease interactions and presenting therapeutic alternatives to the medical provider. The continued coordinated efforts of the PACE medical providers and the PACE clinical pharmacist will assure optimal scrutiny in the use of NSAIDs among our participants with chronic kidney disease. These results are comparable to the 2019 Medicare HEDIS Quality Compass 95th percentile. Based on 2020 updates to HEDIS guidelines, in 2022 we will be changing our goal from <3.90% to <3.47% (Comparable to the 2020 MEDICARE Quality Compass HEDIS 90th percentile, exclusions defined in 2022 QI Work Plan) and feel confident that we will once again exceed this goal.

QI21.16 Monitor participants who are receiving prescription opioids for 15 days or more days at an average milligram morphine equivalent (MME) dose of 90mg

Goal: 100% of participants receiving opioids for 15 or more days at an average MME 90mg will be reevaluated monthly by their treating provider.

Goal: Met

Data/Analysis: The 2021 rate was 100%

Quarter 2021	# Participants with High Dosage of Opioids
Q1	2 out of 2 participants reevaluated (100%)
Q2	2 out of 2 participants reevaluated (100%)
Q3	1 out of 1 participant reevaluated (100%)
Q4	2 out of 2 participants reevaluated (100%)

Summary and Key Findings/Opportunities for Improvement:

In the 2021 we were able to fully meet our goal of 100% for each quarter. It should be noted that we have very few participants who exceed the established recommendations of daily morphine MME dosing. The PACE QI department generates a monthly report of participants who are prescribed higher opioid doses and this list is shared with the medical team. These specific participants are then automatically added onto the provider's monthly schedule so that appropriate participant/PCP follow-up can occur. Discussions around prescribing opioids are a recurring agenda item on weekly provider meetings, thereby enhancing provider education. We will continue to track and monitor this in 2022 and anticipate that we will again achieve 100% in 2022.

QI21.17 Increase the percentage of participants for whom medications were reconciled within 30 days of hospital discharge

Goal: ≥ 90% of participants will have their medications reconciled within 30 days of hospital discharge in 2021

Goal: Met

Data/Analysis: 100% of participants had medications reconciled within 30 days post discharge in 2021.

Medication Reconciliation Post-Discharge	Q1 2021	Q2 2021	Q3 2021	Q4 2021	EOY
Total # of Discharges	41	36	46	33	**156**
Received Reconciliation	41	36	46	33	**156**
Rate	**100%**	**100%**	**100%**	**100%**	**100%**
Goal	**90%**	**90%**	**90%**	**90%**	**90%**

Medication Reconciliation Post-Discharge	
	2019 Medicare Quality Compass

MY 2021 PACE	25th Percentile	50th Percentile	75th Percentile	**90th Percentile**
100%	36.83%	46.16%	59.74%	**71.43%**

Medication Reconciliation Post-Discharge					
	2021 Star Rating Measure Cut Points				
MY 2021 PACE	1 Star	2 Stars	3 Stars	4 Stars	**5 Stars**
100%	<48%	48% to 62%	62% to 71%	71% to 84%	**≥ 84%**

Summary and Key Findings/Opportunities for Improvement:

Medication reconciliation post hospital discharge remains one of our top priorities. In 2018, we contracted with House Calls Medical Associates which serves as our after-hours call center and provides us with our hospitalists and nursing home physicians. In 2019, the contract with House Calls Medical Associates extended to the provision of PCPs within the PACE clinic. Through this partnership, our providers maintain a close relationship with our participants and can take care of our participants across all levels of care thereby improving continuity of care. This partnership allows for prompt medication reconciliation after hospital discharge. Our clinical pharmacist also plays a vital part in the reconciliation process as well as a dedicated additional clinical staff member who handles medication reconciliation for hospital and SNF discharges. These results are comparable to a 5-Star Medicare rating based on the 2020 Star Cut Points and the 2019 Medicare HEDIS Quality Compass 95th percentile. In 2022, we plan to change the goal of Post-Discharge Medication Reconciliation from within 30 after discharge to within 15 days after discharge to better ensure that our participants post-discharge needs are met in a timely manner to prevent readmission.

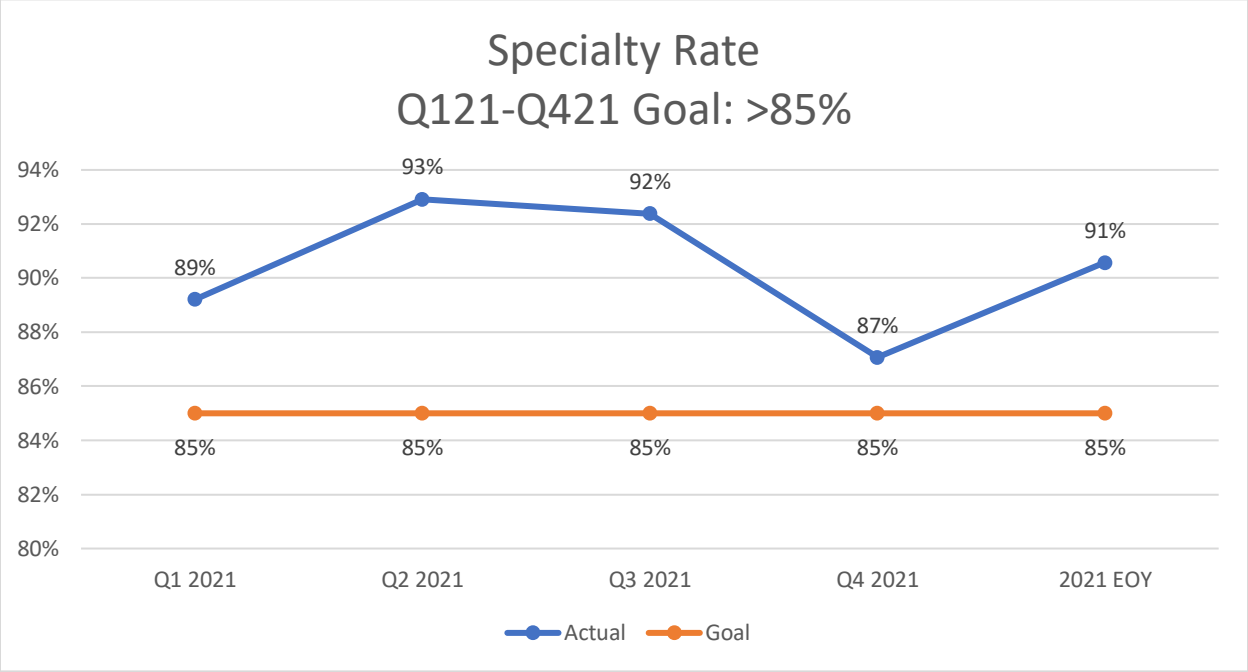
Access and Availability

QI21.18 Improve access to specialty practitioners

Goal: ≥ 85% of specialty care authorizations will be scheduled within 10 business days in 2021

Goal: Met

Data/Analysis: The 2021 rate was 91%.



Summary and Key Findings/Opportunities for Improvement:

Our PACE scheduling department continues to utilize strategies put in place to improve access to specialty care. One area of redesign was the expansion of staff dedicated to scheduling specialty appointments. This task is rather complex in that the staff member not only schedules the appointment for the participant, but also handles appointment confirmation, coordinating transportation needs, and submitting relevant medical records to the specialist. Additionally, we continue to have a scheduler who is assigned to each of our 5 IDT teams and focuses on coordinating all these activities.

We continued to provide dentistry services on-site as well as a nurse practitioner dedicated to primary care podiatry issues. We have also been able to add and on-site psychiatry services and nephrology services. This greatly enhanced specialty access, particularly for our diabetic participants. Throughout 2021 we have been able to return to some of those in house specialist activities, following COVID protocols. As part of our operational Work Plan for 2022, we will look to identify additional core specialists who understand the PACE model of care and are willing to work closely with the program. This will improve scheduling access as well as care coordination through prompt consult notes and real-time dialogue between the specialist and the PACE medical provider. Because of the challenges we have encountered in specialty scheduling for some services, in 2022 we are changing our benchmark to ≥ 85% of specialty care authorizations will be scheduled within 14 business days.

Utilization Management

QI21.19 Increase the rate of participants who are utilizing the telehealth platform

Goal: ≥65% of participants will be able to engage in telehealth visits

Goal: Not Met

Data/Analysis: 63% of participants were able to engage in telehealth visits

Summary/Key Findings/Opportunities for Improvement

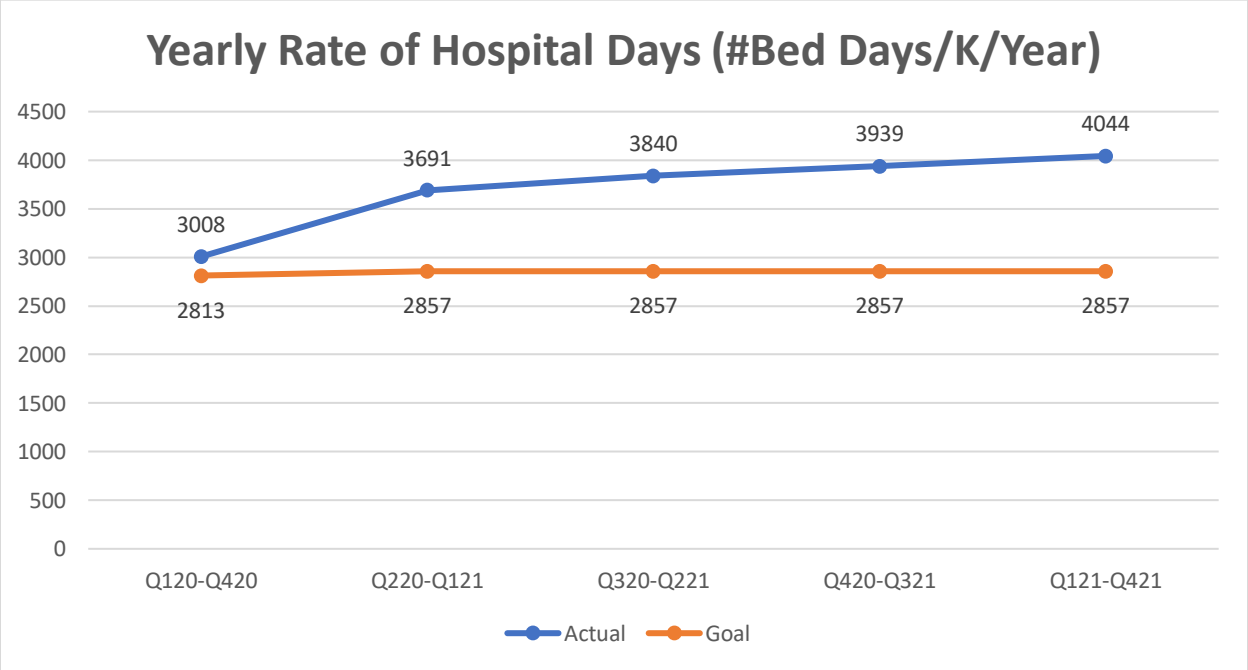
Though we came close to goal, PACE did not meet the benchmark of ≥ 65% of participants will be able to engage in telehealth visits. Telehealth access is measured by the percentage of participants who are able install and correctly use our PACE designated telehealth platform VSEE or other video conferencing applications. There are several challenges in providing video telehealth visits including a lack of accessibility to participants who may not have the devices, bandwidth or capability of using these applications. By the end of 2021, participants were being seen in person at the center again, and so the need for video conferencing lessened. Due to the many complexities involved, in 2022 we propose to return telehealth engagement to a PACE quality initiative, with a goal of increasing accessibility to ≥66%.

QI21.20 Reduce the rate of acute hospital days by PACE participants

Goal: < 2,857 hospital days per 1000 per year

Goal: Not Met

Data/Analysis: The 2021 rate was 4,044 bed days per 1000 per year.



Summary/Key Findings/Opportunities for Improvement

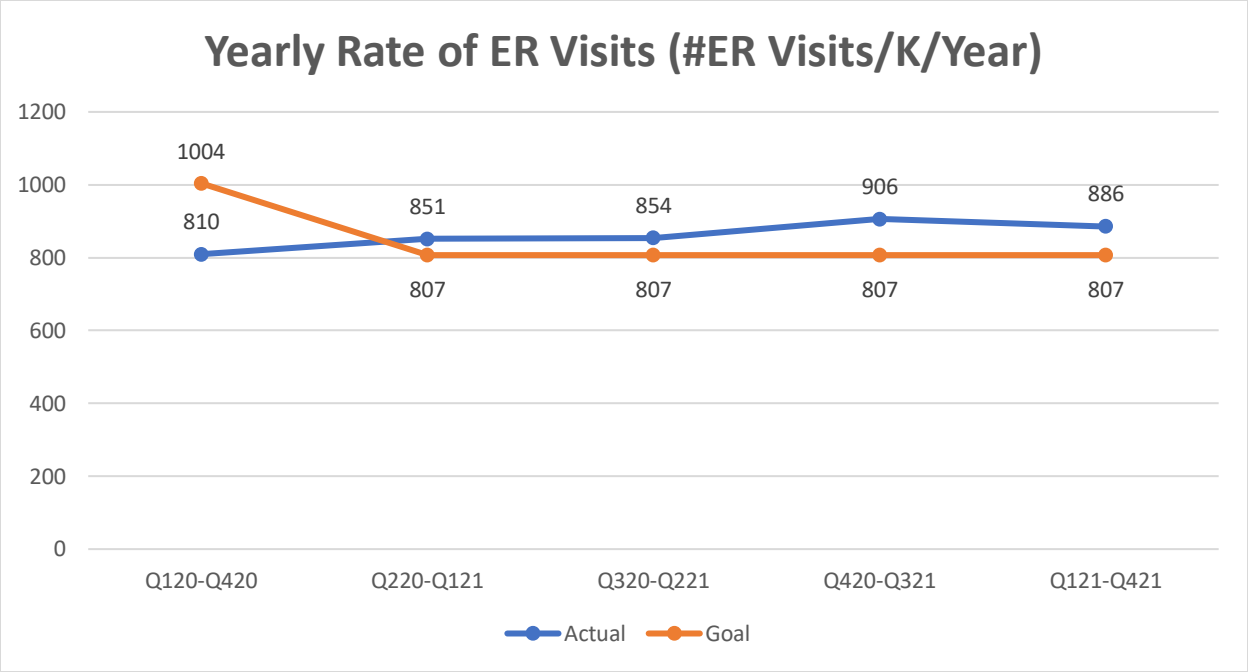
CalOptima PACE did not meet our goal of <2,857 hospital days per 1000 per year in 2021. The main reason for this is the high number of medically complex patients that are part of our program. In order to reach realistic standards for our program while continuing to strive for improvement, in 2022 we will be adjusting our goal <3,330 hospital days per 1000 per year. PACE participants hospital days will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education.

QI21.21 Reduce the rate of ER utilization by PACE participants

Goal: < 807 emergency room visits per 1000 per year

Goal: Not Met

Data/Analysis: The 2021 rate was 886 emergency room only visits per 1000 per year.



Summary and Key Findings/Opportunities for Improvement:

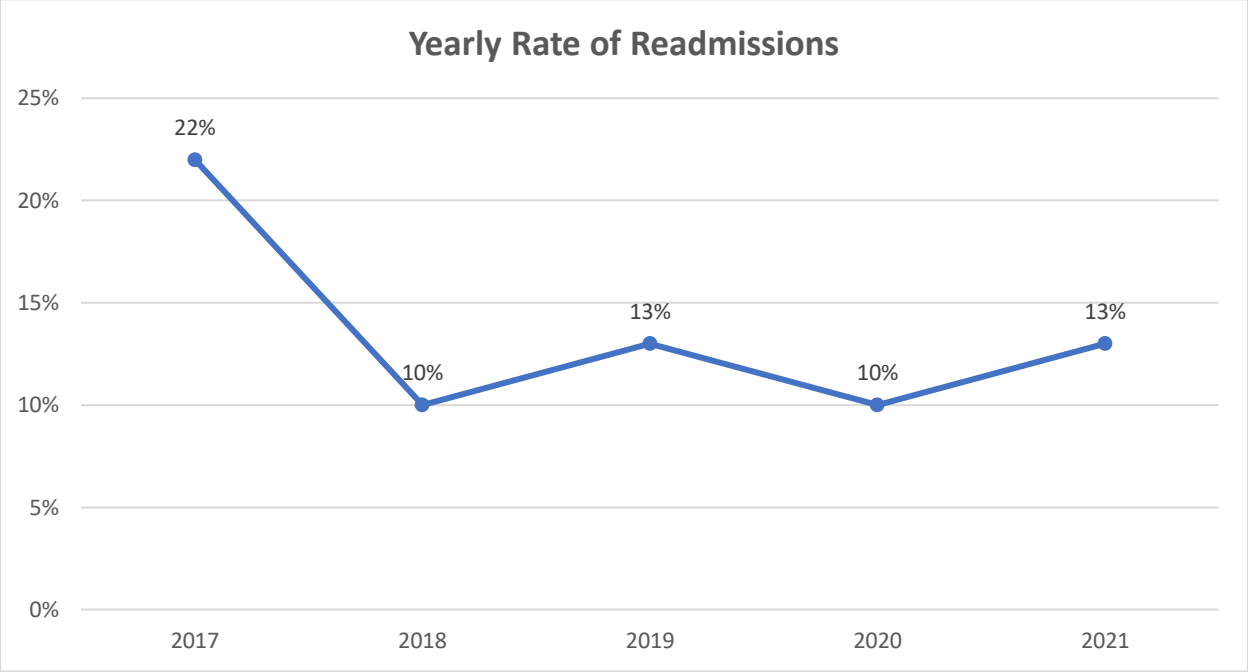
Emergency rooms visits increased throughout the year in 2021 and our of the year rate did not meet our goal. Similar to our hospital utilization rates, we will be changing this goal in 2022. The goal in 2022 will be <850 emergency room visits per 1000 per year. ER utilization by PACE participants will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education.

QI21.22 Reduce the 30-day all cause readmission rates by PACE participants

Goal: Less than 15% 30-day all cause readmissions

Goal: Met

Data/Analysis: The 2021 rate was 13%.



Summary and Key Findings/Opportunities for Improvement:

The readmission rates tend to have a great deal of variance year to year due to the small total number of participants and readmissions. We ended 2021 with a 13% 30-day readmission rate which is a 3% increase from 2020, but still met our benchmark. Our major challenges in readmissions are the medical complexity of our participants, non-compliance on the part of the participant and lack of family support. In 2021, we continued to incorporate the morning clinical huddles into the interdisciplinary team meetings (IDT). This concept was piloted in Q4 of 2019 with one IDT with great success and was adopted program wide in 2020. Additionally, important measures taken by PACE PCPs aided in our ability to meet our goal to reduce 30-day hospital readmissions. PCPs utilized telehealth to triage participants health needs before they required emergency services, such as following up on wellness calls as necessary and providing telemedicine services though the afterhours clinic line. PCPs also followed up with participants soon after their hospital discharge in order reassess the participants immediate health needs following hospitalization as well as any long-term need for changes in care plan to prevent future hospitalizations.

For 2022, we strive to continue our low readmission rates and change our goal from <15% to <14% readmission rate.

QI21.23 Decrease the percentage of participants who are placed in a long-term care facility

Goal: < 4% of participants will reside in long-term care (LTC)

Goal: Met

Data/Analysis: 2021 rate was 2.8% of the PACE enrollment

Summary and Key Findings/Opportunities for Improvement:

One of the most important goals of the PACE program is to help our participants continue to live safely at home for as long as possible. We ended the year with 2.8 % of our participants who resided in LTC. This is a slight increase from the 1.7% rate in 2020 but is still less than the CalPACE average of all California PACE programs of 3%. However, this is an area that we are monitoring closely as we expect we may see an increase in the upcoming years. There are several issues which is contributing to the rise in PACE LTC census for our high-risk participants, especially for those with multiple advanced chronic conditions. These are participants whose outpatient management has been unsuccessful in the home, assisted living facility (ALF) or board and care (B&C) environment. Families and caregivers may be unable or unwilling to assist with necessary care tasks at home. Poor family support and fragile living environments can lead to increased ER and hospital utilization. On some occasions, participants need temporary placement in LTC as a custodial care measure. These are participants with complex medical conditions that require complicated workups, specialty care, and who have difficulty with maintaining their care plan on their own at home. For example, participants who are noncompliant with their prescribed medications, refuse to attend their hemodialysis sessions, or have recurrent falls where all other fall prevention measures have failed. These participants benefit from placement in LTC facilities until their health is stabilized and they can be reassessed and reeducated regarding their health plan. In 2022, we plan to maintain our benchmark and investigate solutions to address the individualized care needs of our unique population.

Enrollment

QI201.24 Reduce the percentage of participants who disenroll for controllable reasons from the PACE program within the first 90 days of enrollment

Goal: The percentage of participants who disenroll for controllable reasons from the PACE program within the first 90 days of enrollment will be less than 6.5%

Goal: Met

Data/Analysis: We had 1 controllable disenrollment within 90 days which was 1.3% of the total disenrollment (77 total disenrollment in 2021)

Summary and Key Findings/Opportunities for Improvement:

In 2021, we meet our goal of less than 6.5% controllable disenrollments. Our controllable disenrollment rate for 2021 was 1.3%. In the past we had participants who had disenrolled for controllable reasons with the main reason of wanting to keep their pre-enrollment PCP and/or health plan. In effort to reduce these numbers, data related to disenrollment for controllable reasons is shared with the enrollment team throughout the year. Marketing and Enrollment has made progress in this area by having developed the team infrastructure required to address this metric during the enrollment process and by collaborating with both Operations and Clinic on participant issues that may arise up to 3 months after a participant's program capitation date. In 2021, we saw that those efforts worked well, and we fell within our benchmark. Now that we have an established method for making sure all participants are aware of what PACE offers, we have decided that this no longer needs to be a quality element and will instead continue to be an operational issue. We will remove this element in 2022.

QI21.25 Increase the Qualified Lead to Enrollment conversion rate

Goal: Increase the Qualified Lead to Enrollment conversion rate to 60%

Goal: Met

Data/Analysis: Final rate was 79%.

Quarter 2021	Rate
Q1	88%
Q2	88%
Q3	72%
Q4	74%
EOY	**79%**

Summary and Key Findings/Opportunities for Improvement:

In 2021, we exceeded our goal in the percentage of qualified leads to enrollment. This afforded the frail and elderly in our community greater access to health care in an environment which also supports their physical, rehabilitative, and psychosocial needs.

Several strategies led to successful enrollment:

1. Revision of our screening, intake, and assessment tools to screen-out enrollees including those who were too high-functioning and would not be eligible per State certification, although they initiated an inquiry.
2. Utilization of data indicating origins of referrals to PACE.
3. Redesigned marketing collateral which educated the community in the benefits of enrolling in PACE.

In 2022 we will continue to review and analyze the Qualified Lead to Enrollment conversion rate and develop strategies to maintain our current benchmark of >60%

Transportation

QI21.26 and QI201.27: Transportation

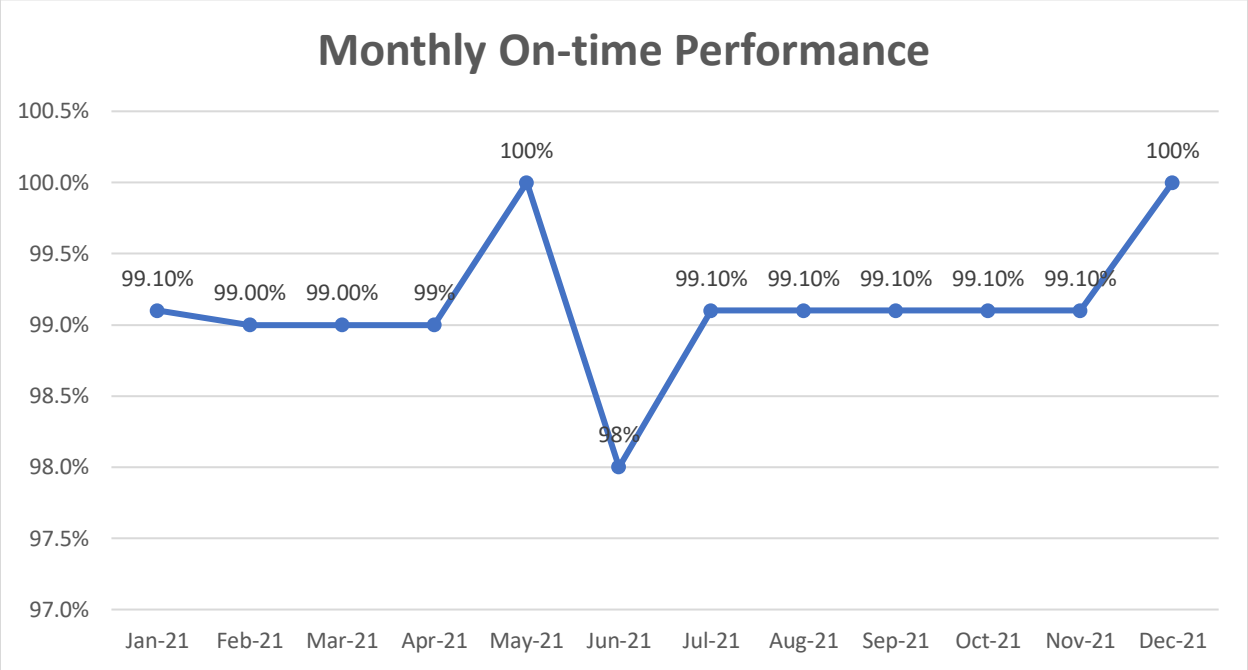
Goal: Ensure PACE transportation ride times are less than 60 minutes per trip with a g 0 trips > 60 minutes in duration and improve participant experience by providing timely transportation services with a goal of ≥ 92% on-time performance.

Goal: Met

More than 60 minutes in ride duration: 0 trips
On-time performance: ≥ 92%

Data/Analysis: 2021 data

More than 60 minutes in ride duration: 0 trips
On-time performance: 99%



Summary and Key Findings/Opportunities for Improvement:

2021 was a transitional time for the transportation department. Due to the pandemic, as with 2020 the transportation department was utilized for drive-through immunization and COVID-19 testing, delivery of care packages and durable medical equipment. In Q3 of 2021 we reopened day center services for selected participants on a limited basis. Despite the increased demands and ever-changing protocols, the transportation has continued to meet their benchmark. For the year, transportation completed 30,696 one-way trips with an on-time performance of 99%. We will continue to actively monitor trends in transportation, not just in terms of on-time-performance, but also for participant satisfaction.

Meals

QI21.28 Improve the overall satisfaction of participants with meals within the PACE program

Goal: ≥ 71% on Satisfaction with Meals summary score on the 2021 PACE Satisfaction Survey

Goal: Met

Data/Analysis: 80% overall weighted participant satisfaction summary score.

2021 Participant Survey Satisfaction with Meals Domains

Domain	2020	2021	2021 National Average
Do the lunches look good?	81%	88%	69.6%
Do the lunches taste good?	75%	75%	61.6%
Do you get a variety of foods here?	78%	80%	81.7%
Meal satisfaction composite score	78%	**80%**	70.8%
Overall, would you rate the lunches as excellent, very good and/or good?	80%	84%	79.2%

Summary and Key Findings/Opportunities for Improvement:

In 2021, we met our benchmark with 80% of PACE participants indicating satisfaction with their meals, exceeding the PACE national average of 70.8%. In 2021, we engaged the services of a research entity which surveyed participant satisfaction for PACE programs statewide. One of the domains surveyed was a participant's satisfaction with meals. Survey responses indicated that participants were generally satisfied with meals provided by PACE. In 2021, we made an active effort to present a variety of meals which were not only nutritious, but also consistent with the cultural background of our participants. For 2021-40,268 meals were delivered to PACE participants in their homes.

Most participants indicated that the meals looked appealing, tasted good and were varied. Our dietary team monitored participant meals, frequently adjusting menus to be consistent with therapeutic diet parameters as well as an individual's preference. We will continue to monitor this domain in 2022.

Overall Satisfaction

QI21.29 Improve the overall satisfaction of participants and their families with the CalOptima PACE program

Goal: Greater than or equal to 88% on the Overall Satisfaction Weighted Average on the 2021 PACE Satisfaction Survey.

Goal: Met

Data/Analysis: 91% overall weighted participant satisfaction summary score.

Participant Survey Overall Satisfaction Domains

Domain	2020	2021	2021 National Average
Would you recommend the program to a close friend or relative?	91%	94%	92.3%
Overall satisfaction with the care received	88%	96%	94.8%

2021 Participant Survey Domains

Domain	2020	2021	2021 National Averages
Transportation	95%	96%	93.6%
Center Aids	96%	95%	91.2%
Home Care	90%	90%	86.2%
Medical Care	91%	93%	90.1%
Health Care Specialist	87%	88%	89.1%
Social Worker	93%	97%	94.5%
Meals	78%	80%	70.8%
Rehabilitation Therapy and Exercise	87%	91%	93.1%
Recreational Therapy	85%	85%	79.0%
General Service Delivery	N/A	92%	86.9%
Weighted Summary Score	89%	**91%**	88.5%

Summary and Key Findings/Opportunities for Improvement:

In fall 2021, CalOptima PACE contracted with Vital Research to conduct the Participant Satisfaction Survey. Vital Research interviewed 112 participants via telephone, to gauge the participant's satisfaction with CalOptima PACE services. This is a standardized survey taken by most of the PACE programs in the country.

The overall satisfaction score was 91%. High marks were given to our center aides, transportation, medical team, home care, and social work departments. Overall, our scores increased in all but one area from 2020 to 2021 and we exceeded national averages on most domains. 94% of our participants indicating they would recommend PACE to a close friend or relative in need of this kind of care. In 2022 we hope to reopen the day center to full capacity and once again be able to provide our comprehensive therapy and exercise programs to all participants to improve satisfaction in that area.

SECTION 5: 2020 HEALTH PLAN MANAGEMENT SYSTEM (HPMS)

2021 HPMS: In 2018, CMS implemented changes to the Level I event and Level II reporting structure. Level I and Level II events are now referred to as Unusual Quality Incidents and are reported to CMS on a quarterly basis via the Health Plan Management System (HPMS). The following elements are reported:

1. Grievances
2. Appeals
3. Unusual Quality Incidents
4. Medication Errors
5. Immunizations (evaluated in the Quality-of-Care section of this report)
6. Falls without Injury
7. ER Visits (evaluated in the Utilization Management section of this report)
8. Denials of Prospective Enrollees

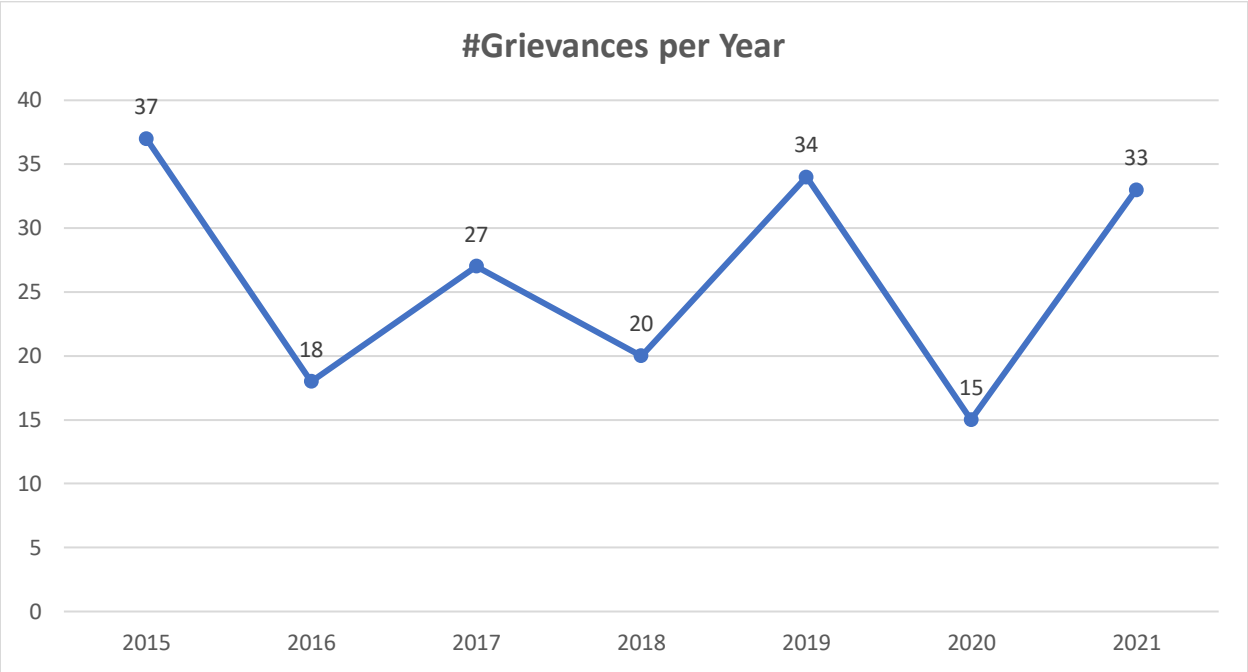
Grievances

Data Analysis:

Quarterly Grievances Q1 2021–Q4 2021

	CENTER							CLINIC			
					Transportation			Clinical Care/Service/ Treatment			
	# Grievances	Other	Food	Home Care	Timeliness	Prt-Driver Interaction	Escort	Dissatisfaction	Timeliness	Comm-unication about care	Scheduling/ Communication
Q1 2021	4	0	0	0	2	1	0	1	0	0	0
Q2 2021	10	0	0	0	5	0	0	2	0	3	0
Q3 2021	7	1	0	0	4	0	0	1	0	0	1
Q4 2021	12	1	0	0	7	0	0	3	0	1	0

Grievances Per Year 2015–2021



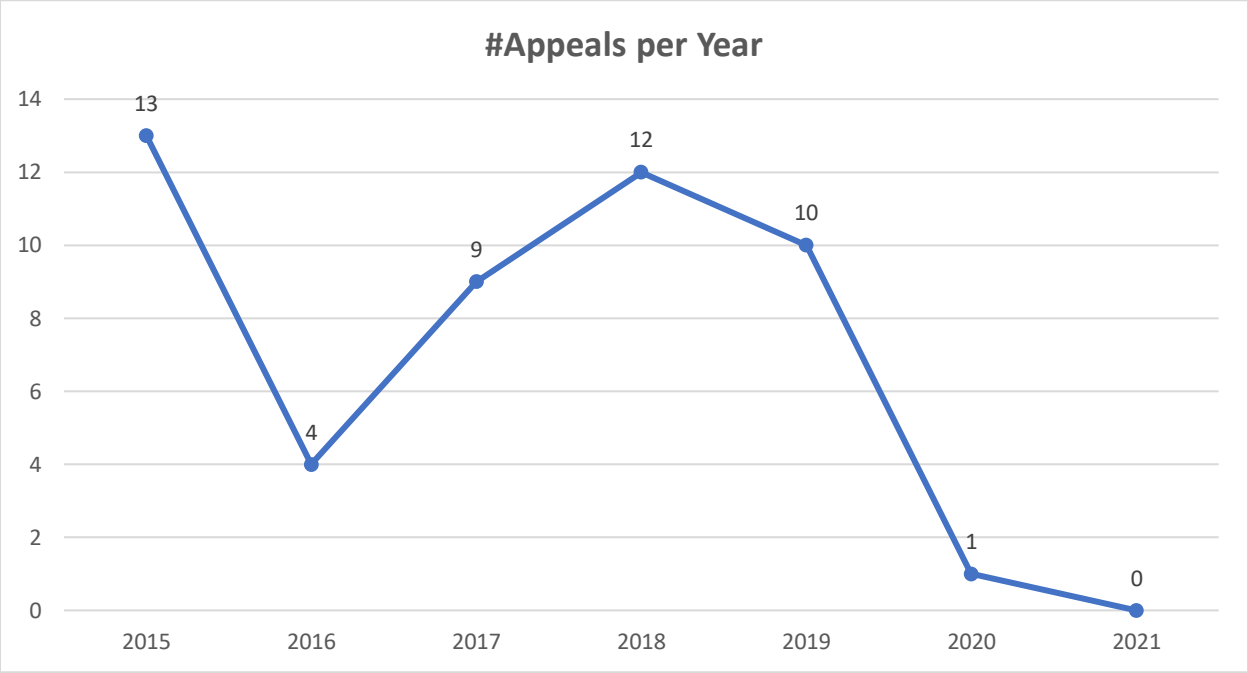
In 2021, we saw an increase in the number of grievances filed by participants. Many of the grievances were transportation related issues such as being picked up late. Despite this, our participant satisfaction survey revealed that 96% of participants were satisfied with transportation services. All grievances are investigated by our QI department and a resolution to the grievance is provided to the participant within a 30-day period.

The majority of participants filing grievances are satisfied with the resolutions reached by the PACE QI department. As with previous years, we will continue to monitor and observe for trends with grievances filed.

Appeals

Data Analysis:

Appeals Per Year 2015–2021

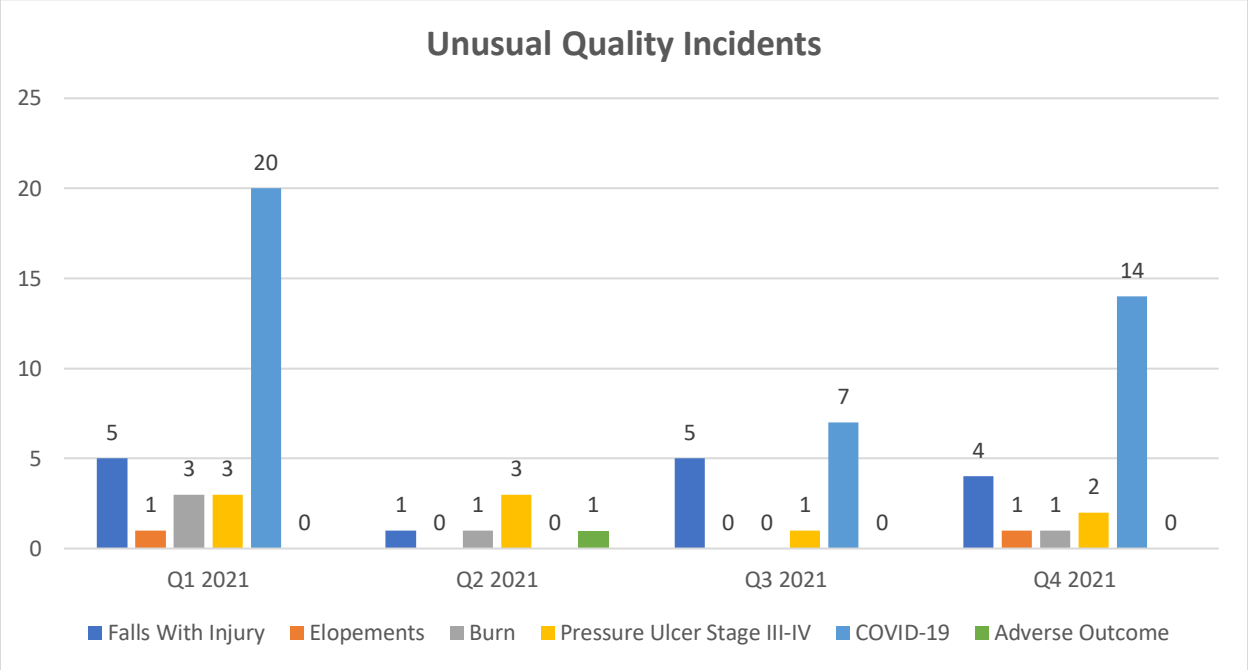


No appeals were submitted in 2021. This is likely due to processes in place for PACE team to explain the reasons for request denials to our participants and ensure that reasons for denials are thoroughly elucidated.

Level II Events/Unusual Quality Incidents

Description of Level II Events: Unusual quality incidents (formerly referred to as Level II events) are monitored by the PACE QI team. Unusual quality events including falls with injury, elopements, burns, pressure ulcers (stage III–IV) and infectious disease outbreaks and are reported to CMS and DHCS on a quarterly basis. Essentially, the objective is to monitor the health and safety of PACE participants as well as the effectiveness of our risk management and QI program. All unusual quality incidents are reported to the QI team with an ensuing root cause analysis (RCA) completed on each incident. The RCA begins with the QI team investigating the incident (what, where and when) then followed by a meeting of appropriate disciplines such as nursing, social worker, rehabilitation services. Potential causes of the incident are discussed and interventions to prevent further occurrences are implemented. In some instances, interventions could include systemic or operational failures which need remediation. In 2021, there was only one quality incident that required an operational change (transportation team completed a corrective action plan regarding a reported elopement).

Data Analysis: See graph below



Falls with injury are usually one of the most prevalent unusual quality event at PACE. As the stay-at-home orders were mandated, participants sustained more falls in their home. The number of falls however did not increase significantly from 2020. As with the previous year, the majority of falls are either a result of non-use of durable medical equipment or lack of family supervision. In 2021, due to the ongoing COVID-19 pandemic, we saw an increase in reporting of infectious disease cases under unusual quality incidents, especially in Quarter 1 (before availability of widespread COVID-19 vaccination) and in Quarter 4 (worldwide COVID-19 Omicron variant surge).

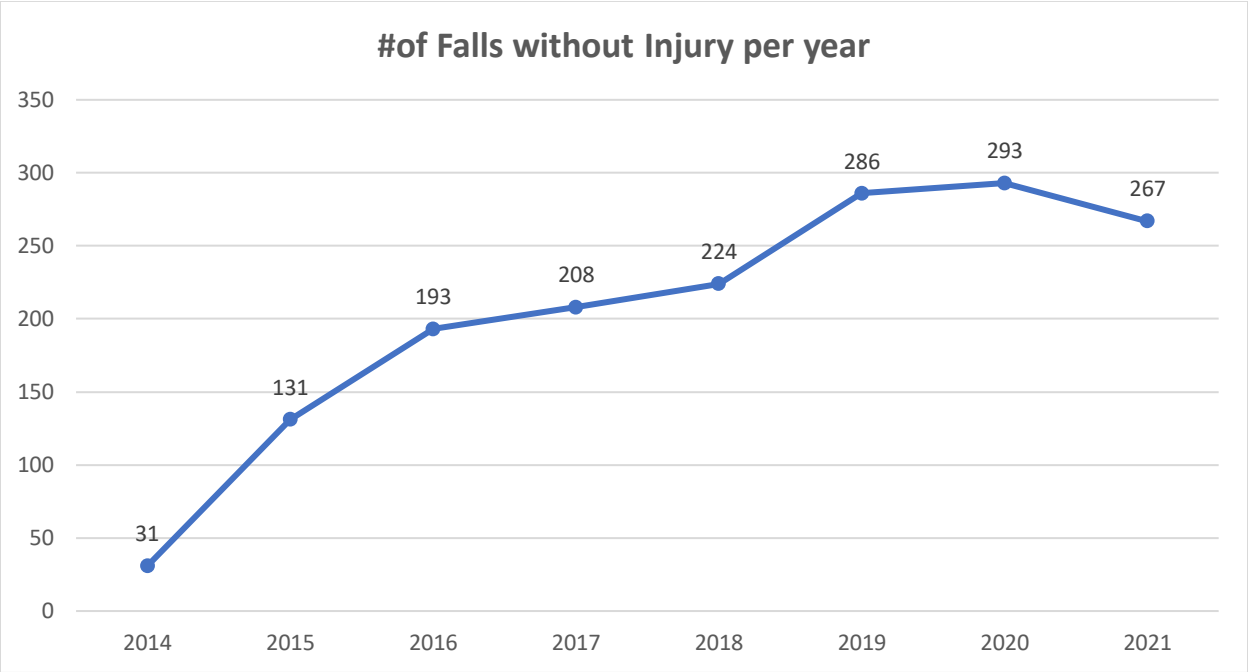
Medication Errors

A total of 2 medication (dosage) errors were reported in 2021. One of the medication errors was attributable to PACE clinic staff error. In response to the staff error, education and training were implemented. Another dosage error was made by a contracted home health nurse. In this case, we requested a corrective action plan from the home health agency and they complied with this request. No further incidents have occurred.

Falls Without Injury

Data Analysis**:**

Falls without Injury 2014–2021



As in previous years, we have continued to maintain a relatively low number of falls. In 2021, we saw a decrease from 2020 figures. Most falls are continuing to occur in the community, specifically in the participant's home environment. CalOptima PACE has spearheaded fall prevention groups among the high fall risk participants, with the goal of continued decreasing fall trends. The "PACE Fall Prevention" group is comprised of PACE participants who are educated by the rehabilitation staff in fall recovery mechanisms.

Other groups PACE created to reduce falls include:

1. *Fallers Anonymous*: Comprised of PACE participants who meet quarterly with the rehabilitation team to discuss safety in the home and environment.
2. *Matter of Balance*: Targets those participants with cognitive impairment. Discusses the many misconceptions surrounding falls.

These groups were put on hold d/t current closure and restrictions in the center- they will both resume once PACE returns to normal scheduling.

Disciplines, including physicians, nurses, social workers, physical and occupational therapy, and clinical pharmacy, collaborate to develop participant-specific strategies for fall prevention. PACE is using an individualized approach to falls. Once any of the disciplines get information from participants and/or families via wellness calls related to a fall, they will send a Clinic Service Request to clinic and rehab for quick intervention. Rehab then reaches out to participant/family to provide immediately education and follow-up. If further evaluation and skilled rehab is warranted, PACE will ask the participant to do an in-person visit at PACE center. In this way, PACE maintains a direct response to each and every fall reported in a timely manner.

Denials of Prospective Enrollees

In 2021, one prospective enrollee w**as** denied enrollment by the State. This prospective enrollee's health and safety would be jeopardized by living in a community setting.

Quality Initiatives

In 2021, we focused on our Quality Initiatives to improve the participant experience and assure optimal clinical outcomes related to the COVID-19 pandemic. Quality Initiatives identify areas of improvement ultimately leading to enhanced clinical outcomes, appropriate changes in systems and overall participant satisfaction. PACE Quality Initiatives specify expected outcomes, strategies, and measurable interventions to meet our goals. The status of PACE Quality Initiatives is presented to the PQIC on a quarterly basis. The program's two quality initiatives in 2021 were in response to the COVID-19 pandemic.

- COVID-19 Vaccine Quality Initiative.
  - This initiative focused on vaccine education, outreach, and vaccine distribution coordination.
- Telehealth Engagement Quality Initiative
  - This initiative focused on accelerating the adoption and utilization of telehealth by the PACE participants. It involved education, training and ensuring our participants have the hardware to utilize our telehealth services.

SECTION 5: OPPORTUNITIES FOR IMPROVEMENT IN 2022

1. **Improve the Quality of Care (QOC) for Participants**
   a. Addition of new COVID-19 booster immunization quality initiative to ensure all participants get vaccinated.
   b. Continue to expand telehealth services, drive through clinics and home visits.
   c. Refine clinical triage workflow.
2. **Ensure the Safety of Clinical Care**
   a. The QI team will continue to focus on strengthening oversight activities of external providers and vendors specifically related to home care, skilled nursing facilities, board and care facilities and transportation.
   b. The grievances and potential quality issues involving downstream vendors will continue to be tracked and trended to assure no service or clinical trend is emerges.
   c. Participants receiving more than an average MME dose of 90 MME will continue to be closely monitored.
3. **Ensure the Appropriate Use of Resources**
   a. Inpatient/ER Utilization
      i. Further expansion of our complex case management program with individualized interventions with a focus on high-risk participants.
      ii. Continue to refine the ER Diversion program.
   b. Specialty Care

i. Increase the number of core PACE specialists who are willing to work closely with the PACE program, receive training in the PACE Model of Care.
ii. PACE will leverage CalOptima's Provider Relations department to ensure that the specialist network meets the needs of PACE.

c. Staffing
i. Continue refinement of the staff relative value units (RVUs) to monitor staff productivity.

4. **Improve Participant Experience**
a. Participants will be updated on the satisfaction survey process.
b. Grievances and potential quality issues will be monitored and analyzed to find opportunities for improvement.
c. Once participants return to the PACE day center at full capacity, we will restart the monthly meal satisfaction surveys and make refinements to our meal program based on the feedback.

5. **Ensure Appropriate Access and Availability**
a. Reopening of access to ACS sites will continue to be considered in 2022 based on appropriate COVID-19 guidelines.
b. Continued development of our list of preferred specialists who are willing to work closely with PACE, be trained in the PACE model of care and attend occasional interdisciplinary care team meetings.
c. Will continue to bring specialists in to provide specialty care within the PACE clinic.

SUMMARY

CalOptima PACE developed and implemented systems using evidence-based guidelines that incorporate data and best practices tailored to the frail and elderly participants within our community. Our focus is to prevent institutionalization of these participants and enable them to live safely in our community with the support of PACE services. To accomplish our goals, we target many aspects of the health care continuum, such as preventive care, care management and disease management, closing any potential gaps in care. Through our ongoing data analysis, we are positioned to identify opportunities for improvement resulting in optimal clinical outcomes and participant satisfaction. Although individual measures may vary in their level of accomplishment, our overall effort has been a considerable success. As we continue to monitor our performance and refine our methods, we are confident that our QI efforts will continue to make a positive impact amongst our participants.

APPENDIX: 2021 PACE QI EVALUATION

2021 CalOptima PACE Quality Improvement (QI) Work Plan																	
QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person	Q1 Results	Q1 Action	Q2 Results	Q2 Action	Q3 Results	Q3 Action	Q4 Results	Q4 Action	EOY Total	MET/NOT MET
QI21.01	Improve the Quality of Care for Participants	2020 PACE QAPI Plan and Work Plan Annual Evaluation	2020 PACE QAPI Plan will be evaluated by March 1st, 2021	PACE QAPI Plan and Work Plan will be evaluated for effectiveness on an annual basis	Annually	3/1/2021	PACE Medical Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Met	Met
QI21.02	Improve the Quality of Care for Participants	2021 PACE QI Plan and Work Plan Annual Oversight	PACE QI Plan and Work Plan will be updated, reviewed and approved by March 1st, 2021	QI Plan and QI Work Plan will be approved and adopted on an annual basis	Annually	3/1/2021	PACE Medical Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Met	Met
QI21.03	Improve the Quality of Care for Participants	Influenza Immunization Rates	≥94% of eligible participants will have their annual influenza vaccination by December 31st, 2021	Improve compliance with influenza immunization recommendations (Exclusion: Participants who enroll in the PACE program in December 2021)	Q3 and Q4 2021	12/31/2021	PACE Clinical Operations Manager	N/A	N/A	N/A	N/A	10%	Not Met	91%	Not Met	91%	Not Met
QI21.04	Improve the Quality of Care for Participants	Pneumococcal Immunization Rates	≥94% of eligible participants will have had their PCV23 pneumococcal vaccination by December 31st, 2021	Improve compliance with pneumococcal immunization recommendations (Exclusion: Participants who enroll in the PACE program in December 2021)	Quarterly	12/31/2021	PACE Clinical Operations Manager	83%	Not Met	93%	Not Met	96%	Met	94%	Met	94%	Met
QI21.05	Improve Quality of Care for Participants	COVID-19 Immunization Rates	≥80% of eligible participants will have had their COVID-19 vaccination by December 31st, 2021	Improve compliance with COVID-19 immunization recommendations (Exclusion: Participants who enroll in the PACE program in December 2021)	Quarterly	12/31/2021	PACE Clinical Operations Manager	86%	Met	93%	Met	96%	Met	95%	Met	95%	Met
QI21.06	Improve the Quality of Care for Participants	Infection Control	In 2021, maintain respiratory infection rates of less than the national benchmarks of 0.1-2.4 respiratory infections/1000 participant days	Monitor and analyze the incidence of respiratory infections in the elderly at PACE and compare against national benchmark to find opportunities for quality improvement.	Quarterly	12/31/2021	PACE Clinical Operations Manager	0.8	Met	0.08	Met	0.41	Met	0.61	Met	0.48	Met
QI21.07	Improve the Quality of Care for Participants	Advanced Care Planning: Physician's Orders for Life-Sustaining Treatment	≥95% of participants who have been enrolled in the PACE program for 6 months will have a POLST completed by December 31st, 2021	Ensure all PACE members are offered POLST upon enrollment and every six months until they have one completed in order to improve POLST utilization.	Quarterly	12/31/2021	PACE Center Manager	89%	Not Met	90%	Not Met	94%	Not Met	93%	Not Met	91%	Not Met
QI21.08	Improve the Quality of Care for Participants	Advanced Care Planning: Advance Health Care Directive	≥40% of participants will have an Advanced Health Care Directive in place by December 31st, 2021	Ensure all PACE members are offered assistance with the completion of the Advance Health Care Directive	Quarterly	12/31/2021	PACE Center Manager	41%	Met	44%	Met	44%	Met	42%	Met	43%	Met
QI21.09	Improve the Quality of Care for Participants	Care for Older Adults (COA): Functional Status Assessment	Ensure that 100% of PACE participants have a functional status assessment completed every 6 months by the disciplines required by CMS	Ensure all PACE participants have a functional status assessment completed by the required disciplines every 6 months. Exclusion: Participants in unstable condition due to a hospitalization. Assessment to be	Quarterly	12/31/2021	PACE Center Manager	100%	Met	100%	Met	100%	Met	100%	Met	100%	Met
QI21.10	Improve the Quality of Care for Participants	Diabetes Care	>81.50% of Diabetics will have a Blood Pressure of <140/90 (Comparable to the 2019 MEDICARE Quality Compass HEDIS 90th percentile, exclusions defined in QI Plan)	PACE participants with diabetes will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams to develop strategies for improvement.	Quarterly	12/31/2021	PACE Clinical Medical Director	83%	Met	84%	Met	84%	Met	89%	Met	89%	Met
QI21.11	Improve the Quality of Care for Participants	Diabetes Care	>85.33% of Diabetics will have an Annual Eye Exam (Comparable to the 2019 MEDICARE Quality Compass HEDIS 90th percentile, exclusions defined in QI Plan)	PACE participants with diabetes will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams to develop strategies for improvement.	Quarterly	12/31/2021	PACE Clinical Medical Director	99%	Met	100%	Met	100%	Met	95%	Met	95%	Met

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QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person	Q1 Results	Q1 Action	Q2 Results	Q2 Action	Q3 Results	Q3 Action	Q4 Results	Q4 Action	EOY Total	MET/NOT MET
QI21.12	Improve the Quality of Care for Participants	Diabetes Care	>98.30% of Diabetics will have Nephropathy Monitoring (Comparable to the 2019 MEDICARE Quality Compass HEDIS 90th percentile, exclusions defined in QI Plan)	PACE participants with diabetes will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams to develop strategies for improvement.	Quarterly	12/31/2021	PACE Clinical Medical Director	100%	Met	100%	Met	100%	Met	100%	Met	100%	Met
QI21.13	Ensure the Safety of Clinical Care	Falls at Home or in the PACE Day Center	<6.65 Falls per 1000 member months) occurring at the PACE day centers (ACS and Garden Grove PACE) ≥17% of participants will not experience a recurring fall within the same quarter	Falls occurring at the PACE or ACS centers will be monitored by the PACE QI department who will work with the interdisciplinary teams, clinical teams and day center staff to develop strategies for improvement. Falls occurring in the home or community will be monitored by the PACE QI department who will work	Quarterly	12/31/2021	PACE Center Manager	0 71%	Met	0.84 87%	Met	0.82 83%	Met	0 80%	Met	0.41 80%	Met
QI21.14	Improve the Quality of Care for Participants	Reduce Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Dementia + tricyclic antidepressant or anticholinergic agents	<35.73% (Comparable to the 2019 MEDICARE Quality Compass HEDIS 90th percentile, exclusions defined in QI Plan)	PACE participants with a diagnosis of Dementia will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams as well as the PACE pharmacist to develop strategies for improvement.	Quarterly	12/31/2021	PACE Clinical Medical Director	16%	Met	17%	Met	18%	Met	17%	Met	17%	Met
QI21.15	Improve the Quality of Care for Participants	Reduce Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Chronic Renal Failure + Nonaspirin NSAIDS or Cox2 Selective NSAIDs	<3.90% (Comparable to the 2019 MEDICARE Quality Compass HEDIS 90th percentile, exclusions defined in QI Plan)	PACE participants with a diagnosis of Chronic Renal Failure will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams as well as the PACE pharmacist to develop strategies for improvement.	Quarterly	12/31/2021	PACE Clinical Medical Director	0%	Met	0.0%	Met	0.0%	Met	0.0%	Met	0.0%	Met
QI21.16	Ensure the Safety of Clinical Care	Decrease the Use of Opioids at High Dosage (UOD)	100% of members receiving opioids for 15 or more days at an average of 90 MME/day will be reevaluated monthly by their treating provider in 2021.	The PACE QI Department will monitor any participant who is receiving prescription opioids for ≥15 days at an average milligram morphine dose MME >90 MME/day	Quarterly	12/31/2021	PACE Clinical Medical Director	100%	Met	100%	Met	100%	Met	100%	Met	100%	Met
QI21.17	Improve the Quality of Care for Participants	Medication Reconciliation Post Discharge (MRP)	≥90% of participants will have their medications reconciled within 30 days of hospital discharge in 2021	The PACE QI Department will work with the PACE Interdisciplinary Team, Pharmacist and Providers to develop strategies for improvement	Quarterly	12/31/2021	PACE Pharmacist	100%	Met	100%	Met	100%	Met	100%	Met	100%	Met
QI21.18	Ensure Appropriate Access and Availability	Improve Access to Specialty Care	≥85% of specialty care authorizations will be scheduled within 10 business days in 2021 (exclusions defined in QI Plan)	Appointments for specialty care will be scheduled within 10 business days to improve access to specialty care for initial consultations	Quarterly	12/31/2021	PACE C inical Operations Manager	89%	Met	93%	Met	92%	Met	87%	Met	91%	Met
QI21.19	Ensure Appropriate Access and Availability	Improve Access to PACE Care: Increase Telehealth Engagement	≥65% of members will be able to engage in telehealth visits	Increase the % of participants who are utilizing the telehealth platform.	Quarterly	12/31/2021	Community-Based Program Manager	65%	Met	66%	Met	64%	Not Met	59%	Not Met	63%	Not Met
QI21.20	Ensure Appropriate Use of Resources	Reduce Acute Hospital Day Utilization	<2,857 hospital days per 1000 per year (5% decrease from 2020)	PACE participants hospital days will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education	Quarterly	12/31/2021	PACE Clinical Director	3691	Not Met	3840	Not Met	3939	Not Met	4044	Not Met	4044	Not Met

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QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person	Q1 Results	Q1 Action	Q2 Results	Q2 Action	Q3 Results	Q3 Action	Q4 Results	Q4 Action	EOY Total	MET/NOT MET
QI21.21	Ensure Appropriate Use of Resources	Reduce Emergency Room Utilization	<807 emergency room visits per 1000 per year (maintain improvements made in 2020)	ER utilization by PACE participants will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education	Quarterly	12/31/2021	PACE Clinical Director	851	Not Met	854	Not Met	906	Not Met	886	Not Met	886	Not Met
QI21.22	Ensure Appropriate Use of Resources	30-Day All Cause Readmission Rates	<15% 30-day all cause readmission	30-day all cause readmission rates for hospita ized PACE participants will be monitored and analyzed by the PACE QI department who will work with PACE interdisciplinary and clinical teams to find opportunities for quality improvement	Quarterly	12/31/2021	PACE Clinical Director	16%	Not Met	14%	Met	13%	Met	9%	Met	13%	Met
QI21.23	Ensure Appropriate Use of Resources	Long Term Care Placement	<4% of members will reside in long term care	PACE participants placed in long term care will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education	Quarterly	12/31/2021	PACE Center Manager	2.6%	Met	3.5%	Met	2.9%	Met	2.1%	Met	2.8%	Met
QI21.24	Improve Participant Experience	Enrollment/Disenrollment	The percentage of participants who disenro l for controllable reasons from the PACE program within the first 90 days of enrollment will be less than 6.5%	Review and analyze the participants who disenrolled from PACE within 90 days of enrollment, excluding deaths and withdrawals, to develop strategies for improvement	Quarterly	12/31/2021	PACE Marketing and Enrollment Manager	0%	Met	0%	Met	7.7%	Not Met	0%	Met	1.3%	Met
QI21.25	Improve Participant Experience	Enrollment/Disenrollment	Increase the Qualified Lead to Enrollment conversion rate to 60%) in 2021	Review and analyze the Qua ified Lead to Enrollment conversion rate and develop strategies for improvement.	Quarterly	12/31/2021	PACE Marketing and Enrollment Manager	88%	Met	88%	Met	72%	Met	74%	Met	79%	Met
QI21.26	Improve Participant Experience	Transportation	I00% of transportation trips will be less than 60 minutes in 2021	Ensure all PACE participants are on the vehicle for less than 60 minutes per trip. Monitor and analyze one-hour violations, define areas for improvement and implement interventions to maintain compliance with regulation	Quarterly	12/31/2021	PACE Center Manager	100%	Met	100%	Met	100%	Met	100%	Met	100%	Met
QI21.27	Improve Participant Experience	Transportation	≥92% of all transportation rides wi l be on-time in 2021	Review and analyze transportation records to track transportation rides with a scheduled and actual trip time of +/- 15 minutes. Validate reports with ride-along to ensure accuracy of reported times.	Quarterly	12/31/2021	PACE Center Manager	99%	Met	100%	Met	99.1%	Met	99.40%	Met	99.13%	Met
QI21.28	Improve Participant Experience	Increase Participant Satisfaction with Meals	≥71% on Satisfaction with Meals summary score (2020 PACE National Average) on the 2021 PACE Satisfaction Survey	Define areas for improvement and implement interventions to improve the participant and their families satisfaction with the meals within the PACE program.	Quarterly	12/31/2021	PACE Center Manager	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	80%	Met
QI21.29	Improve Participant Experience	Increase Overall Participant Satisfaction	≥88% on the Overall Satisfaction Weighted Average (2020 PACE National Average) on the 2021 PACE Satisfaction Survey	Review and analyze the annual satisfaction survey results, define areas for improvement and implement interventions to improve the participant and their families satisfaction with the PACE program	Annually	12/31/2021	PACE Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	91%	Met

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CALOPTIMA PROGRAM ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)
QUALITY IMPROVEMENT PLAN DESCRIPTION

202210

PACE Quality Improvement Subcommittee Chairperson:

David RamirezEmily Fonda, M.D. Richard Helmer Miles Masatsugu, M.D. **Date**
Medical Director, PACEInterim Chief Medical Officer

Board of Directors' Quality Assurance Committee Chairperson:

Trieu TranMary Giammona, M.D.Paul Yost, M.D.
Date

Board of Directors Chairperson:

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~~**Paul Yost, M.D.**~~**Andrew Do** **Date**
Supervisor, First District

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INTRODUCTION

The Quality Improvement (QI) Plan Description at CalOptima's Program of All-Inclusive Care for the Elderly (PACE) is the data-driven assessment program that drives continuous QI for all the services at CalOptima PACE. It is designed and organized to support the mission, ~~values~~values, and goals of PACE.

Overview

- The goal of the CalOptima PACE QI Plan is to improve future performance through effective improvement activities, driven by identifying key objective performance measures, tracking ~~them~~them, and reliably reporting them to decision-making and care-giving staff.
- The CalOptima PACE QI Plan is developed by the PACE Quality Improvement Committee (PQIC). As CalOptima's governing body, the Board of Directors has the final authority to review and approve the QI Plan annually and direct the PACE Medical Director to revise the QI Plan, as necessary and appropriate. The PACE QI Plan is comprised of both the PACE QI Program Description and specific goals and objectives described in the PACE QI Work Plan. (See Appendix ~~B)~~A).
- The PACE Medical Director has oversight and responsibility for implementation of the PACE QI Plan. The PACE QI Manager will ensure timely collection and completeness of data.
- The CalOptima PACE QI Committee (PQIC) will complete an annual evaluation of the approved QI Plan. This evaluation and analysis will help to find opportunities for quality improvement and will drive appropriate additions or revisions in the QI Plan to the goals and objectives for the following year.

Goals

- **Improve the quality of health care for participants.**
    - Ensure all QI activities fit into a well-integrated system that oversees quality of care and coordination of all services.
    - Ensure the QI program involves all providers of care within the PACE program.
    - Implement population health management (PHM) techniques, such as immunizations, for specific participant populations.
    - Identify and address areas for improvement that arise from unusual incidents, and sentinel events.
    - Monitor, analyze and report the aggregated data elements required by the Centers for Medicare & Medicaid Services (CMS) via the Health Plan Management System (HPMS) ~~in order to~~to identify areas needing quality improvement.
    - ~~Meet or exceeds minimum levels of performance on standardized quality measures as established by CMS and the state administering agencies (SAA) which includes achieving an immunization rate for both influenza and pneumococcal vaccinations of 90% for the appropriate participant population.~~
    - Communicate relevant QI activities and outcomes to the PACE staff and contractors, the PACE Member Advisory Committee (PMAC), and the Board of Directors.
    - Share results of QI identified benchmarks with staff and contracted providers at least annually.
    - Involve the physicians and other providers in establishing the most current,

evidenced-based clinical guidelines to ensure standardization of care. Professional standards of CalOptima PACE staff will be measured against those outlined by their respective licensing agencies in the State of California (e.g. California Board of Nursing, etc.).

- Ensure that all levels of care are consistent with professionally recognized standards of practice.
- Assure compliance with regulatory requirements of all responsible agencies.

- **Improve the participant experience.**
  - Use the annual participant satisfaction survey, grievances and appeals, and feedback from participant committees to identify areas for improvement related to participant experience.
  - Provide education to staff on the multiple dimensions of patient experience.
  - Identify and implement ways to better engage participants in the PACE experience (e.g., menu selection and PMAC).
  - Evaluate customer service, access, and timeliness of care provided by contracted licensed providers.
  - Monitor and track transportation services in terms of on-time performance and trips less than 60 minutes in duration
  - Ensure participant's end of life wishes are discussed and documented in the Physician's Order for Life Sustaining Treatment (POLST) and in an Advanced Health Care Directives which honors members' wishes as well as advance directive rights.
- **Ensure the appropriate use of resources.**
  - Review and analyze utilization data regularly, including hospital admissions, ~~hospital readmissions,~~ Emergency Room (ER) visits, and hospital 30-day all-cause readmissions, to identify high-risk members and opportunities for improvement.
  - Review documentation and coordination of care for participants receiving care in institutional settings and investigate any potential infractions in the quality of care provided in these settings.~~perform site visits on an ongoing basis.~~
  - Ensure high levels of coordination and communication between specialists and primary care providers (PCPs).
  - Ensure high levels of coordination and communication between inpatient facilities, nursing facilities and PACE PCPs.
  - Review and analyze clinic medical records to ensure appropriate documentation and coding.
- **Ensure the safety of clinical care**
  - Reduce potential risks to safety and health of PACE participants through ongoing risk management.
  - Ensure that every member of the PACE staff organization has responsibility for risk assessment and management.
  - Monitor, report and perform a Root Cause Analysis on all participant-involved events resulting in a significant adverse outcome, for the purpose of identifying areas for quality improvement.
  - Monitor and track falls occurring in the PACE Day Center and in the home and within the community.
  - Monitor and track the use of opioids at high dosages.
  - Meet or exceed community standards for credentialing of licensed providers.
  - Monitor staff and contractors to ensure that appropriate standards of care are met.
- **Ensure appropriate access and availability.**
  - Monitor and analyze the PACE provider network continuously to ensure appropriate levels of access.
  - Monitor and analyze access to specialty care
  - Continue to develop the network of Alternate Care Setting (ACS) sites to ensure the program can provide services to all Orange County residents who qualify and are interested in joining the PACE program.

Organizational and Committee Structure

CalOptima Board of Directors provides oversight and direction to CalOptima PACE. The Board has the final authority to ensure that adequate resources are committed and that a culture is created that allows the QI Plan efforts to flourish. The Board, while maintaining ultimate authority, has delegated the duty of immediate oversight of the QI programs at CalOptima — including the CalOptima PACE QI Program — to the Board's Quality Assurance Committee (QAC), which performs the functions of CalOptima's Quality Improvement Committee (QIC) described in CalOptima's state and federal contracts, and to CalOptima's Chief Executive Officer who is responsible to allocate operational resources to fulfill quality objectives.

The QAC is a subcommittee of the Board and consists of currently active Board members. The QAC reviews the quality and utilization data that are discussed during the PQIC reports. The QAC provides progress reports, reviews the annual PACE QI ~~Plan~~Plan, and makes recommendations to the full Board regarding these items, which are ultimately approved by the Board.

PACE Quality Improvement Committee

Purpose
This committee provides oversight for the overall administrative and clinical operations of PACE and will meet, at a minimum, once a quarter. The PQIC will review all QI initiatives, review the results of monitoring activities, provide oversight for proposed changes to improve quality of service and review follow-up of all changes implemented. The PQIC may create Ad Hoc Focus Review Committees for limited time periods ~~in order to~~to address quality problems in any clinical or administrative process that have been identified as critical to participants, families or staff. Potential areas for improvement will be identified through analysis of the data and through root cause analysis. This meeting will be chaired by the PACE Medical Director who will report its activities up to QIC, QAC, and the Board. The PACE Clinical Medical Director, PACE Program Director or PACE QI Manager may facilitate the meeting in the PACE Medical Director's absence. The PACE Clinical Medical Director, PACE Program Director or the PACE QI Manager may report up to QAC if the PACE Medical Director is not available.

Membership
Membership shall be comprised of the PACE Medical Director, PACE Program Director, PACE Clinical Medical Director, PACE Center Manager, PACE Clinical Operations Manager, PACE QI Manager, PACE Program Manager, PACE QI Coordinator, Manager of Community-Based Programs, and PACE Intake/Enrollment Manager. At least four regular members shall constitute a quorum. The PACE Medical Director will act as the standing chair of the committee.

PACE Focused Review Committees

Purpose
These committees will be formed to respond to or to proactively address specific quality issues that rise to the level of warranting further study and action. Key performance elements are routinely reviewed by administrative staff as part of ongoing operations, including, but not limited to, deaths and other adverse outcomes, inpatient utilization and other clinical areas that

indicate significant over/under utilization.

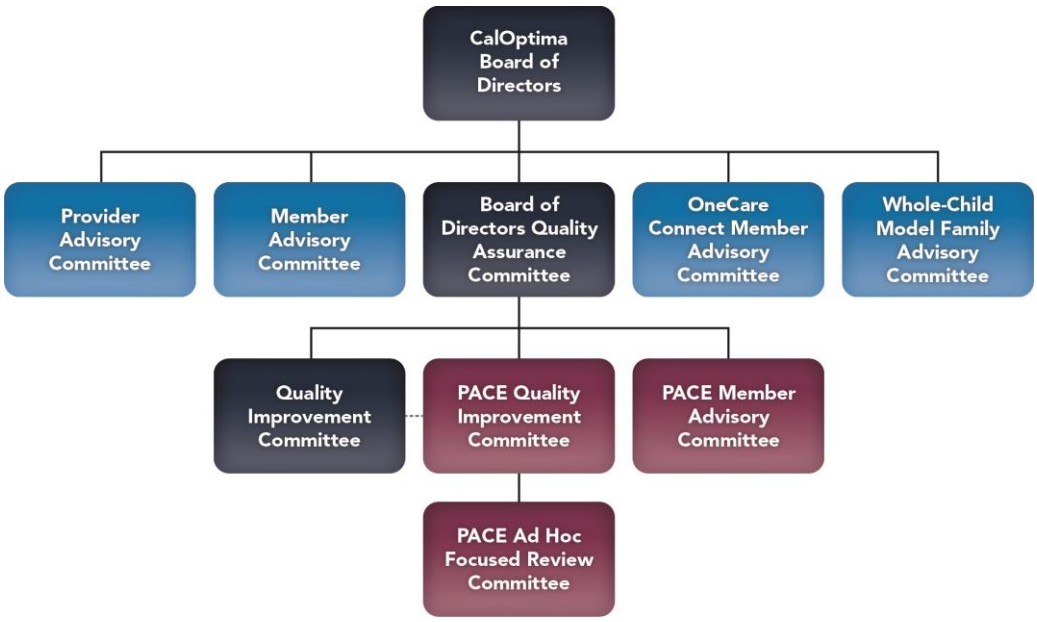
Membership
Membership will be flexible based on those with knowledge of the specific issues being addressed, but will consist of at least four members to include at least two of the following positions and/or functions: PACE Medical Director, PACE Clinical Medical Director, PACE QI Manager, PACE Program Director, PACE Center Manager, PACE Clinical Operations Manager, PACE Program Manager, PACE QI Coordinator, PACE Intake/Enrollment Manager or direct care staff. The Committee will be chaired by the PACE Medical Director, PACE Clinical Medical Director, PACE Director, PACE Manager or PACE QI Manager. The chair will report on activities and results to the PQIC. The committee will meet on an ad hoc basis as needed to review those critical indicators assigned to them by the PQIC.

PACE Member Advisory Committee

Purpose
PMAC provides recommendations~~advice~~ to the Board on issues related to participant care concerns that arise with participant care decisions and program operations from a community perspective. A member of the PMAC shall report its activities to QAC, which then will be reported to the Board. The PACE Program Director or the PACE Center Manager shall report its activities to the PQIC.

Membership
The PMAC comprises representatives of participants, participants' families, and communities from which participants are referred. PMAC membership is open to all participants and/or caregivers and no application process is required. Information related to upcoming PMAC meetings is disseminated through announcements at the PACE Day Center floor and all interested participants are invited to join. Participants and representatives of participants shall constitute a majority of membership. The committee will be comprised of at least seven members. At least four regular members shall constitute a quorum. The PACE Program Director will act as the standing chair and will facilitate for the committee. The PACE Center Manager or PACE QI Manager may facilitate the meeting in the PACE Director's absence.

2022 ~~10~~ Committee Organization Structure — Diagram



QUALITY AND PERFORMANCE IMPROVEMENT ACTIVITIES, OUTCOMES AND REPORTING

Quality Indicators and Opportunities for Improvement

Routine quality indicators appropriate to the PACE population are identified for analysis and trending. These indicators are related to the care and services provided at PACE. The indicators and opportunities for performance improvement are identified through:

Utilization of Services

- PACE will collect, ~~analyze~~analyze, and report any utilization data it deems necessary to evaluate both quality of care and fiscal well-being of the organization including:
    - Hospital Bed Days
    - ER Visits
    - 30-Day All-Cause Readmissions
    - Participants residing in Long-Term Care
- Data analysis will allow for analyzing both overutilization and underutilization for areas of quality improvement.

Participant and Caregiver Satisfaction

- PACE shall survey the participants and their caregivers on at least an annual basis. Additionally, PACE will look for other opportunities for feedback ~~in order to~~to improve quality of services.
- Due to the nature of the participants in PACE, caregiver feedback is an integral part of our data elements.
- The PMAC shall provide direct feedback on satisfaction to both the PACE leadership staff and QAC.
- Grievance data is reviewed and analyzed quarterly for trends and opportunities for improvement.

- PACE will monitor the percentage of participants who disenroll from the PACE program within 90 days for controllable reasons.
- The qualified lead to enrollment conversion rate will be monitored to ensure the program continues to have a smooth enrollment process.

Clinically Relevant HPMS Data

- Unusual Incidents
-
- Medication Errors
- Falls without Injury
- Clinical measures from the QI Work Plan elements which include:
    - Influenza Immunizations Rates ~~and~~
    - Pneumococcal Immunizations Rates ~~(mandated by CMS)~~
        - Exclusion criteria: ~~:~~
            - Participants who enrolled in the program in December 2021
    - COVID-19 Immunization Rates
        - Exclusion criteria:
            - ~~o~~ Participants who enrolled in the program in December 2022~~1~~
    - Infection Control: Respiratory Infection Rates
    - Advanced Health Care Planning: POLST Completion
    - ~~o~~ Advance Health Care Planning: Advanced Health Care ~~Healthcare~~ Directive Completion
    - ~~o Functional Status Assessment Completion~~

~~o Day Center Fall Rates~~Day Center Falls and falls occurring in the participant home or ~~within the community~~

    - ~~Opioids at High Dosage Monitoring~~
    - ~~o Medication Reconciliation Post Discharge~~
    - Diabetes Care: Annual Eye Exams
        - The following inclusion and exclusion criteria will be in place for this measure:
            - Inclusion criteria:
                - Enrolled for at least six months during measurement year
            - Exclusion criteria:
                - Participants who are end of life (less than six months)
                - Participants who are 76 years and older as of December 31, 2021~~0~~
    - Diabetes Care: Nephropathy Monitoring and Blood Pressure Control
        - The following inclusion and exclusion criteria will be in place for this measure:
            - Inclusion criteria:
                - Enrolled for at least six months during 2021~~0~~
            - Exclusion criteria:
                - Participants who are end of life (less than six months)
                - Participants who are 76 years and older as of December 31, 2021~~0~~
                - Participants with End Stage Renal Disease
    - Monitoring of treatment for Participants with Osteoporosis

- Falls at Home Classified as CMS Reportable Quality Incidents
- Potentially Harmful Drug-Disease Interactions in the Elderly: Dementia plus a tricyclic antidepressant or anticholinergic agent
  - The following inclusion and exclusion criteria will be in place for this measure:
    - Inclusion criteria:
      - Continuous enrollment throughout year
      - Participants who are 66 years and older as of December 31, 20210
    - Exclusion criteria:
      - Participants who are end of life (less than six months)
      - Participants with Schizophrenia or Bipolar Disorder
- Potentially Harmful Drug-Disease Interactions in the Elderly: Chronic Kidney Disease plus Nonaspirin NSAIDS or Cox2 Selective NSAIDs
  - The following inclusion and exclusion criteria will be in place for this measure:
    - Inclusion criteria:
      - Continuous enrollment throughout year
      - Participants who are 66 years and older as of December 31, 20210
    - Exclusion criteria:
      - Participants who are end of life (less than six months)
- Opioids at High Dosage Monitoring
- Medication Reconciliation Post Discharge
-
- Access to Specialty Care

Effectiveness and Safety of Staff-Provided and Contract-Provided Services

- This will be measured by participants' ability to achieve treatment goals as reviewed by the Interdisciplinary Team (IDT) with each reassessment, review of medical records, and success of infection control efforts.
- All clinical and certain non-clinical positions have competency profiles specific to their positions.
- Annual competency evaluations of PACE staff.
- PACE staff will monitor providers by methods such as review of providers' QI activities, medical record review, grievance investigations, observation of care and interviews.
- Unannounced visits to inpatient provider sites will be made by PACE staffstaff, as necessary.
- Oversight of contracted Alternative Care Sites (ACS), assuring compliance to PACE regulations (including, but not limited to participant rights, infection control, emergency preparedness, staff competencies) as well as CalOptima guidelines (e.g. HIPAA, FWA, licensing, etc.).

Non-Clinical Areas

- The PACE PQIC has oversight to all activities offered by PACE.
- Member grievances will be forwarded to the PACE QI DepartmentQI Coordinator and QI

~~Manager~~ for investigation, tracking, ~~trending~~trending, and data gathering. These results will be forwarded to the PACE Director for review and further direction on any corrective actions that may be implemented. Participants and caregivers will be informed of the results of the investigations, decisions and will be assisted with furtherment of the process as needed. Results will also be reported to the PQIC for direction on how appropriate staff should implement any corrective actions.

- Member appeals will be forwarded to the PACE QI ~~Deparment~~Department~~QI Coordinator and QI Manager~~ for tracking, trending and data gathering and the PACE Director or PACE Medical Director for review. The case will then be forwarded to a third-party with the appropriate licensure for review. The third-party reviewer's decision shall be reviewed by either the PACE Director or the PACE Medical Director and will be immediately shared with the IDT who will inform caregivers and participants of the decision and assist them with furtherment of the process as needed.

- Continued
- i~~I~~ntegration of telehealth to expand access to care through the COVID-19 pandemic and beyond.
- Transportation services will continue to be monitored through monthly metrics and grievance trending. The monthly report generated by the transportation vendor will be reviewed at the monthly transportation leadership meeting and will be reported quarterly to the PQIC. The PACE QI department will monitor transportation services with perio~~d~~tic ride alongs. The times gathered during the ride alongs will be compared against the data in the transportation reports to ensure accuracy.
- Meal quality will be monitored through ~~periodic~~ participant ~~meal~~ satisfaction surveys as well as comments solicited by the PMAC.
- ~~Meal quality will be monitored through periodicregular participant meal satisfaction surveys as well as comments solicited by the PMAC.~~
- Life safety will be monitored internally via quarterly fire drills and annual mock code and mock disaster drills, as well as regulatory agency inspections.
- Plans of correction on problems noted will be implemented by center staff, reviewed by the PACE Program Director, PACE Medical Director or the PACE QI Manager, and presented to the PQIC.
- The internal environment will be monitored through ongoing preventive maintenance of equipment and through repair of equipment or physical plant issues as they arise.

Priority Setting for Performance Improvement Initiatives

- Potential impact on quality of care, clinical outcomes, improved participant function and improved participant quality of life.
- Potential impact on participant access to necessary care or services.
- Potential impact on participant safety.
- Participant, ~~caregiver~~caregiver, or other customer satisfaction.
- Potential impact on efficiency and cost-effectiveness.
- Potential mitigation of high risk, high ~~volume~~volume, or high frequency events.
- Relevance to the mission and values of PACE.

External Monitoring and Reporting

PACE will report both aggregate and individual-level data to CMS and SAA to allow them to monitor PACE performance. This includes certain Unusual Quality Incidents (previously referred to as Level II Events), Health Outcomes Survey Modified (HOS-M) participation, and any other required reporting elements. Certain data elements are tracked in response to federal and state mandates and will be reported up through the PACE monitoring module of HPMS. The following data is reported to CMS via the HPMS on a quarterly basis:

- Grievances
- Appeals
- Unusual Incidents
- Medication Errors
- Immunizations
- Enrollment Data
- Denials of Prospective Enrollees
- Falls without Injury
- ER Visits

Unusual Quality Incidents

- When unusual incidents reach specified thresholds, PACE must notify CMS on a quarterly basis through HPMS. PACE must complete a Root Cause Analysis and present the results of the analysis on a conference call with both CMS and the Department of Health Care Services (DHCS) as well as internally at PQIC. The goal of this analysis is to identify systems failures and improvement opportunities. Examples of Unusual Quality Incidents include:
    - Deaths related to suicide or homicide, unexpected and with active coroner investigation.
    - Falls that result in death, a fracture or an injury requiring hospitalization related directly to the fall.
    - Infectious disease outbreak that meet the threshold of three or more cases linked to the same infectious agent within the same time frame.
    - Pressure injuries acquired while enrolled in PACE.
    - Traumatic injuries which result in death or hospitalization of five days or more or result in permanent loss of function.
    - E~~Any e~~lopement by cognitively impaired participant ~~.~~
    - Adverse drug reactions
    - Foodborne outbreak
    - Burns 2nd degree or higher
    - COVID-19 infections
- HOS-M
    - PACE will participate in the annual HOS-M to assess the frailty of the population in our center.
- Other external reporting requirements
    - Suspected elder abuse shall be reported to appropriate state agency.
    - Equipment failure or serious adverse reaction to any administered medications will be reported to the Food and Drug Administration (FDA).
    - Any infectious disease outbreak will be reported to the Centers for Disease Control and Prevention (CDC) and the Orange County Health Care Agency.

Corrective Action Plans (CAP)

- When opportunities for improvement are identified, a corrective plan will be created.
- Each CAP will include an explanation of the problem, the individual who is responsible for implementing the CAP, the time frame for each step of the plan, and an evaluation process to determine effectiveness.
- CAPs from contracted providers will be requested by the QI Manager or another member of the PQIC, as appropriate.

Urgent Corrective Measures

- Problems that are found to threaten the immediate health and safety of participants or staff will be reported immediately to the PACE Medical Director and the PACE Director.
- The QI Manager or QI Coordinator will consult with relevant PACE staff and be responsible for developing an appropriate corrective plan within 24 hours of notification.
- Urgent corrective measures will be discussed during IDT morning meetings and, when appropriate, with participants.
- Disciplinary action and/or the use of appropriate community resources such as Adult Protective Services, notification and cooperation with law enforcement agencies, emergency placement of participants, etc. will be implemented immediately.

Re-Evaluation and Follow-Up

- Monitoring activities will be conducted to determine the effectiveness of plans of action. The timeliness of follow-up is dependent upon the following:
    - Severity of the problem
    - Frequency of occurrence
    - Impact of the problem on participant outcomes
    - Feasibility of implementation
- If follow-up shows the desired results have been achieved, the issue will be re-evaluated on a periodic basis to ensure continued improvement.
- If follow-up indicates that the desired results are not being achieved, then a more in-depth analysis of the problem and further determination of the source of variation are needed. A subcommittee of the PQIC or other workgroup may be established to address specific problems.
- All quality assessment and improvement steps and follow-up results will be shared with appropriate staff for discussion.

Quality Initiatives

- Quality Initiatives will be implemented as an adjunct to the PACE QI Plan. Quality Initiatives identify areas of improvement ultimately leading to enhanced clinical outcomes, appropriate changes in systems and overall participant satisfaction. PACE Quality Initiatives specify expected outcomes, ~~strategies~~strategies, and measurable interventions to meet our goals. The status of PACE Quality Initiatives is presented to the PQIC on a quarterly basis. The program's three~~two~~ quality initiatives in 2022~~1~~ are~~: in response to the COVID-19 pandemic.~~

    ~~Two quality initiatives will be added in 2021.~~
    - COVID-19 Booster Vaccine Quality Initiative.
        - This initiative will focus on vaccine education, outreach, and vaccine distribution coordination with a goal of getting at least 8~~9~~0% of eligible

participants their COVID-19 booster~~vaccinated~~ by the end of December 2022. ~~March 2021.~~

- Telehealth Engagement Quality Initiative
  - This initiative will focus on accelerating the adoption and utilization of telehealth by the PACE participants. -It will involve education, training and ensuring our participants have the hardware to utilize our telehealth services. The PACE Community Based Services Program Manager will implement a plan to increase prt telehealth access. The goal for 2022 is ≥ 66% or participants will have access to telehealth platforms such as VSEE.
- Advance Health Care Directive
  - This initiative will focus on increasing the number of PACE participants who have a completed Advance Health Directive in their medical chart. The PACE leadership team has created a plan to be implemented by the PACE Center Manager and the Social Work team, with a goal of ≥ 50% of participants having a completed AHCD in 2022.

- ~~In 2020, a new advanced health care directive quality initiative will be added.~~

ANNUAL REVIEW OF PACE QI PLAN

- The PACE QI Plan will be assessed annually for effectiveness.
- Enhancements to the plan will be made through appropriate additions and revisions to the specific goals and objectives in the QI Work Plan.
- The Board will review and approve the PACE QI Plan and direct the PACE Medical Director to revise the QI Plan, as necessary and appropriate, to assure organizational oversight and commitment.

APPENDIX A (SEE ATTACHMENT)

~~2021~~2022 CalOptima PACE Quality Improvement (QI) Work Plan

QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person
~~QI21.01~~ QI22.01	Improve the Quality of Care for Participants	2021 PACE QAPI Plan and Work Plan Annual Evaluation	2021 PACE QAPI Plan will be evaluated by March 1st, 2022	PACE QAPI Plan and Work Plan will be evaluated for effectiveness on an annual basis	Annually	3/1/2022	PACE Medical Director
~~QI21.02~~ QI22.02	Improve the Quality of Care for Participants	2022 PACE QI Plan and Work Plan Annual Oversight	PACE QI Plan and Work Plan will be updated, reviewed and approved by March 1st, 2022	QI Plan and QI Work Plan will be approved and adopted on an annual basis	Annually	3/1/2022	PACE Medical Director
~~QI21.03~~ QI22.03	Improve the Quality of Care for Participants	Influenza Immunization Rates	≥94% of eligible participants will have their annual influenza vaccination by December 31st, 2022	Improve compliance with influenza immunization recommendations ~~(Exclusion: Participants who enroll in the PACE program in December 2022)~~	Q1, Q3 and Q4 2022	12/31/2022	PACE Clinical Operations Manager
~~QI21.04~~ QI22.04	Improve the Quality of Care for Participants	Pneumococcal Immunization Rates	≥94% of eligible participants will have had their PCV23 pneumococcal vaccination by December 31st, 2022	Improve compliance with pneumococcal immunization recommendations (Exclusion: Participants who enroll in the PACE program in December 2022)	Quarterly	12/31/2022	PACE Clinical Operations Manager
~~QI21.05~~ QI22.05	Improve Quality of Care for Participants	COVID-19 Immunization Rates	≥~~80~~95% of eligible participants will have had their COV D-19 vaccination by December 31st, 2022	Improve compliance with COVID-19 immunization recommendations (Exclusion: Participants who enroll in the PACE program in December 2022)	Quarterly	12/31/2022	PACE Clinical Operations Manager
~~QI21.06~~	~~Improve the Quality of Care for Participants~~	~~Infection Control~~	~~In 2021, maintain respiratory infection rates of less than the national benchmarks of 0.1-2.4 respiratory infections/1000 participant days~~	~~Monitor and analyze the incidence of respiratory infections in the elderly at PACE and compare against national benchmark to find opportunities for quality improvement.~~	~~Quarterly~~	~~12/31/2021~~	~~PACE Clinical Operations Manager~~
~~QI21.07~~ QI22.06	Improve the Quality of Care for Participants	Advanced Care Planning Physician's Orders for Life-Sustaining Treatment	≥95% of participants who have been enrolled in the PACE program for 6 months will have a POLST completed by December 31st, 2022	Ensure all PACE members are offered POLST upon enrollment and every six months until they have one completed in order to improve POLST utilization.	Quarterly	12/31/2022	~~PACE Center Manager~~ PACE Clinical Operations Manager and Clinical Medical Director
~~QI21.08~~	~~Improve the Quality of Care for Participants~~	~~Advanced Care Planning Advance Health Care Directive.~~ Move to Quality Initiative	~~≥40% of participants will have an Advanced Health Care Directive in place by December 31st, 2021~~	~~Ensure all PACE members are offered assistance with the completion of the Advance Health Care Directive~~	~~Quarterly~~	~~12/31/2021~~	~~PACE Center Manager~~
~~QI21.09~~	~~Improve the Quality of Care for Participants~~	~~Care for Older Adults (COA) Functional Status Assessment~~	~~Ensure that 100% of PACE participants have a functional status assessment completed every 6 months by the disciplines required by CMS~~	~~Ensure all PACE participants have a functional status assessment completed by the required disciplines every 6 months. Exclusion: Participants in unstable condition due to a hospitalization. Assessment to be completed upon participant discharge.~~	~~Quarterly~~	~~12/31/2021~~	~~PACE Center Manager~~

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QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person
~~QI21.10~~ QI22.07	Improve the Quality of Care for Participants	Diabetes Care	>81.50% of Diabetics will have a Blood Pressure of <140/90 (Comparable to the 2020 MEDICARE Quality Compass HEDIS 95th percentile, exclusions defined in QI Plan)	PACE participants with diabetes will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams to develop strategies for improvement.	Quarterly	12/31/2022	PACE Clinical Medical Director
~~QI21.11~~ QI22.08	Improve the Quality of Care for Participants	Diabetes Care	~~>85.33%~~ 82.77% of Diabetics will have an Annual Eye Exam (Comparable to the ~~2019~~ 2020 MEDICARE Quality Compass HEDIS 95th percentile, exclusions defined in QI Plan)	PACE participants with diabetes will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams to develop strategies for improvement.	Quarterly	12/31/2022	PACE Clinical Medical Director
~~QI21.12~~ QI22.09	Improve the Quality of Care for Participants	Diabetes Care	>98.30% of Diabetics will have Nephropathy Monitoring (Comparable to the ~~2019~~ 2020 MEDICARE Quality Compass HEDIS 95th percentile, exclusions defined in QI Plan)	PACE participants with diabetes will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams to develop strategies for improvement.	Quarterly	12/31/2022	PACE Clinical Medical Director
QI22.10	Improve the Quality of Care for Participants	Osteoporosis (New Element)	>= 90% of participants with the diagnosis of Osteporosis will have treatment by PCP	PACE participants with diagnosis of osteoporosis witll be managed by their PCP using appropriate therapy resu ting in a decrease risk of fracture.	Quarterly	01/01/2022	PACE Clinical Medical Director
~~QI21.13~~ QI22.11	Ensure the Safety of Clinical Care	~~Falls at Home or in the PACE Day Center~~ Falls at Home Clasified as CMS Reportable Quality Incidents	~~<6 65 Falls per 1000 member months) occurring at the PACE day centers (ACS and Garden Grove PACE) ≥80% of participants will not experience a recurring fall within the same quarter (At Home Only)~~ <= 207 Falls per 1000 per year	~~Falls occurring at the PACE or ACS centers will be monitored by the PACE QI department who will work with the interdisciplinary teams, clinical teams and day center staff to develop strategies for improvement Falls occurring in the home or community will be monitored by the PACE QI department who wl work with the interdisciplinary teams, clinical teams and day center staff to develop strategies for improvement.~~ Falls with Injury will be mornitored by PACE QI department who will work with the interdisciplinary teams and clinical teams to develop strategies for improvement.	Quarterly	12/31/2022	PACE Center Manager
~~QI21.14~~ QI22.12	Improve the Quality of Care for Participants	Reduce Potentially Harmful Drug/Disease Interactions in the Elderly (DDE) Dementia + tricyclic antidepressant or anticholinergic agents	~~<35.73%~~ 27 24% (Comparable to the ~~2019~~ 2020 MEDICARE Quality Compass HEDIS 90th percentile, exclusions defined in QI Plan)	PACE participants with a diagnosis of Dementia will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams as well as the PACE pharmacist to develop strategies for improvement.	Quarterly	12/31/2022	PACE Clinical Medical Director
~~QI21.15~~ QI22.13	Improve the Quality of Care for Participants	Reduce Potentially Harmful Drug/Disease Interactions in the Elderly (DDE) Chronic Renal Failure + Nonaspirin NSAIDS or Cox2 Selective NSAIDs	~~<3 90%~~ 3.47% (Comparable to the ~~2019~~ 2020 MEDICARE Quality Compass HEDIS 90th percentile, exclusions defined in QI Plan)	PACE participants with a diagnosis of Chronic Renal Failure will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams as well as the PACE pharmacist to develop strategies for improvement.	Quarterly	12/31/2022	PACE Clinical Medical Director

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QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person
~~QI21.16~~ QI22.14	Ensure the Safety of Clinical Care	Decrease the Use of Opioids at High Dosage (UOD)	100% of members receiving opioids for 15 or more days at an average of 90 MME/day will be reevaluated monthly by their treating provider in 2022.	The PACE QI Department will monitor any participant who is receiving prescription opioids for ≥15 days at an average milligram morphine dose MME >90 MME/day	Quarterly	12/31/2022	PACE Clinical Medical Director
~~QI21.17~~ QI22.15	Improve the Quality of Care for Participants	Medication Reconciliation Post Discharge (MRP)	≥90% of participants will have their medications reconciled within ~~30~~ 15 days of hospital discharge in 2022	The PACE QI Department will work with the PACE Interdisciplinary Team, Pharmacist and Providers to develop strategies for improvement	Quarterly	12/31/2022	PACE Pharmacist and PACE Clinical Medical Director
~~QI21.18~~ QI22.16	Ensure Appropriate Access and Availability	Improve Access to Specialty Care	≥85% of specialty care authorizations will be scheduled within ~~10~~ 14 business days in 2022 (exclusions defined in QI Plan)	Appointments for specialty care will be scheduled within ~~10~~ 14 business days to improve access to specialty care for initial consultations	Quarterly	12/31/2022	PACE Clinical Operations Manager
~~QI21.19~~ QI22.17	Ensure Appropriate Access and Availability	Improve Access to PACE Care Increase Telehealth Engagement	≥~~65~~ 66% of members will be able to engage in telehealth visits	Increase the % of participants who are utilizing the telehealth platform.	Quarterly	12/31/2022	Community-Based Program Manager
~~QI21.21~~ QI22.18	Ensure Appropriate Use of Resources	Reduce Acute Hospital Day Utilization	<~~2957~~ 3,330 hospital days per 1000 per year	PACE participants hospital days will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education	Quarterly	12/31/2022	PACE Clinical Director
~~QI21.22~~ QI22.19	Ensure Appropriate Use of Resources	Reduce Emergency Room Utilization	<~~807~~ 850 emergency room visits per 1000 per year	ER utilization by PACE participants will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education	Quarterly	12/31/2022	PACE Clinical Director
~~QI21.23~~ QI22.20	Ensure Appropriate Use of Resources	30-Day All Cause Readmission Rates	<~~15~~ 14% 30-day all cause readmission	30-day all cause readmission rates for hospitalized PACE participants will be monitored and analyzed by the PACE QI department who will work with PACE interdisciplinary and clinical teams to find opportunities for quality improvement	Quarterly	12/31/202	PACE Clinical Director

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QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person
~~QI21.24 QI22.21~~	Ensure Appropriate Use of Resources	Long Term Care Placement	<4% of members will reside in long term care	PACE participants placed in long term care will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education	Quarterly	12/31/2022	PACE Center Manager
~~QI22.25~~	~~Improve Participant Experience~~	~~Enrollment/Disenrollment~~	~~The percentage of participants who disenroll for controllable reasons from the PACE program within the first 90 days of enrollment will be less than 6 5%~~	~~Review and analyze the participants who disenrolled from PACE within 90 days of enrollment, excluding deaths and withdrawals, to develop strategies for improvement~~	~~Quarterly~~	~~12/31/2022~~	~~PACE Marketing and Enrollment Manager~~
~~QI21.26 QI22.22~~	Improve Participant Experience	Enrollment/Disenrollment	Increase the Qualified Lead to Enrollment conversion rate to 60% in 2022	Review and analyze the Qualified Lead to Enrollment conversion rate and develop strategies for improvement.	Quarterly	12/31/2022	PACE Marketing and Enrollment Manager
~~QI21.27 QI22.23~~	Improve Participant Experience	Transportation	I00% of transportation trips will be less than 60 minutes in 2022	Ensure all PACE participants are on the vehicle for less than 60 minutes per trip. Monitor and analyze one-hour violations, define areas for improvement and implement interventions to maintain compliance with regulation	Quarterly	12/31/2022	PACE Center Manager
~~QI21.28 QI22.24~~	Improve Participant Experience	Transportation	≥92% of all transportation rides will be on-time in 2022	Review and analyze transportation records to track transportation rides with a scheduled and actual trip time of +/- 15 minutes. Validate reports with ride-along to ensure accuracy of reported times.	Quarterly	12/31/2022	PACE Center Manager
~~QI21.29 QI22.25~~	Improve Participant Experience	Transportation	≥92% on the Overall Satisfaction with Transportation Services - Weighted Average (2021 PACE National Average) on the 2022 PACE Satisfaction Survey	Review and analyze the annual satisfaction survey results, define areas for improvement and implement interventions to improve the participant and their families satisfaction with the PACE Transportation program	Quarterly	01/01/2022	PACE Center Manager
~~QI21.30 QI22.26~~	Improve Participant Experience	Increase Participant Satisfaction with Meals	≥71% on Satisfaction with Meals summary score (2020 PACE National Average) on the 2022 PACE Satisfaction Survey	Define areas for improvement and implement interventions to improve the participant and their families satisfaction with the meals within the PACE program.	Annually	12/31/2022	PACE Center Manager
~~QI21 31 QI22.27~~	Improve Participant Experience	Increase Overall Participant Satisfaction	≥88% on the Overall Satisfaction Weighted Average (2020 PACE National Average) on the 2022 PACE Satisfaction Survey	Review and analyze the annual satisfaction survey results, define areas for improvement and implement interventions to improve the participant and their families satisfaction with the PACE program	Annually	12/31/2022	PACE Director

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CALOPTIMA PROGRAM ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)
QUALITY IMPROVEMENT PLAN DESCRIPTION

2022

PACE Quality Improvement Subcommittee Chairperson:

Richard Helmer, M.D. **Date**
Medical Director, PACE

Board of Directors' Quality Assurance Committee Chairperson:

Trieu Tran, M.D. **Date**

Board of Directors Chairperson:

Andrew Do **Date**
Supervisor, First District

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INTRODUCTION

The Quality Improvement (QI) Plan Description at CalOptima's Program of All-Inclusive Care for the Elderly (PACE) is the data-driven assessment program that drives continuous QI for all the services at CalOptima PACE. It is designed and organized to support the mission, values, and goals of PACE.

Overview

- The goal of the CalOptima PACE QI Plan is to improve future performance through effective improvement activities, driven by identifying key objective performance measures, tracking them, and reliably reporting them to decision-making and care-giving staff.
- The CalOptima PACE QI Plan is developed by the PACE Quality Improvement Committee (PQIC). As CalOptima's governing body, the Board of Directors has the final authority to review and approve the QI Plan annually and direct the PACE Medical Director to revise the QI Plan, as necessary and appropriate. The PACE QI Plan is comprised of both the PACE QI Program Description and specific goals and objectives described in the PACE QI Work Plan. (See Appendix A).
- The PACE Medical Director has oversight and responsibility for implementation of the PACE QI Plan. The PACE QI Manager will ensure timely collection and completeness of data.
- The CalOptima PACE QI Committee (PQIC) will complete an annual evaluation of the approved QI Plan. This evaluation and analysis will help to find opportunities for quality improvement and will drive appropriate additions or revisions in the QI Plan to the goals and objectives for the following year.

Goals

- **Improve the quality of health care for participants.**
    - Ensure all QI activities fit into a well-integrated system that oversees quality of care and coordination of all services.
    - Ensure the QI program involves all providers of care within the PACE program.
    - Implement population health management (PHM) techniques, such as immunizations, for specific participant populations.
    - Identify and address areas for improvement that arise from unusual incidents, and sentinel events.
    - Monitor, analyze and report the aggregated data elements required by the Centers for Medicare & Medicaid Services (CMS) via the Health Plan Management System (HPMS) to identify areas needing quality improvement.
    - Communicate relevant QI activities and outcomes to the PACE staff and contractors, the PACE Member Advisory Committee (PMAC), and the Board of Directors.
    - Share results of QI identified benchmarks with staff and contracted providers at least annually.
    - Involve the physicians and other providers in establishing the most current, evidenced-based clinical guidelines to ensure standardization of care. Professional standards of CalOptima PACE staff will be measured against those outlined by their respective licensing agencies in the State of California (e.g. California Board of Nursing, etc.).

- Ensure that all levels of care are consistent with professionally recognized standards of practice.
- Assure compliance with regulatory requirements of all responsible agencies.

- **Improve the participant experience.**
    - Use the annual participant satisfaction survey, grievances and appeals, and feedback from participant committees to identify areas for improvement related to participant experience.
    - Provide education to staff on the multiple dimensions of patient experience.
    - Identify and implement ways to better engage participants in the PACE experience (e.g., menu selection and PMAC).
    - Evaluate customer service, access, and timeliness of care provided by contracted licensed providers.
    - Monitor and track transportation services in terms of on-time performance and trips less than 60 minutes in duration
    - Ensure participant's end of life wishes are discussed and documented in the Physician's Order for Life Sustaining Treatment (POLST) and in an Advanced Health Care Directives which honors members' wishes as well as advance directive rights.
- **Ensure the appropriate use of resources.**
    - Review and analyze utilization data regularly, including hospital admissions, Emergency Room (ER) visits, and hospital 30-day all-cause readmissions, to identify high-risk members and opportunities for improvement.
    - Review documentation and coordination of care for participants receiving care in institutional settings and investigate any potential infractions in the quality of care provided in these settings.
    - Ensure high levels of coordination and communication between specialists and primary care providers (PCPs).
    - Ensure high levels of coordination and communication between inpatient facilities, nursing facilities and PACE PCPs.
    - Review and analyze clinic medical records to ensure appropriate documentation and coding.
- **Ensure the safety of clinical care**
    - Reduce potential risks to safety and health of PACE participants through ongoing risk management.
    - Ensure that every member of the PACE staff organization has responsibility for risk assessment and management.
    - Monitor, report and perform a Root Cause Analysis on all participant-involved events resulting in a significant adverse outcome, for the purpose of identifying areas for quality improvement.
    - Monitor and track falls occurring in the PACE Day Center and in the home and within the community.
    - Monitor and track the use of opioids at high dosages.
    - Meet or exceed community standards for credentialing of licensed providers.
    - Monitor staff and contractors to ensure that appropriate standards of care are met.
- **Ensure appropriate access and availability.**
    - Monitor and analyze the PACE provider network continuously to ensure appropriate levels of access.
    - Monitor and analyze access to specialty care
    - Continue to develop the network of Alternate Care Setting (ACS) sites to ensure the program can provide services to all Orange County residents who qualify and are interested in joining the PACE program.

Organizational and Committee Structure

CalOptima Board of Directors provides oversight and direction to CalOptima PACE. The Board has the final authority to ensure that adequate resources are committed and that a culture is created that allows the QI Plan efforts to flourish. The Board, while maintaining ultimate authority, has delegated the duty of immediate oversight of the QI programs at CalOptima — including the CalOptima PACE QI Program — to the Board's Quality Assurance Committee (QAC), which performs the functions of CalOptima's Quality Improvement Committee (QIC) described in CalOptima's state and federal contracts, and to CalOptima's Chief Executive Officer who is responsible to allocate operational resources to fulfill quality objectives.

The QAC is a subcommittee of the Board and consists of currently active Board members. The QAC reviews the quality and utilization data that are discussed during the PQIC reports. The QAC provides progress reports, reviews the annual PACE QI Plan, and makes recommendations to the full Board regarding these items, which are ultimately approved by the Board.

PACE Quality Improvement Committee

Purpose
This committee provides oversight for the overall administrative and clinical operations of PACE and will meet, at a minimum, once a quarter. The PQIC will review all QI initiatives, review the results of monitoring activities, provide oversight for proposed changes to improve quality of service and review follow-up of all changes implemented. The PQIC may create Ad Hoc Focus Review Committees for limited time periods to address quality problems in any clinical or administrative process that have been identified as critical to participants, families or staff. Potential areas for improvement will be identified through analysis of the data and through root cause analysis. This meeting will be chaired by the PACE Medical Director who will report its activities up to QIC, QAC, and the Board. The PACE Clinical Medical Director, PACE Program Director or PACE QI Manager may facilitate the meeting in the PACE Medical Director's absence. The PACE Clinical Medical Director, PACE Program Director or the PACE QI Manager may report up to QAC if the PACE Medical Director is not available.

Membership
Membership shall be comprised of the PACE Medical Director, PACE Program Director, PACE Clinical Medical Director, PACE Center Manager, PACE Clinical Operations Manager, PACE QI Manager, PACE Program Manager, PACE QI Coordinator, Manager of Community-Based Programs, and PACE Intake/Enrollment Manager. At least four regular members shall constitute a quorum. The PACE Medical Director will act as the standing chair of the committee.

PACE Focused Review Committees

Purpose
These committees will be formed to respond to or to proactively address specific quality issues that rise to the level of warranting further study and action. Key performance elements are routinely reviewed by administrative staff as part of ongoing operations, including, but not limited to, deaths and other adverse outcomes, inpatient utilization and other clinical areas that indicate significant over/under utilization.

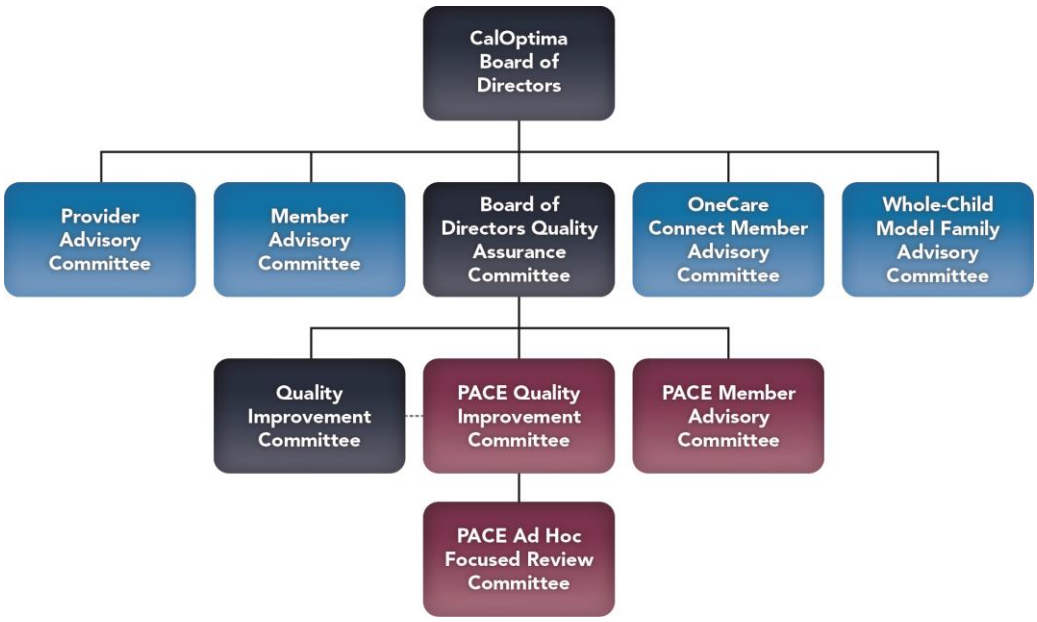
Membership
Membership will be flexible based on those with knowledge of the specific issues being addressed, but will consist of at least four members to include at least two of the following positions and/or functions: PACE Medical Director, PACE Clinical Medical Director, PACE QI Manager, PACE Program Director, PACE Center Manager, PACE Clinical Operations Manager, PACE Program Manager, PACE QI Coordinator, PACE Intake/Enrollment Manager or direct care staff. The Committee will be chaired by the PACE Medical Director, PACE Clinical Medical Director, PACE Director, PACE Manager or PACE QI Manager. The chair will report on activities and results to the PQIC. The committee will meet on an ad hoc basis as needed to review those critical indicators assigned to them by the PQIC.

PACE Member Advisory Committee

Purpose
PMAC provides recommendations to the Board on issues related to participant care concerns that arise with participant care decisions and program operations from a community perspective. A member of the PMAC shall report its activities to QAC, which then will be reported to the Board. The PACE Program Director or the PACE Center Manager shall report its activities to the PQIC.

Membership
The PMAC comprises representatives of participants, participants' families, and communities from which participants are referred. PMAC membership is open to all participants and/or caregivers and no application process is required. Information related to upcoming PMAC meetings is disseminated through announcements at the PACE Day Center floor and all interested participants are invited to join. Participants and representatives of participants shall constitute a majority of membership. The committee will be comprised of at least seven members. At least four regular members shall constitute a quorum. The PACE Program Director will act as the standing chair and will facilitate for the committee. The PACE Center Manager or PACE QI Manager may facilitate the meeting in the PACE Director's absence.

2022 Committee Organization Structure — Diagram



QUALITY AND PERFORMANCE IMPROVEMENT ACTIVITIES, OUTCOMES AND REPORTING

Quality Indicators and Opportunities for Improvement

Routine quality indicators appropriate to the PACE population are identified for analysis and trending. These indicators are related to the care and services provided at PACE. The indicators and opportunities for performance improvement are identified through:

Utilization of Services

- PACE will collect, analyze, and report any utilization data it deems necessary to evaluate both quality of care and fiscal well-being of the organization including:
    - Hospital Bed Days
    - ER Visits
    - 30-Day All-Cause Readmissions
    - Participants residing in Long-Term Care
- Data analysis will allow for analyzing both overutilization and underutilization for areas of quality improvement.

Participant and Caregiver Satisfaction

- PACE shall survey the participants and their caregivers on at least an annual basis. Additionally, PACE will look for other opportunities for feedback to improve quality of services.
- Due to the nature of the participants in PACE, caregiver feedback is an integral part of our data elements.
- The PMAC shall provide direct feedback on satisfaction to both the PACE leadership staff and QAC.
- Grievance data is reviewed and analyzed quarterly for trends and opportunities for improvement.
- PACE will monitor the percentage of participants who disenroll from the PACE program within 90 days for controllable reasons.

- The qualified lead to enrollment conversion rate will be monitored to ensure the program continues to have a smooth enrollment process.

Clinically Relevant HPMS Data

- Unusual Incidents
- Medication Errors
- Falls without Injury
- Clinical measures from the QI Work Plan elements which include:
    - Influenza Immunizations Rates
    - Pneumococcal Immunizations Rates
        - Exclusion criteria:
            - Participants who enrolled in the program in December 2021
    - COVID-19 Immunization Rates
        - Exclusion criteria:
            - Participants who enrolled in the program in December 2022
    - Infection Control: Respiratory Infection Rates
    - Advanced Health Care Planning: POLST Completion
    - Advance Health Care Planning: Advanced Health Care Directive Completion
    - Diabetes Care: Annual Eye Exams
        - The following inclusion and exclusion criteria will be in place for this measure:
            - Inclusion criteria:
                - Enrolled for at least six months during measurement year
            - Exclusion criteria:
                - Participants who are end of life (less than six months)
                - Participants who are 76 years and older as of December 31, 2021
    - Diabetes Care: Nephropathy Monitoring and Blood Pressure Control
        - The following inclusion and exclusion criteria will be in place for this measure:
            - Inclusion criteria:
                - Enrolled for at least six months during 2021
            - Exclusion criteria:
                - Participants who are end of life (less than six months)
                - Participants who are 76 years and older as of December 31, 2021
                - Participants with End Stage Renal Disease
    - Monitoring of treatment for Participants with Osteoporosis
    - Falls at Home Classified as CMS Reportable Quality Incidents
    - Potentially Harmful Drug-Disease Interactions in the Elderly: Dementia plus a tricyclic antidepressant or anticholinergic agent
        - The following inclusion and exclusion criteria will be in place for this measure:
            - Inclusion criteria:
                - Continuous enrollment throughout year
                - Participants who are 66 years and older as of December 31, 2021

                - Exclusion criteria:
                    - Participants who are end of life (less than six months)
                    - Participants with Schizophrenia or Bipolar Disorder
    - Potentially Harmful Drug-Disease Interactions in the Elderly: Chronic Kidney Disease plus Nonaspirin NSAIDS or Cox2 Selective NSAIDs
        - The following inclusion and exclusion criteria will be in place for this measure:
            - Inclusion criteria:
                - Continuous enrollment throughout year
                - Participants who are 66 years and older as of December 31, 2021
            - Exclusion criteria:
                - Participants who are end of life (less than six months)
    - Opioids at High Dosage Monitoring
    - Medication Reconciliation Post Discharge
    - Access to Specialty Care

Effectiveness and Safety of Staff-Provided and Contract-Provided Services

- This will be measured by participants' ability to achieve treatment goals as reviewed by the Interdisciplinary Team (IDT) with each reassessment, review of medical records, and success of infection control efforts.
- All clinical and certain non-clinical positions have competency profiles specific to their positions.
- Annual competency evaluations of PACE staff.
- PACE staff will monitor providers by methods such as review of providers' QI activities, medical record review, grievance investigations, observation of care and interviews.
- Unannounced visits to inpatient provider sites will be made by PACE staff, as necessary.
- Oversight of contracted Alternative Care Sites (ACS), assuring compliance to PACE regulations (including, but not limited to participant rights, infection control, emergency preparedness, staff competencies) as well as CalOptima guidelines (e.g. HIPAA, FWA, licensing, etc.).

Non-Clinical Areas

- The PACE PQIC has oversight to all activities offered by PACE.
- Member grievances will be forwarded to the PACE QI Department for investigation, tracking, trending, and data gathering. These results will be forwarded to the PACE Director for review and further direction on any corrective actions that may be implemented. Participants and caregivers will be informed of the results of the investigations, decisions and will be assisted with furtherment of the process as needed. Results will also be reported to the PQIC for direction on how appropriate staff should implement any corrective actions.
- Member appeals will be forwarded to the PACE QI Department for tracking, trending and data gathering and the PACE Director or PACE Medical Director for review. The case will then be forwarded to a third-party with the appropriate licensure for review. The third-party reviewer's decision shall be reviewed by either the PACE Director or the PACE Medical Director and will be immediately shared with the IDT who will inform caregivers and participants of the decision and assist them with furtherment of the process as needed.

- Continued integration of telehealth to expand access to care through the COVID-19 pandemic and beyond.
- Transportation services will continue to be monitored through monthly metrics and grievance trending. The monthly report generated by the transportation vendor will be reviewed at the monthly transportation leadership meeting and will be reported quarterly to the PQIC. The PACE QI department will monitor transportation services with periodic ride alongs. The times gathered during the ride alongs will be compared against the data in the transportation reports to ensure accuracy.
- Meal quality will be monitored through participant satisfaction surveys as well as comments solicited by the PMAC.
- Life safety will be monitored internally via quarterly fire drills and annual mock code and mock disaster drills, as well as regulatory agency inspections.
- Plans of correction on problems noted will be implemented by center staff, reviewed by the PACE Program Director, PACE Medical Director or the PACE QI Manager, and presented to the PQIC.
- The internal environment will be monitored through ongoing preventive maintenance of equipment and through repair of equipment or physical plant issues as they arise.

Priority Setting for Performance Improvement Initiatives

- Potential impact on quality of care, clinical outcomes, improved participant function and improved participant quality of life.
- Potential impact on participant access to necessary care or services.
- Potential impact on participant safety.
- Participant, caregiver, or other customer satisfaction.
- Potential impact on efficiency and cost-effectiveness.
- Potential mitigation of high risk, high volume, or high frequency events.
- Relevance to the mission and values of PACE.

External Monitoring and Reporting

PACE will report both aggregate and individual-level data to CMS and SAA to allow them to monitor PACE performance. This includes certain Unusual Quality Incidents (previously referred to as Level II Events), Health Outcomes Survey Modified (HOS-M) participation, and any other required reporting elements. Certain data elements are tracked in response to federal and state mandates and will be reported up through the PACE monitoring module of HPMS. The following data is reported to CMS via the HPMS on a quarterly basis:

- Grievances
- Appeals
- Unusual Incidents
- Medication Errors
- Immunizations
- Enrollment Data
- Denials of Prospective Enrollees
- Falls without Injury
- ER Visits

Unusual Quality Incidents

- When unusual incidents reach specified thresholds, PACE must notify CMS on a quarterly basis through HPMS. PACE must complete a Root Cause Analysis and present the results of the analysis on a conference call with both CMS and the Department of Health Care Services (DHCS) as well as internally at PQIC. The goal of this analysis is to identify systems failures and improvement opportunities. Examples of Unusual Quality Incidents include:
    - Deaths related to suicide or homicide, unexpected and with active coroner investigation.
    - Falls that result in death, a fracture or an injury requiring hospitalization related directly to the fall.
    - Infectious disease outbreak that meet the threshold of three or more cases linked to the same infectious agent within the same time frame.
    - Pressure injuries acquired while enrolled in PACE.
    - Traumatic injuries which result in death or hospitalization of five days or more or result in permanent loss of function.
    - Elopement by cognitively impaired participant
    - Adverse drug reactions
    - Foodborne outbreak
    - Burns 2nd degree or higher
    - COVID-19 infections
- HOS-M
    - PACE will participate in the annual HOS-M to assess the frailty of the population in our center.
- Other external reporting requirements
    - Suspected elder abuse shall be reported to appropriate state agency.
    - Equipment failure or serious adverse reaction to any administered medications will be reported to the Food and Drug Administration (FDA).
    - Any infectious disease outbreak will be reported to the Centers for Disease Control and Prevention (CDC) and the Orange County Health Care Agency.

Corrective Action Plans (CAP)

- When opportunities for improvement are identified, a corrective plan will be created.
- Each CAP will include an explanation of the problem, the individual who is responsible for implementing the CAP, the time frame for each step of the plan, and an evaluation process to determine effectiveness.
- CAPs from contracted providers will be requested by the QI Manager or another member of the PQIC, as appropriate.

Urgent Corrective Measures

- Problems that are found to threaten the immediate health and safety of participants or staff will be reported immediately to the PACE Medical Director and the PACE Director.
- The QI Manager or QI Coordinator will consult with relevant PACE staff and be responsible for developing an appropriate corrective plan within 24 hours of notification.
- Urgent corrective measures will be discussed during IDT morning meetings and, when appropriate, with participants.
- Disciplinary action and/or the use of appropriate community resources such as Adult Protective Services, notification and cooperation with law enforcement agencies, emergency placement of participants, etc. will be implemented immediately.

Re-Evaluation and Follow-Up

- Monitoring activities will be conducted to determine the effectiveness of plans of action. The timeliness of follow-up is dependent upon the following:
    - Severity of the problem
    - Frequency of occurrence
    - Impact of the problem on participant outcomes
    - Feasibility of implementation
- If follow-up shows the desired results have been achieved, the issue will be re-evaluated on a periodic basis to ensure continued improvement.
- If follow-up indicates that the desired results are not being achieved, then a more in-depth analysis of the problem and further determination of the source of variation are needed. A subcommittee of the PQIC or other workgroup may be established to address specific problems.
- All quality assessment and improvement steps and follow-up results will be shared with appropriate staff for discussion.

Quality Initiatives

- Quality Initiatives will be implemented as an adjunct to the PACE QI Plan. Quality Initiatives identify areas of improvement ultimately leading to enhanced clinical outcomes, appropriate changes in systems and overall participant satisfaction. PACE Quality Initiatives specify expected outcomes, strategies, and measurable interventions to meet our goals. The status of PACE Quality Initiatives is presented to the PQIC on a quarterly basis. The program's three quality initiatives in 2022 are:
    - COVID-19 Booster Vaccine Quality Initiative.
        - This initiative will focus on vaccine education, outreach, and vaccine distribution coordination with a goal of getting at least 80% of eligible participants their COVID-19 booster by the end of December 2022.
    - Telehealth Engagement Quality Initiative
        - This initiative will focus on accelerating the adoption and utilization of telehealth by the PACE participants. It will involve education, training and ensuring our participants have the hardware to utilize our telehealth services. The PACE Community Based Services Program Manager will implement a plan to increase prt telehealth access. The goal for 2022 is ≥ 66% or participants will have access to telehealth platforms such as VSEE.
    - Advance Health Care Directive
        - This initiative will focus on increasing the number of PACE participants who have a completed Advance Health Directive in their medical chart. The PACE leadership team has created a plan to be implemented by the PACE Center Manager and the Social Work team, with a goal of ≥ 50% of participants having a completed AHCD in 2022.

ANNUAL REVIEW OF PACE QI PLAN

- The PACE QI Plan will be assessed annually for effectiveness.

- Enhancements to the plan will be made through appropriate additions and revisions to the specific goals and objectives in the QI Work Plan.
- The Board will review and approve the PACE QI Plan and direct the PACE Medical Director to revise the QI Plan, as necessary and appropriate, to assure organizational oversight and commitment.

APPENDIX A (SEE ATTACHMENT)

2022 CalOptima PACE Quality Improvement (QI) Work Plan

QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person
QI22.01	Improve the Quality of Care for Participants	2021 PACE QAPI Plan and Work Plan Annual Evaluation	2021 PACE QAPI Plan will be evaluated by March 1st, 2022	PACE QAPI Plan and Work Plan will be evaluated for effectiveness on an annual basis	Annually	3/1/2022	PACE Medical Director
QI22.02	Improve the Quality of Care for Participants	2022 PACE QI Plan and Work Plan Annual Oversight	PACE QI Plan and Work Plan will be updated, reviewed and approved by March 1st, 2022	QI Plan and QI Work Plan will be approved and adopted on an annual basis	Annually	3/1/2022	PACE Medical Director
QI22.03	Improve the Quality of Care for Participants	Influenza Immunization Rates	≥94% of eligible participants will have their annual influenza vaccination by December 31st, 2022	Improve compliance with influenza immunization recommendations	Q1, Q3 and Q4 2022	12/31/2022	PACE Clinical Operations Manager
QI22.04	Improve the Quality of Care for Participants	Pneumococcal Immunization Rates	≥94% of eligible participants will have had their PCV23 pneumococcal vaccination by December 31st, 2022	Improve compliance with pneumococcal immunization recommendations (Exclusion: Participants who enroll in the PACE program in December 2022)	Quarterly	12/31/2022	PACE Clinical Operations Manager
QI22.05	Improve Quality of Care for Participants	COVID-19 Immunization Rates	≥95% of eligible participants will have had their COVID-19 vaccination by December 31st, 2022	Improve compliance with COVID-19 immunization recommendations (Exclusion: Participants who enroll in the PACE program in December 2022)	Quarterly	12/31/2022	PACE Clinical Operations Manager
QI22.06	Improve the Quality of Care for Participants	Advanced Care Planning: Physician's Orders for Life-Sustaining Treatment	≥95% of participants who have been enrolled in the PACE program for 6 months will have a POLST completed by December 31st, 2022	Ensure all PACE members are offered POLST upon enrollment and every six months until they have one completed in order to improve POLST ut lization.	Quarterly	12/31/2022	PACE Clinical Operations Manager and PACE C inical Medical Director
QI22.07	Improve the Quality of Care for Participants	Diabetes Care	>81.50% of Diabetics will have a Blood Pressure of <140/90 (Comparable to the 2020 MEDICARE Qua ity Compass HEDIS 95th percentile, exclusions defined in QI Plan)	PACE participants with diabetes will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams to develop strategies for improvement.	Quarterly	12/31/2022	PACE Clinical Medical Director
QI22.08	Improve the Quality of Care for Participants	Diabetes Care	> 82.77% of Diabetics will have an Annual Eye Exam (Comparable to the 2020 MEDICARE Qua ity Compass HEDIS 95th percentile, exclusions defined in QI Plan)	PACE participants with diabetes will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams to develop strategies for improvement.	Quarterly	12/31/2022	PACE Clinical Medical Director
QI22.09	Improve the Quality of Care for Participants	Diabetes Care	>98.30% of Diabetics will have Nephropathy Monitoring (Comparable to the 2020 MEDICARE Quality Compass HEDIS 95th percentile, exclusions defined in QI Plan)	PACE participants with diabetes will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams to develop strategies for improvement.	Quarterly	12/31/2022	PACE Clinical Medical Director
QI22.10	Improve the Quality of Care for Participants	Osteoporosis	>= 90% of participants with the diagnosis of Osteporosis will have treatment initiated by PCP	PACE participants with diagnosis of osteoporosis witll be managed by their PCP using appropriate therapy resulting in a decrease risk of fracture.	Quarterly	01/01/2022	PACE Clinical Medical Director
QI22.11	Ensure the Safety of Clinical Care	Falls at Home Clasified as CMS Reportable Quality Incidents	<= 207 Falls per 1000 per year	Falls with Injury will be mornitored by PACE QI department who will work with the interdiscip inary teams and clinical teams to develop strategies for improvement.	Quarterly	12/31/2022	PACE Center Manager

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QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person
QI22.12	Improve the Quality of Care for Participants	Reduce Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Dementia + tricyclic antidepressant or anticholinergic agents	<27.24% (Comparable to the 2020 MEDICARE Quality Compass HEDIS 90th percentile, exclusions defined in QI Plan)	PACE participants with a diagnosis of Dementia will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams as well as the PACE pharmacist to develop strategies for improvement.	Quarterly	12/31/2022	PACE Clinical Medical Director
QI22.13	Improve the Quality of Care for Participants	Reduce Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Chronic Renal Failure + Nonaspirin NSAIDS or Cox2 Selective NSAIDs	<3.47% (Comparable to the 2020 MEDICARE Quality Compass HEDIS 90th percentile, exclusions defined in QI Plan)	PACE participants with a diagnosis of Chronic Renal Failure will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams as well as the PACE pharmacist to develop strategies for improvement.	Quarterly	12/31/2022	PACE Clinical Medical Director
QI22.14	Ensure the Safety of Clinical Care	Decrease the Use of Opioids at High Dosage (UOD)	100% of members receiving opioids for 15 or more days at an average of 90 MME/day will be reevaluated monthly by their treating provider in 2022.	The PACE QI Department will monitor any participant who is receiving prescription opioids for ≥15 days at an average milligram morphine dose MME >90 MME/day	Quarterly	12/31/2022	PACE Clinical Medical Director
QI22.15	Improve the Quality of Care for Participants	Medication Reconciliation Post Discharge (MRP)	≥90% of participants will have their medications reconc led within 15 days of hospital discharge in 2022	The PACE QI Department will work with the PACE Interdisciplinary Team, Pharmacist and Providers to develop strategies for improvement	Quarterly	12/31/2022	PACE Pharmacist
QI22.16	Ensure Appropriate Access and Availability	Improve Access to Specialty Care	≥85% of specialty care authorizations will be scheduled within 14 business days in 2022 (exclusions defined in QI Plan)	Appointments for specialty care will be scheduled within 14 business days to improve access to specialty care for initial consultations	Quarterly	12/31/2022	PACE Clinical Operations Manager
QI22.17	Ensure Appropriate Access and Availability	Improve Access to PACE Care: Increase Telehealth Engagement	≥66% of members will be able to engage in telehealth visits	Increase the % of participants who are uti izing the telehealth platform.	Quarterly	12/31/2022	Community-Based Program Manager
QI22.18	Ensure Appropriate Use of Resources	Reduce Acute Hospital Day Utilization	<3,330 hospital days per 1000 per year	PACE participants hospital days will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education	Quarterly	12/31/2022	PACE Clinical Director
QI22.19	Ensure Appropriate Use of Resources	Reduce Emergency Room Utilization	<850 emergency room visits per 1000 per year	ER utilization by PACE participants will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education	Quarterly	12/31/2022	PACE Clinical Director

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QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person
QI22.20	Ensure Appropriate Use of Resources	**30-Day All Cause Readmission Rates**	<14% 30-day all cause readmission	30-day all cause readmission rates for hospitalized PACE participants will be monitored and analyzed by the PACE QI department who will work with PACE interdisciplinary and clinical teams to find opportunities for quality improvement	Quarterly	12/31/202	PACE Clinical Director
QI22.21	Ensure Appropriate Use of Resources	**Long Term Care Placement**	<4% of members will reside in long term care	PACE participants placed in long term care will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education	Quarterly	12/31/2022	PACE Center Manager
QI22.22	Improve Participant Experience	**Enrollment/Disenrollment**	Increase the Qualified Lead to Enrollment conversion rate to 60% in 2022	Review and analyze the Qualified Lead to Enrollment conversion rate and develop strategies for improvement.	Quarterly	12/31/2022	PACE Marketing and Enrollment Manager
QI22.23	Improve Participant Experience	**Transportation**	l00% of transportation trips will be less than 60 minutes in 2022	Ensure all PACE participants are on the vehicle for less than 60 minutes per trip. Monitor and analyze one-hour violations, define areas for improvement and implement interventions to maintain compliance with regulation	Quarterly	12/31/2022	PACE Center Manager
QI22.24	Improve Participant Experience	**Transportation**	≥92% of all transportation rides will be on-time in 2022	Review and analyze transportation records to track transportation rides with a scheduled and actual trip time of +/- 15 minutes. Validate reports with ride-along to ensure accuracy of reported times.	Quarterly	12/31/2022	PACE Center Manager
QI22.25	Improve Participant Experience	**Transportation**	≥92% on the Overall Satisfaction with Transportation Services - Weighted Average (2021 PACE National Average) on the 2022 PACE Satisfaction Survey	Review and analyze the annual satisfaction survey results, define areas for improvement and implement interventions to improve the participant and their families satisfaction with the PACE Transportation program	Quarterly	12/31/2022	PACE Center Manager
QI22.26	Improve Participant Experience	**Increase Participant Satisfaction with Meals**	≥71% on Satisfaction with Meals summary score (2020 PACE National Average) on the 2022 PACE Satisfaction Survey	Define areas for improvement and implement interventions to improve the participant and their families satisfaction with the meals within the PACE program.	Annually	12/31/2022	PACE Center Manager
QI22.27	Improve Participant Experience	**Increase Overall Participant Satisfaction**	≥88% on the Overall Satisfaction Weighted Average (2020 PACE National Average) on the 2022 PACE Satisfaction Survey	Review and analyze the annual satisfaction survey results, define areas for improvement and implement interventions to improve the participant and their families satisfaction with the PACE program	Annually	12/31/2022	PACE Director

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PACE

CalOptima

A Public Agency

Better. Together.

2021 PACE Quality Improvement (QI) Workplan Evaluation and 2022 Workplan

Quality Assurance Committee
March 9, 2022

Monica Macias
PACE Director

2021 PACE Accomplishments

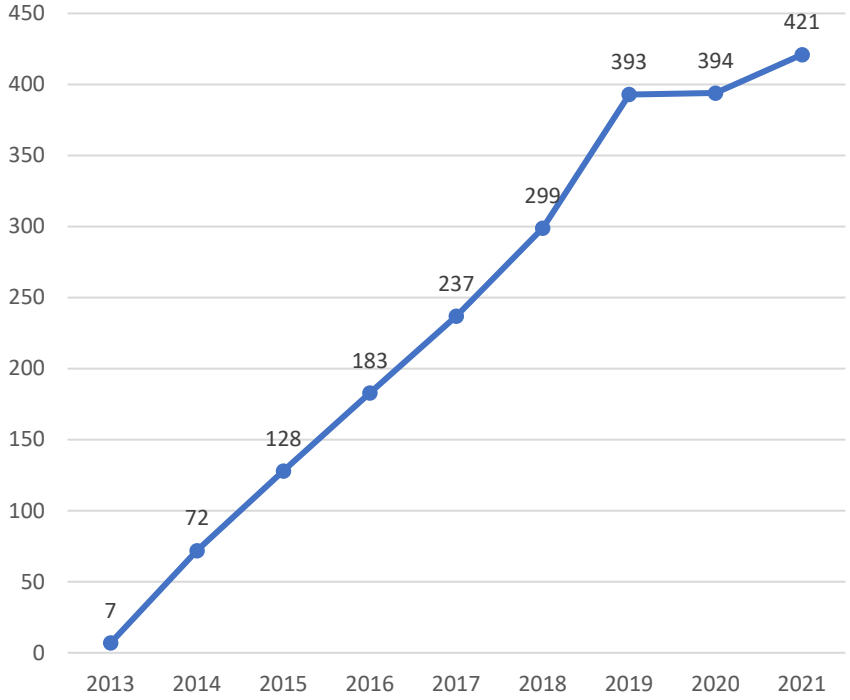
- Swift response to updated regulation regarding the COVID-19 pandemic, to follow all federal, state, and local guidance.
- Only 2.8% of participants resided in Long-Term Care
- 94% pneumococcal immunization rate
- 91% influenza immunization rate
- 96% COVID-19 immunization rate
- Quality of Diabetes Care
  - 95% had annual eye exam completed
  - 100% had nephropathy monitoring
  - 89% had blood pressure controlled

2021 PACE Accomplishments

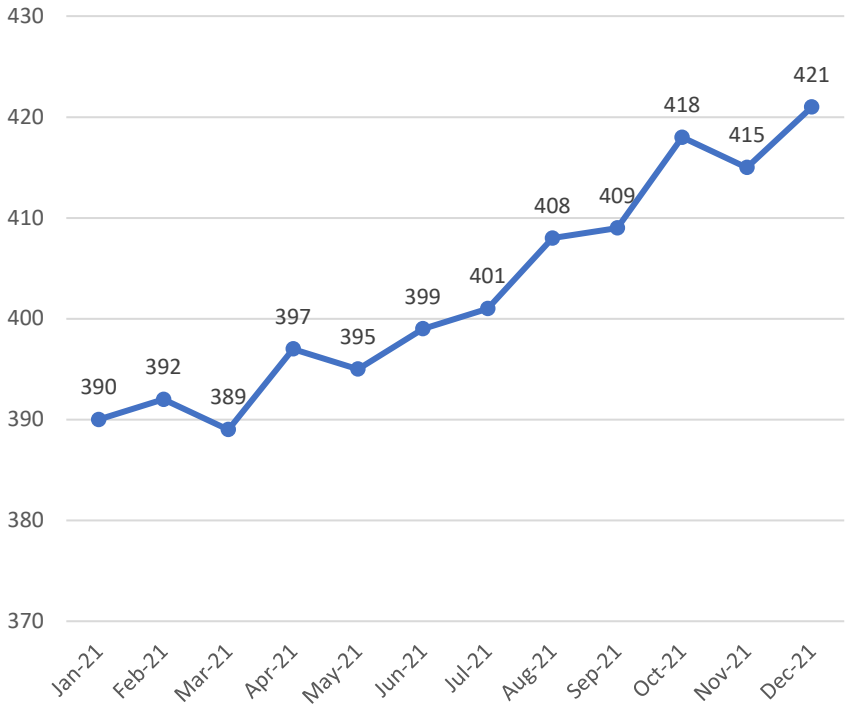
- 100% medication reconciliation rate following a hospital discharge
- 91% of participants had a Physician's Order for Life-sustaining Treatment (POLST) completed
- Transportation with 30,696 one-way trips with an on-time performance of 99%
- Overall participant satisfaction score of 91% compared to national average of 88.5%
- Met 25 of 29 work plan element goals

PACE Membership Growth 2013-2021

Total Membership since 2013



2021 Monthly Membership
Jan 2021-Dec 2021



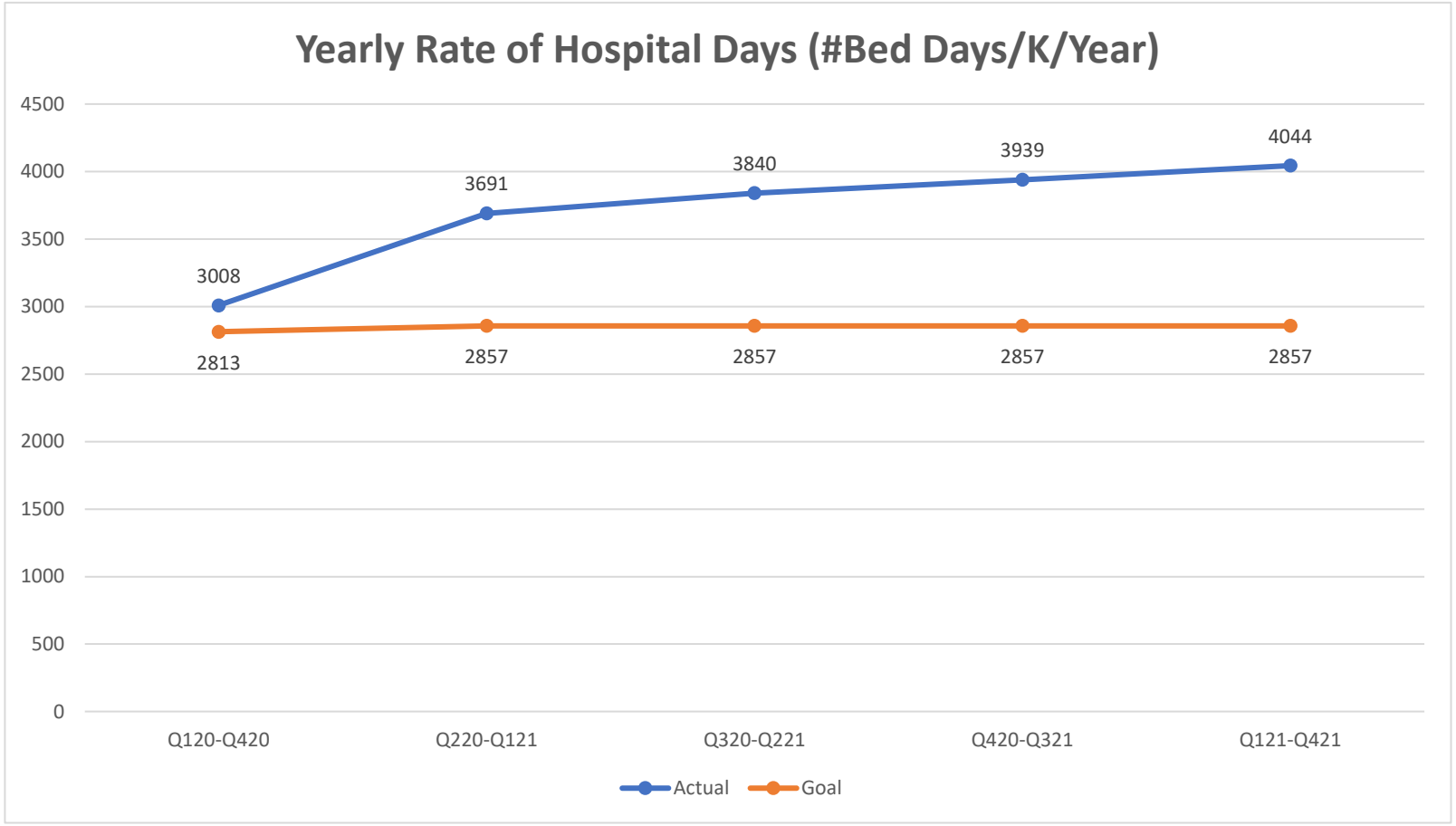
Elements 8-10: Comprehensive Diabetes Care

Higher Is Better		Medicare Quality Compass 2019 HEDIS Percentiles			
Domain	**2021 PACE Rate**	50th Percentile	75th Percentile	**90th Percentile**	**95th Percentile**
Annual Diabetic Eye Exams	**95%**	75.28%	82%	85.33%	**87.10%**
Nephropathy Monitoring	**100%**	95.95%	97.08%	98.30%	**98.78%**
Blood Pressure Control	**89%**	69.53%	76.56%	81.50%	**84.91%**

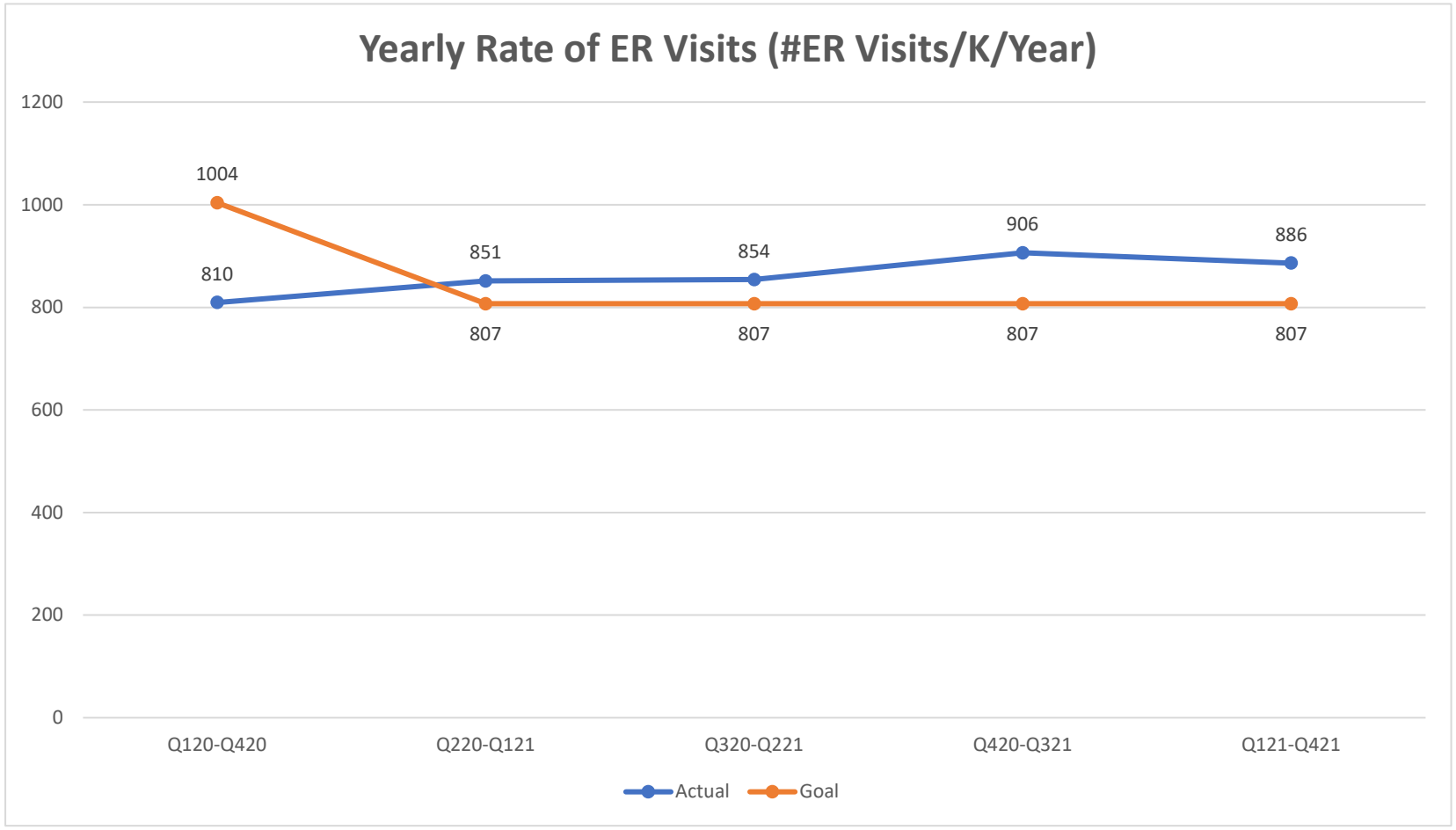
Elements 12–13: Potential Harmful Drug/Disease Interactions in the Elderly

Lower Is Better		Medicare Quality Compass 2019 HEDIS Percentiles			
Domain	**2021 PACE Rate**	50th Percentile	75th Percentile	90th Percentile	**95th Percentile**
Dementia + Tricyclic Antidepressants or anticholinergic Agents	**17%**	44.44%	40%	35.73	**33.96%**
Chronic Renal Failure + NSAID	**0%**	9.31%	6.36%	3.90%	**2.47%**

Element 17: Hospital Bed Days (Goal: <2857 Bed Days/K/Year)



Element 18: ER Visits (Goal: <807 ER Visits/K/Year)



Element 25: Annual Participant Satisfaction Survey Results (Goal: 88% on Overall Weighted Score)

Domain	2020 CalOptima PACE	2021 CalOptima PACE	2021 National PACE Average
Transportation	95%	96%	93.6%
Center Aids	96%	95%	91.2%
Home Care	90%	90%	86.2%
Medical Care	91%	93%	90.1%
Health Care Specialist	87%	88%	89.1%
Social Worker	93%	97%	94.5%
Meals	78%	80%	70.8%
Rehabilitation Therapy and Exercise	87%	91%	93.1%
Recreational Therapy	85%	81%	79.0%
General Service Delivery	85%	92%	86.9%
Overall Weighted Score	89%	91%	88.5%

Opportunities for Improvement in 2022

- Quality and Safety of Clinical Care
  - Add COVID-19 booster related quality initiative for 2022
  - Monitor participants with Osteoporosis diagnosis to ensure that they are receiving treatment to prevent fractures.
- Ensure Appropriate Access and Availability
  - Continued use of the PACE telehealth program
  - Reopening of the PACE day center based on safety
- Ensure the Appropriate Use of Resources
  - Continue the Emergency Room Diversion program
  - Increase the number of PACE core specialists willing to work closely with the PACE program

2022 PACE Quality Improvement (QI) Program Description

- Encompasses all clinical care, clinical services and organizational services provided to our participants
- Aligns with our vision and mission
- Focuses on optimal health outcomes for our participants
- Uses evidence-based guidelines, data and best practices tailored to our populations
- Updated to address the COVID-19 pandemic, including three 2022 quality initiatives

2022 PACE QI Work Plan Goals

- Improve the Quality of Care for Participants
- Ensure the Safety of Clinical Care
- Ensure Appropriate Access and Availability
- Ensure Appropriate Use of Resources
- Improve Participant Experience
- Additional Focus on COVID-19

2022 PACE QI Work Plan Elements Removed, Added and Modified

- Removed:
  - *Infection Control: Respiratory Rates*. Consistently above benchmark
  - *Care for Older Adults (COA): Functional Status Assessment.* Consistently at 100% and this is tracked elsewhere as a regulatory issue.
  - *Advanced Care Planning: Advance Health Care Directive*. This will now be a **Quality Initiative** for 2022
  - *Enrollment/Disenrollment: Disenroll for controllable reasons from the PACE program within the first 90 days of enrollment will be less than 6.5%.* Consistently above benchmark. Will continue to monitor as an operational issue.

2022 PACE QI Work Plan Elements Removed, Added and Modified Cont.

- Added a new Quality Element
    1. Monitoring of participants with diagnosis of Osteoporosis to ensure appropriate management of disease. >= 90% of participants with the diagnosis of Osteoporosis will have treatment initiated by PCP
- Modified Falls Element
    1. Changed Falls related element to focus on prevention of Falls with Injury
- Total of 27 QI Work Plan Goals in 2022

2022 Quality Initiatives

- COVID-19 Vaccine Booster Quality Initiative:
  - Goal of getting at least 80% of eligible participants their COVID-19 booster by the end of December 2022.
- Telehealth Engagement Quality Initiative
  - The goal for 2022 is ≥ 66% or participants will have access to telehealth platforms such as VSEE.
- Advance Health Care Directive
  - The goal for 2022 is ≥ 50% of participants having a completed AHCD in 2022.

Recommended Action

- Recommend approval of the 2022 CalOptima Program of All-Inclusive Care for the Elderly (PACE) Quality Improvement Plan Description

Our Mission

To provide members with access to quality health care services delivered in a cost-effective and compassionate manner

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 7, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

8. Ratify Amendments to Contract with Newmark Knight Frank

Contacts

Michael Hunn, Chief Executive Officer, (657) 900-1481
Nancy Huang, Chief Financial Officer, (657) 235-6935

Recommended Action

1. Ratify amendments to contract with Newmark Knight Frank and authorize unbudgeted expenditures in an amount not to exceed $50,000 from existing reserves for additional real estate services.

Background/Discussion

At its February 6, 2020, meeting, the CalOptima Board of Directors authorized entering into an agreement with Newmark Knight Frank for real estate related services. These services addressed the following: status of the office space and parking capacity at the 505 Building, the PACE lease renewal and the potential value and uses of the Development Agreement.

At its December 20, 2021, special meeting, the Board authorized amending the current agreement with Newmark Knight Frank for expenditures estimated up to $50,000 to complete transactions leading up to a purchase and sale agreement for the Board's consideration.

At this time, Staff requests the Board to ratify the contract amendments with Newmark Knight Frank.

Fiscal Impact

The recommended action is unbudgeted. An allocation of up to $50,000 from existing reserves will fund the recommended action.

Rationale for Recommendation

The recommendation will allow CalOptima continued support for immediate and long-term planning solution for ongoing space and parking issues around 505 City Parkway West Building.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Entities Covered by this Recommended Board Action
2. Contract Amendment No. 2 with Newmark Knight Frank
3. Contract Amendment No. 3 with Newmark Knight Frank

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Board Action(s)

Board Meeting Dates	Action	Term	Not to Exceed Amount
February 6, 2020	Authorize contract with Newmark Knight Frank	Through February 28, 2023	Per contracted commissions schedule

/s/ Michael Hunn — *03/31/2022*
Authorized Signature — **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

CalOptima Medi-Cal Health Networks				
Name	**Address**	**City**	**State**	**Zip Code**
Newmark Knight Frank	700 South Flower Street, Suite 2500	Los Angeles	CA	90017

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AMENDMENT NO. 2 TO CONTRACT 20-10931
BETWEEN
ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY,
DBACALOPTIMA
AND
NEWMARK OF SOUTHERN CALIFORNIA, INC., A CALIFORNIA CORPORATION
DBA NEWMARK KNIGHT FRANK (CONTRACTOR)

AMENDMENT NO. 2 TO THIS CONTRACT is entered into as of the date last executed below, with respect to the following facts:

A. CalOptima and CONTRACTOR (hereinafter collectively referred to as "the Parties") entered into Contract 20-10931 on March 9th, 2020 and as amended in Amendment No. 1 on June 30, 2021, under which agreed to provide Real Estate Advisory & Brokerage Services (hereinafter, "Contract").

B. Pursuant to Article 17 of the Contract, the Contract may be amended only in writing and executed by the parties.

C. The Parties now desire to amend the Contract to extend the term and add pricing for Third Party Reports.

NOW, THEREFORE, THE PARTIES AGREE AS FOLLOWS:

1. Extend the term of the contract through February 28, 2023.

2. Third Party Reports. CalOptima hereby authorizes CONTRACTOR to order the third-party reports listed below for the due diligence associated with the potential acquisition of 500 City Parkway, Orange, CA. CONTRACTOR will use commercially reasonable efforts to obtain industry standard reports from third party vendors that have been deemed reliable, however, CONTRACTOR is not responsible for their timely deliver and/or reliability of the content of those reports. Upon delivery of the reports to CalOptima, payment to Contractor shall be made pursuant to Exhibit B-1 (C.) of the Contract.

REPORT	VENDOR	ESTIMATED TIME TO COMPLETE	ESTIMATED COST
Property Condition Report-Equity, Acquisition - Supplemental Reports: MEP-FLS Roofing Inspection	Partner Engineering & Science, Inc.	30 Days	$4,000 $5,500 $2,000
Phase I Environmental Site Assessment	Partner Engineering & Science, Inc.	30 Days	$2,500
ALTA Survey	Huitt-Zollars, Inc.	30 Days	$7,500
Appraisal (3 options)	CBRE	3 Options	• 7 Business Days (after the commencement date) $20,000 • 13 Business Days (after the commencement date) $15,000 • 20 Business Days (after the commencement date) $7,500
		TOTAL:	$41,500.00 (w/ 7 Business Day Appraisal)
		TOTAL:	$36,500.00 (w/13 Business Day Appraisal
		TOTAL:	$29,000.00 (w/20 Business Day Appraisal

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3. No Other Changes. This Amendment No. 2 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. 2 shall in all respect govern and control. Unless otherwise specifically defined herein, terms used in this Amendment shall have the same meaning as ascribed to them in the Contract. The execution and delivery of this Amendment shall have the same meaning as ascribed to them in the Contract. The execution and delivery of this Amendment shall not operate as a waiver of or, except as expressly set forth herein, an amendment of any right, power or remedy of either party in effect prior to the date hereof.

IN WITNESS THEREOF, these Parties have, by their duly authorized representatives, executed thisAmendment on the day and year last shown below.

"CALOPTIMA"

Date: 12/28/2021

DocuSigned by:
Nancy Huang
D22E3B87032946F...

By: Nancy Huang

Its: CFO

Date: 12/28/2021

DocuSigned by:
Michael Hunn
EDDDDCC19C894FB...

By: Michael Hunn

Its: Interim CEO

Date: 12/27/2021

"CONTRACTOR"

DocuSigned by:
06F51BD4A6D6460...

By: Gregory P. May

Its: EVP, Regional Managing Director
CA #00946118
18401 Von Karman Ave., Suite 150
Irvine, CA 92612

AMENDMENT NO. 3 TO CONTRACT 20-10931
BETWEEN
ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY,
DBACALOPTIMA
AND
NEWMARK OF SOUTHERN CALIFORNIA, INC., A CALIFORNIA CORPORATION
DBA NEWMARK KNIGHT FRANK (CONTRACTOR)

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 CONTRACTOR (hereinafter collectively referred to as "the Parties") entered into Contract 20-10931 on March 9th, 2020, Amendment No. 1 on June 30, 2021 and Amendment No.2 on December 28,2021, under which agreed to provide Real Estate Advisory & Brokerage Services (hereinafter,"Contract").

B. Pursuant to Article 17 of the Contract, the Contract may be amended only in writing and executed by the parties.

C. The Parties now desire to amend the Exhibit on Amendment No. 2.

NOW, THEREFORE, THE PARTIES AGREE AS FOLLOWS:

1. Remove Exhibit B-1 (C). Upon delivery of the reports to CalOptima, payment to Contractor shall be made pursuant to Exhibit B (C) of the Contract.

2. No Other Changes. This Amendment No. 3 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.3 shall in all respect govern and control. Unless otherwise specifically defined herein, terms used in this Amendment shall have the same meaning as ascribed to them in the Contract. The execution and delivery of this Amendment shall have the same meaning as ascribed to them in the Contract. The execution and delivery of this Amendment shall not operate as a waiver of or, except as expressly set forth herein, an amendment of any right, power or remedy of either party in effect prior to the date hereof.

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IN WITNESS THEREOF, these Parties have, by their duly authorized representatives, executed thisAmendment on the day and year last shown below.

"CALOPTIMA"

Date: 01/19/2022

DocuSigned by:
Nancy Huang
D22E3B87032946F...

By: Nancy Huang

Its: CFO, CalOptima

Date: 01/19/2022

DocuSigned by:
Michael Hunn
EDDDDCC19C894FB...

By: Michael Hunn

Its: Interim CEO

Date: January 18, 2022

"CONTRACTOR"

DocuSigned by:
06F51BD4A6D6460...

By: Gregory P. May

Its: EVP, Regional Managing Director
CA #00946118
18401 Von Karman Ave., Suite 150
Irvine, CA 92612

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to be Taken April 7, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar
9. Retire Policies GG.1331 and GG.1350 for the Health Homes Program.

Contact
Kelly Giardina, MSG, CCM, Executive Director, Clinical Operations, (657) 900-1013

Recommended Actions
Recommend retiring two (2) Medical Affairs Health Homes Program (HHP) policies.

Background
On December 31, 2021, the Department of Health Care Services (DHCS) concluded the Health Homes Program (HHP), which was designed to serve eligible Medi-Cal beneficiaries with complex medical needs and chronic conditions. These HHP members have transitioned to the California Advancing and Innovating Medi-Cal (CalAIM) program on January 1, 2022.

Discussion
CalOptima has concluded the Health Homes Program and therefore retiring the policies related to this program.

Below are the two (2) Medical Management policies that will be retired.
1. Policy GG.1331 Health Homes Program (HHP) Services and Care Management
2. Policy GG.1350 Health Homes Program (HHP) Member Eligibility

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
The Health Homes Program has concluded on 12/31/21.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. CalOptima Policy GG.1331 Health Homes Program (HHP) Services and Care Management
2. CalOptima Policy GG.1350: Health Homes Program (HHP) Member Eligibility

/s/ Michael Hunn *03/31/2022*
Authorized Signature **Date**

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Policy:	GG.1350
Title:	**Health Homes Program (HHP) Member Eligibility**
Department:	Medical Management
Section:	Case Management
CEO Approval:	*/s/*
Effective Date:	01/01/2020
Revised Date:	TBD
Program Sunset:	12/31/2021

I. PURPOSE

This policy describes the process to identify Member eligibility for and prioritization for the CalOptima Health Homes Program (HHP).

II. POLICY

A. CalOptima shall implement the HHP in two (2) phases, as prescribed by the Department of Health Care Services (DHCS):

1. No sooner than January 1, 2020: For HHP Members with eligible chronic physical conditions and substance use disorders; and

2. No sooner than July 1, 2020: For HHP Members with eligible serious mental illness conditions.

B. CalOptima shall conduct targeted, progressive outreach during the first eighteen (18) months after the implementation of the HHP in accordance with CalOptima Policy GG.1331: Health Homes Program (HHP) Services and Care Management

1. CalOptima shall evaluate and finalize the list of Members meeting HHP eligibility criteria for engagement activities by analyzing the Targeted Engagement List (TEL), as provided by DHCS, incorporating Member data from CalOptima's data warehouse to develop a Finalized Engagement List (FEL).

   a. CalOptima and Community Based Care Management Entities (CB-CMEs) will coordinate to ensure that Members who meet exclusionary criteria are excluded or disenrolled from the HHP pursuant to the HHP Program Guide and Sections III.A.1.b. and c. of this Policy.

   b. CalOptima shall prioritize HHP-eligible Members to identify those Members most likely to benefit from the HHP and who present the greatest opportunity for improvement in care management and reduction in avoidable utilization. CalOptima shall make available a specific FEL identifying HHP-eligible Members to each CB-CME for their assigned Members. CalOptima will update the FEL at least every six (6) months upon receipt of the TEL from DHCS.

C. CalOptima shall provide training prior to administration of the HHP as well as ongoing training to participating CB-CME care management staff members. Training shall encompass HHP program overview, Health Action Plans (HAP), care coordination, and care transitions within the HHP, community resources and referrals, as well as operational and condition-specific trainings. In

addition, CalOptima will provide training on special populations, social determinants of health, motivational interviewing, trauma-informed care, health literacy assessment, and information sharing.

D. CalOptima and CB-CMEs shall conduct outreach, engagement and care coordination activities for HHP-eligible Members in accordance with CalOptima Policy GG.1331: Health Homes Program Services and Care Management.

E. CalOptima shall conduct oversight of the CB-CMEs to ensure that the CB-CMEs have implemented and continuously meet the HHP requirements, policies and operational processes, including outreach, engagement, and care management functions. CalOptima shall provide regular feedback and reporting of oversight results as described in CalOptima Policy GG.1331: Health Homes Program (HHP) Services and Care Management.

F. CalOptima and CB-CMEs shall use medical management and data warehouse systems to:

1. Record HHP-eligible Members referrals to HHP; and

2. Record outreach attempts and Member decisions regarding enrolling in HHP.

G. CalOptima and CB-CMEs shall ensure compliance with all applicable State and federal requirements related to HHP and all HHP requirements determined by DHCS, including but not limited to DHCS All Plan Letter (APL) 18-012: Health Homes Program Requirements and the HHP Program Guide.

III. PROCEDURE

A. Eligibility

1. To be eligible for HHP, a CalOptima Member must be full-scope Medi-Cal, have no share of cost, meet the following eligibility criteria in subsection a. below and not be excluded per the criteria in subsection b. below:

a. HHP Member eligibility criteria:

i. Chronic condition criteria: Member must meet at least one (1) condition category below:

a) At least two (2) of the following: chronic obstructive pulmonary disease, diabetes, traumatic brain injury, chronic or congestive heart failure, coronary artery disease, chronic kidney disease, chronic liver disease, dementia, or substance use disorders; or

b) Hypertension, and one (1) of the following: chronic obstructive pulmonary disease, diabetes, coronary artery disease, or chronic or congestive heart failure; or

c) Asthma; or

d) One (1) of the following: major depression disorders, bipolar disorder, or psychotic disorders (including schizophrenia).

ii. Acuity criteria: Member meets at least one (1) acuity criteria below:

a) Has three (3) or more of the HHP-eligible chronic conditions; or

b) Has at least one inpatient hospital stay in the last year; or

c) Has visited the emergency department three (3) or more times in the last year; or

d) Is Chronically Homeless.

b. HHP Member eligibility exclusions:

i. Members meeting the following criteria shall be excluded from the HHP and, if enrolled, must be disenrolled:

a) Members determined through further assessment to be sufficiently Well-Managed through self-management or through another program, or the Member is otherwise determined not to fit the high-risk eligibility criteria;

b) Members whose condition management cannot be improved because the Member is uncooperative;

c) Members whose behavior or environment is unsafe for CB-CME staff; or

d) Members determined to be more appropriate for an alternate care management program.

ii. CalOptima shall screen Members to ensure that Members participating in any of the following programs are excluded from th FEL as these Members cannot participate in HHP:

a) Skilled Nursing Facil ty res dents with a duration of stay longer than the month of admission and the following month; or

b) Hospice recipients.

iii. CalOptima and the CB-CME shall screen Members to ensure non-duplication of care coordination services by allowing Members who are enrolled in any of the following programs to choose whether to enroll in HHP or continue with their current services:

a) County-operated Targeted Case Management (TCM), excluding Specialty Mental Health TCM; or,

b) 1915(c) Home and Community Based Services (HCBS) Waiver programs: HIV/AIDS, Assisted Living Waiver (ALW), Developmentally Disabled (DD), In-Home Operations (IHO), Multipurpose Senior Services Program (MSSP), and Nursing Facility Acute Hospital (NF/AH); or,

c) Program of All-Inclusive Care for the Elderly (PACE); or

d) Cal Medi-Connect/OneCare Connect.

c. Disenrollment

i. If an HHP-eligible Member has or develops a condition that excludes him or her from HHP, or the Member cannot be engaged by CalOptima or the CB-CME within a specified period, or chooses not to participate, or fails to participate actively in HHP planning and coordination, CalOptima or the CB-CME will disenroll the HHP-eligible Member from the HHP.

ii. If determined by CalOptima or CB-CME that the Member's eligible chronic conditions have become Well-Managed to the extent that HHP services are not medically necessary and will not significantly change the Member's health status, CalOptima or CB-CME will disenroll the Member from HHP.

iii. CalOptima Direct or CB-CME shall send a Notice of Action (NOA) for Members disenrolled involuntarily from HHP. The requirement to send an NOA shall not apply in instances when an HHP-eligible Member chooses or agrees not to participate in HHP. An HHP-eligible Member who declines participation in HHP may later choose to participate in the HHP.

d. For Members who choose not to participate in HHP, CalOptima or a CB-CME shall close the Member's case in the HHP and offer the Member additional alternative care management services or referrals, as appropriate.

e. Members enrolled in Whole Person Care (WPC) may participate in HHP; however, there are services, such as care coordination, that can be provided only under HHP.

f. Members who are dually eligible or have End-Stage Renal Disease (ESRD) or are enrolled in a specific program such as California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), Specialty Mental Health or Drug Medi-Cal can be referred to HHP and receive services through both HHP and their current program. CalOptima shall exclude these Members from the FEL.

g. Members meeting HHP eligibility requirements must consent to HHP in order to participate. Consent may be oral or in writing and will be documented by CalOptima's and CB-CME's Customer Service staff or HHP Care Team staff prior to Member participation in HHP.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services
B. CalOptima Policy GG.1206: Readability and Suitability of Written Health Education Materials
C. CalOptima Policy GG.1331 Health Homes Program Services and Care Management
D. Welfare and Institutions Code §§ 14127-14128
E. Health and Safety Code §§ 50675.2 and 50675.14
F. Department of Health Care Services All Plan Letter 18-012: Health Homes Program Requirements
G. Department of Health Care Services Medi-Cal Health Homes Program Guide (11/01/2019)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
03/04/2020	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
11/15/2019	Regular Meeting of the CalOptima Finance and Audit Committee
12/05/2019	Regular Meeting of the CalOptima Board of Directors

Date	Meeting
TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2020	GG.1350	Health Homes Program (HHP) Member Eligibility	Medi-Cal
Program Sunset	12/31/2021	GG.1350	Health Homes Program (HHP) Member Eligibility	Medi-Cal
RETIRED	TBD	GG.1350	Health Homes Program (HHP) Member Eligibility	Medi-Cal

IX. GLOSSARY

Term	Definition
Chronically Homeless Member	A Member with a condition limiting the activities of daily living and who has been continually Homeless for one (1) year or more or had at least four (4) episodes of homelessness in the past three (3) years. For the purposes of this policy, a Member who is currently residing in transitional housing (as defined in Health and Safety Code Section 50675.2) or who has been residing in permanent supportive housing (as defined in Health and Safety Code Section 50675.14) for less than two (2) years shall also be considered Chronically Homeless if the Member was Chronically Homeless prior to residence.
Community Based-Care Management Entities (CB-CME)	Providers within the community that have a contractual relationship with a CalOptima, or CalOptima acting directly, to provide HHP services to HHP Members.
Finalized Engagement List (FEL)	The list created from the DHCS TEL combined with CalOptima Member data after removal of members who meet data-based identifiable exclusion criteria. The FEL is prioritized for Member engagement activities and provided to CalOptima's CB-CMEs.
Health Action Plan (HAP)	A comprehensive individualized care plan with the inclusion of any elements specific to HHP.
Health Homes Program (HHP)	All of the California Medicaid State Plan amendments and relevant waivers that DHCS seeks and CMS approves for the provision of HHP services that provide supplemental services to HHP eligible and enrolled Members coordinating the full range of physical health, behavioral health, and community-based LTSS needed for chronic conditions.
HHP Care Team	The HHP Care Team includes Care Coordinators, a CB-CME HHP Director, Clinical Consultants, a housing navigator (for HHP enrolled members experiencing homelessness), and community health workers (recommended, but not required).
HHP Member	A Member that is enrolled, and continuously participating in, CalOptima Health Homes Program, and assigned to a Health Network or CalOptima Direct.
Homeless	A Member who, as stated fully in 24 C.F.R. Section 91.5, lacks a fixed, regular, and adequate nighttime residence, or who will imminently lose their primary nighttime residence; or are an unaccompanied Member under twenty-five (25) years of age; or a Member who is fleeing dangerous or life-threatening conditions, has no other residence, and lacks the resources to obtain permanent housing.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Notice of Action	Written notice informing a Member of an adverse benefit determination.
Targeted Case Management	Specialized case management services for Medi-Cal eligible individuals in a defined target population to gain access to needed medical, social, educational, and other services. In prescribed circumstances, TCM is available as a Medi-Cal benefit as a discrete service, as well as through State or local government entities and their contractors.
Targeted Engagement List (TEL)	The lists developed by DHCS of Medi-Cal Members who 1) appear to meet the HHP eligibility criteria based on member characteristics identified in DHCS administrative data; and 2) are to be considered by CalOptima for engagement.

Term	Definition
Well-Managed	Members with HHP chronic conditions that (a) do not have a pattern of utilization of negative health outcomes that are an indication of poor chronic disease management or patient activation or (b) are in an effective care management program. An assessment, which may include utilization data review or a clinical assessment, that determines that the Member's eligible chronic conditions are already well-managed – to the extent that HHP services are not medically necessary and will not significantly change the Member's health status. This includes participation in other CalOptima programs that are not Medicaid-funded that may be available and for which the Member is eligible.

1

Policy:	GG.1331
Title:	**Health Homes Program (HHP) Services and Care Management**
Department:	Medical Management
Section:	Case Management
CEO Approval:	*/s/*
Effective Date:	01/01/2020
Revised Date:	TBD
Program Sunset:	12/31/2021

I. PURPOSE

This policy defines CalOptima's Health Homes Program (HHP) guidelines and processes for outreach and engagement of HHP-eligible Members and enhanced care management and care coordination approach to HHP-enrolled Members, including, but not limited to, office visit accompaniment, housing support services, and in-person care coordination.

II. POLICY

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A. As an HHP-participating Medi-Cal managed care plan, CalOptima is responsible for the overall administration of the HHP including:

1. Improving Member outcomes by coordinating physical health services, mental health services, substance use disorder services, community-based Long-Term Services and Supports (LTSS), oral health services, Palliativ Care and social support needs; and

2. Reducing avoidable health care costs, including hospital admissions/readmissions, emergency department visits, and nursing facility stays

B. CalOptima shall implem nt the HHP in two (2) phases, as prescribed by the Department of Health Care Services (DHCS):

1. No sooner than January 1, 2020: For HHP Members with eligible chronic physical conditions and substance use disorders; and

2. No sooner than July 1, 2020: For HHP Members with eligible serious mental illness conditions.

C. CalOptima shall select Community-Based Care Management Entities (CB-CMEs) in accordance with Welfare and Institutions Code Section 14127.3(d)(1) and the CB-CME qualifications as defined by DHCS in the HHP Program Guide, which are set forth in Attachment B of this Policy. CalOptima shall develop an HHP network that includes:

1. All contracted Health Networks to serve as a CB-CME for their assigned Members; and

2. CalOptima Direct (COD) to serve as a CB-CME for Members assigned to CalOptima Direct.

D. CalOptima and CB-CMEs shall ensure compliance with all applicable State and federal requirements related to HHP and all HHP requirements determined by DHCS, including but not limited to DHCS All Plan Letter (APL) 18-012: Health Homes Program Requirements and the HHP Program Guide.

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E. CalOptima shall ensure an HHP structure that will enable a CB-CME to provide six (6) core HHP services to assigned HHP Members:

1. Comprehensive care management;

2. Care coordination;

3. Health promotion;

4. Comprehensive transitional care;

5. Individual and family support services; and

6. Referrals to community and social supports.

F. CalOptima Member eligibility for participation in the HHP shall be determined in accordance with CalOptima Policy GG.1350: Health Homes Program (HHP) Member Eligibility.

G. CalOptima shall conduct targeted, progressive engagement attempts to Members on the Finalized Engagement List (FEL). Members interested in knowing more about and/or participating in HHP will be transferred to their assigned CB-CME for HHP information and possible program enrollment.

H. CB-CMEs shall utilize a team approach consisting of HHP multi-disciplinary care teams ("HHP Care Teams"), as described in Section III.A of this Policy, which are overseen by an HHP Director at each CB-CME.

I. CalOptima and the CB-CMEs shall complete a Member Health Needs Assessment (HNA), conduct a multidisciplinary case conference by the HHP Care Team as described in Section III.A of this Policy, and create a Health Action Plan (HAP) for each HHP Member.

1. The HAP will be reassessed at regular intervals and when changes occur in the Member's progress or status and health care needs.

2. CalOptima and CB-CMEs shall ensure HHP Member HNAs are available to the primary care providers (PCPs), mental health service providers, substance use disorder services providers, and HHP Care Team care coordinators for all HHP Members.

J. CB-CMEs shall be responsible for coordinating with HHP Members, existing providers and other agencies, including CBOs, in order to serve as the central point of contact of patient-centered care for HHP Members.

K. CalOptima and a CB-CME shall ensure ongoing care coordination, including discharge planning, as necessary, in accordance with this policy and CalOptima Policies GG.1301: Comprehensive Care Management Process and GG.1308: Monitoring Health Network Compliance via Case Management Reports.

L. CB-CMEs shall establish, as necessary, contractual relationships with CBOs or other organizations to provide HHP Members with HHP services, and contractual or non-contractual relationships with CBOs to provide linkages to community and social support services. CB-CMEs may contract for select services, such as office visit accompaniment and housing support services.

M. CalOptima will provide the CB-CMEs with information on admissions and discharges and ensure timely follow-up care.

N. CalOptima shall provide training prior to administration of the HHP as well as ongoing training to participating CB-CME care management staff members. Training shall encompass HHP program overview, HAP, care coordination, and care transitions within the HHP, community resources and referrals, as well as operational and condition-specific trainings. In addition, CalOptima will provide training on special populations, social determinants of health, motivational interviewing, trauma-informed care, health literacy assessment, and information sharing.

O. CalOptima's Case Management Department shall conduct strong oversight of the CB-CMEs by performing regular monitoring and auditing activities to ensure that case conferences occur, the HAP is updated as health care events occur, and all other HHP care management requirements are completed. CalOptima shall provide regular feedback and reporting of oversight results to the CB-CMEs as described in Section III.G. of this Policy. CalOptima's oversight of the CB-CMEs shall also include, but not be limited to, the monitoring and auditing activities described in CalOptima Policy GG.1308: Monitoring Health Network Compliance via Case Management Reports.

P. CalOptima shall use medical management and data warehouse systems to support prioritization and risk stratification of the FEL as well as additional HHP-eligible Members identified through other activities. In addition, CalOptima Direct and CB-CMEs shall use medical management and data warehouse systems to:

1. Record HHP-eligible Members referrals to HHP;
2. Record outreach attempts and Member decisions regarding enrolling in HHP;
3. Record responses to standardized HNA questions;
4. Provide repositories for care management data and HNA responses for reporting purposes;
5. Record Member HAPs based on needs and barriers identified during HNA information collection;
6. Record oversight data of Member HAPs;
7. Record and track care coordination activities provided by individual staff; including but not limited to managing care transitions;
8. Record and track referrals to community resources;
9. House authorization and utilization data; and
10. Store pertinent medical records and information.

Q. CalOptima and CB-CMEs shall establish and maintain a data-sharing agreement with other providers that is compliant with all federal and California state laws and regulations. If applicable laws and/or regulations require an HHP Member's valid authorization for release of his or her health information, CalOptima or a CB-CME, as applicable, may not release such information without the HHP Member's valid authorization.

III. PROCEDURE

A. HHP Care Teams

1. The CB-CME shall be responsible for HHP Care Team staffing, according to HHP required staffing ratios determined by DHCS.

2. The qualification and roles of the HHP Care Team Members are set forth in Attachment A of this policy. Except as otherwise stated below, the HHP Care Team shall include the following:

   a. Dedicated care coordinator;

   b. HHP Director;

   c. Clinical consultants;

   d. For HHP Members experiencing Homelessness, a housing navigator; and

   e. Community health workers are recommended, but not required.

3. Additional team Members, such as a pharmacist or nutritionist, may be included on the HHP Care Team in order to meet the HHP Member's individual care coordination needs.

4. CalOptima or a delegated Health Network serving as a CB-CME, as applicable, shall ensure that physical and/or behavioral health service providers who are not part of the HHP Care Team will cooperate and participate in HAP planning and coordination.

5. CalOptima or a CB-CME shall maintain a strong and direct connection to the HHP Member's PCP and ensure the PCP's participation in HAP development and ongoing coordination.

B. CalOptima and the CB-CME will collaborate to make three (3) progressive attempts to engage Members who are included on the FEL.

1. CalOptima shall work collaboratively with its community partners, CBOs, and institutions where Members choose to receive services, as centers for strategic outreach and to share best practices. CalOptima's partnership with its associates include, but is not limited to, the following:

   a. Assistance in locating and contacting Members, as necessary.

   b. CalOptima shall create and share HHP materials that emphasize the benefits of the HHP for use with Members.

2. Progressive engagement of HHP-eligible Members may include mailed or other written communication, live calls, and in-person engagement:

   a. CalOptima shall provide early and ongoing outreach to Members, specifically for Members who may require additional encouragement or information to participate in HHP. Outreach and engagement with Members shall be culturally appropriate in accordance with CalOptima Policy DD.2002: Cultural and Linguistic Services, and meet health literacy standards and trauma-informed care standards.

b. CB-CMEs shall provide an HHP engagement notice to each HHP-eligible Member that describes the HHP and provides CB-CME contact information for interested HHP-eligible Members.

c. Outreach attempts shall include attempts to validate and update contact information if incorrect.

d. CalOptima Special Population PCCs shall visit local Homeless shelters weekly to engage Members experiencing Homelessness who appear on the FEL or who are HHP-eligible based on CalOptima's data driven preliminary eligibility determination.

e. CalOptima shall evaluate Members who are identified through CalOptima's Homeless Response Team (HRT) for eligibility in HHP.

f. If Members are not able to be engaged after three (3) progressive attempts within ninety (90) calendar days of the initial outreach described in Section III.B.2.b. of this Policy, CalOptima or CB-CME, as applicable, shall notify the Member's PCP and request that the PCP discuss the benefits of the HHP with the Member at the next visit. No further progressive engagement is required.

g. Members meeting HHP eligibility requirements must consent to HHP in order to participate. Consent may be oral or in writing and will be documented by the CB-CME's Customer Service staff or HHP Care Team staff prior to the Member's participation in HHP.

h. HHP Care Team Members shall be available to an HHP-eligible and/or HHP-enrolled Member via telephone to answer questions and receive input about the HHP.

C. Outreach Expectations for Members Enrolled in HHP

1. Following enrollment into the HHP, CB-CMEs shall provide an initial welcome packet to each HHP Member.

2. CB-CMEs should encourage the enrolled Members to see their PCP within the sixty (60) calendars days following the Member's enrollment date in HHP. In order to complete each HHP Member's HAP within the ninety (90) calendar days following the Member's enrollment date in HHP, Members shall receive contact, telephonic or written, from the CB-CME, including:

a. In-person contact will be prioritized, and is the preferred method of care coordination;
   i. Minimum in-person visits for the aggregated population is two hundred sixty (260) visits per one hundred (100) enrolled Members per quarter.

   i. More frequent in-person contacts are expected for Members in complex care management (Tier 1), based on the Member's needs and preferences.

D. HHP Core Services

1. Comprehensive Care Management

a. Upon enrollment of the Member in the HHP, the CB-CME shall administer the DHCS-approved HHP Health Needs Assessment (HNA) to identify Member needs and barriers, and serve as the basis for the person-centered HAP.

i. On an exception basis, such as a Member encountered by CalOptima during in-person outreach, CalOptima may conduct an HNA and assign the care management level, or tier, as part of the enrollment process and submit to the CB-CME for completion of the HAP.

b. A CB-CME clinical consultant shall review and evaluate the responses to the HNA to assign or confirm a care management level as follows:

i. Complex care management (Tier 1);

ii. Care coordination care management (Tier 2); or

iii. Basic care management (Tier 3).

c. For HNAs collected by CalOptima, a CalOptima clinical consultant shall upload the HNA, care management level or tier level, and recommended interventions via secure FTP site to the CB-CME for consideration for inclusion in the HAP.

d. A CB-CME care coordinator shall assist the HHP Member with development of the HAP and complete the HAP within ninety (90) calendar days of HHP enrollment.

e. A CB-CME care coordinator shall provide comprehensive care management services to HHP Members, including, but not limited to the following:

i. Assess and reassess Members as needed for physical health, mental health, substance use, housing instability, Member's perception of gaps in care, impacts related to social determinants of health, oral health care, Palliative Care needs, trauma-informed care needs, harm-reduction practices and social services needs;

ii. Provide care management in accordance with CalOptima Policy GG.1301: Comprehensive Care Management;

iii. Engage the HHP Member in the HHP and his or her own care;

iv. Assess the HHP Member's level of engagement and readiness for change using screenings and assessments with standardized tools;

v. Coach the HHP Member in self-management skills;

vi. Promote the Member's self-management skills to increase their ability to engage with health and service providers;

vii. Support the Member by working with them to achieve their self-directed, individualized, whole-person health goals to improve their functional or health status, or prevent or slow functional declines; and

viii. Develop a Member's HAP and revise it as appropriate;

ix. Ensure the needs identified on the HHP HNA and subsequent assessments are incorporated into the Member's HAP, in accordance with the Member's preferences;

x. Reassess a Member's health status and goals;

xi. Coordinate and collaborate with all involved parties to promote continuity and consistency of care; and

xii. Clarify roles and responsibilities of the multi-disciplinary team, providers, Member and family/support persons.

f. The CB-CME shall submit the HNA, HAP, and HHP tier assignment to CalOptima for oversight.

i. CB-CME shall use HNA and HAP formats as required by CalOptima.

2. Care Coordination

a. A CB-CME care coordination shall provide care coordination services to address the implementation of the HAP and ongoing care coordination, including but not limited to:

i. Member Support:

a) Work with the HHP Member to implement his or her HAP;

b) Assist the HHP Member with ref rrals to and navigation of physical health, oral health, behavioral health, Palliative Care services, social services, and housing supports;

c) Share options with the HHP Member for accessing care and providing information to the HHP Memb r r garding care planning;

d) Identify barriers to medication management and treatment plan adherence and work to overcome barriers;

e) Monitor and support treatment adherence (including medication management and reconciliation);

f) Assist in attainment of the HHP Member's goals as described in the HAP;

g) Encourage HHP Member engagement in decision making and continued participation in HHP; and

h) Ensure accompaniment of HHP Members to appointments, as needed.

ii. Coordination

a) Monitor and coordinate referrals and follow ups to ensure needed services and supports are offered and accessed;

b) Share information with all involved parties to monitor the Member's conditions, health status, care planning, medication usages and side effects;

c) Create and promote linkages to other services and supports, as needed;

d) Facilitate communication between HHP Members and healthcare providers to promote understanding;

e) Facilitate referral to other services and team Members as appropriate, including pharmacy, housing navigator, social services, health educator or health coach;

f) Maintain frequent, in-person contact with the HHP Member and care coordinator when delivering HHP services;

g) Strongly encourage the HHP Member to visit his or her PCP within sixty (60) calendar days of enrollment in HHP, assisting with coordination of this visit as appropriate;

h) Support screening, referral, and co-management of HHP Members with both behavioral and physical health conditions;

b. CalOptima or a CB-CME, as applicable, shall identify and take action to address an HHP Member's gaps in care as follows:

i. Assess existing data sources for evidence of care appropriate to the HHP Member's age and underlying chronic conditions, as appropriate;

ii. Evaluate the HHP Member's perception of gaps in care;

iii. Document gaps in care in the HHP Member's case file, including evaluation of a Member's perceptions of gaps in care;

iv. Document interventions in the HAP and progress notes;

v. Document findings from the HHP Member's response to interventions;

vi. Document discussions of HHP Member's care goals; and

vii. Document follow-up actions, and the person or organization responsible for follow-up.

3. Health Promotion

a. A CB-CME care coordinator shall refer the HHP Member or his or her family/support persons, to health education and disease management programs, as appropriate, for additional support and education regarding the HHP Member's health conditions in accordance with the HHP Member's needs and preferences.

b. Health promotion services shall include, but are not limited to:

i. Encouraging and supporting health education for the HHP Member and family/support persons;

ii. Assessing the HHP Member and family/support persons' understanding of the Member's health condition and motivation to engage in self-management;

iii. Using evidence-based practices, such as motivational interviewing, to engage and help the HHP Member and family/support persons participate in and manage their care;

iv. Coaching HHP Members and family/support persons about chronic conditions and ways to manage health conditions, based on the Member's preferences; and

v. Linking the HHP Member and family/support persons with resources and programs such as:

a) Smoking cessation;

b) Self-help recovery resources;

c) Learning about and management of chronic conditions; and

d) Other services based on Member needs and preferences.

4. Comprehensive Transitional Care

a. A CB-CME care coordinator will assist the HHP Member with transitions between treatment settings, including admissions and discharges from the hospital, residential/treatment facility, out of an incarceration facility or other treatment centers as needed, including, but not limited to:

i. Facilitating medication reconciliation and information;

ii. Assisting with scheduling of timely follow up appointments after discharge with recommended outpatient providers and/or community partners;

iii. Assisting with development or implementation of appropriate discharge plan and a place to stay post-discharge such as temporary housing or stable housing and social services;

iv. Collaborating, communicating and coordinating the transition plan with all involved parties, including informing hospital discharge planners about HHP;

v. Easing the HHP Member's transition by ensuring the HHP Member has an understanding of their post-transition self-management, medication management and rehabilita ion activities, as appropriate;

vi. Preventing and tracking avoidable admissions and readmissions;

vii. Facilitating transportation for transitional care, including to medical appointments, in accordance with CalOptima Policy GG.1505: Transportation: Emergency, Non-Emergency, and Non-Medical;

viii. Evaluating need to revise the HHP Member's HAP;

x. Working with the HHP Member to assess understanding of discharge plan and assisting the Member with engaging with and implementing discharge plan; and

x. Providing housing navigation and support services, as appropriate, including:

a) Temporary housing or stable housing and social services; and

b) Transition support to permanent housing.

b. In order to prevent and track avoidable admissions and readmissions, an HHP Member's care coordinator is notified about HHP Member transitions through the CB-CME's existing

medical management/data systems and as required by CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and CalOptima Policy GG.1508: Authorization and Processing of Referrals that require hospital notification to the CB-CME of emergency department visits, admissions and discharges.

5. Individual and Family Support Services

   a. As part of the assessment and care management processes and with the overall goal of improving Member adherence to treatment and medication management, the HHP Care Team will:

      i. Assess strengths and needs of the HHP Member and family/support persons, including support of caregivers, and readiness to receive information;

      ii. Link the HHP Member and family/support persons to caregiver resources (*e.g.*, peer supports or support groups) to educate, motivate, and improve self-management;

      iii. Connect the HHP Member to self-care programs to help increase their understanding of their conditions and care plan;

      iv. Promote HHP Member and family/support persons in self management and decision-making;

      v. Determine when the HHP Member and family/support persons are ready to receive and act upon information provided and assist them with making informed decisions;

      vi. Advocate for the Member and family support persons to identify and obtain needed resources (e.g., transportation) that support their ability to meet their health goals;

      vii. Arrange accompaniment to critical appointments, as appropriate;

      viii. Identify barriers to improving adherence; and

      ix. Evaluate family/support persons' needs for services.

6. Referral to Community and Social Supports

   a. As part of the assessment and care management processes, the HHP Care Team will:

      i. Identify the Member's community and social support needs and preferences and available resources to meet such needs;

      ii. Identify resources and eligibility criteria for housing, food security and nutrition, employment counseling, childcare, community-based LTSS, school and faith-based services, and disability services, as needed and desired by the Member;

      iii. Actively engage appropriate referrals to the needed resources, access to care, and engagement with other community and social supports;

      iv. Provide the Member with information about and referrals to community resources according to the Member's needs and preferences;

v. Facilitate, coordinate, and follow up on resource referrals;

vi. Provide regular follow up, via in-person or telephonic contacts, to support Member engagement with resources;

vii. Provide Individual Housing Transition Services; and

viii. Provide Individual Housing and Tenancy Sustaining Services.

E. Housing Support Services

1. CalOptima and the CB-CME will work with CBOs and vendors who specialize in housing assistance services and local shelters to ensure seamless access to the delivery of housing support services. The HHP does not provide direct funding for housing.

2. To the extent applicable, housing-based case management services provided by CalOptima, the CB-CME, CBOs and vendors to HHP Members shall be consistent with the Housing First core components as described in Welfare and Institutions Code Section 8255, specifically:

a. Engagement to Members potentially eligible for HHP or the pro ision of HHP housing-based case management services may not be restricted for individuals based on sobriety, completion of treatment, poor credit, financial history, criminal background, or housing readiness, unless they are determined ineligible for HHP or meet one (1) or more of the DHCS defined HHP exclusionary criteria as described in CalOptima Policy GG.1350: Health Homes Program (HHP) Member Eligibility.

b. HHP housing-based services shall incorporate a harm-reduction philosophy that recognizes drug and alcohol use and addiction as a part of Members' lives, where Members are engaged in nonjudgmental communication regarding drug and alcohol use.

c. Members will be offered education regarding how to avoid risky behaviors and engage in safer practices as well as connected to evidence-based treatment if they so choose.

3. A CB-CME shall staff directly or contract with a vendor to provide housing support services for Members experiencing homelessness.

4. A housing navigator, a required role of the HHP Care Team, for HHP Members experiencing homelessness will use Housing First principles and components to provide the following services:

a. Individual Housing Transition Services

Conducting a tenant screening and housing assessment, such as the Vulnerability Index - Service Prioritization Decision Assistance Tool (VI-SPDAT), that identifies the Member's preferences and barriers related to successful tenancy. The assessment may include collecting information on potential housing transition barriers, and identification of housing retention barriers;

ii. Developing an individualized housing support plan based upon the housing assessment that addresses identified barriers, includes short- and long-term measurable goals for each issue, establishes the Member's approach to meeting the goal, and identifies when other providers or services, both reimbursed and not reimbursed by Medicaid, may be required to meet the goal;

iii. Assisting with the housing application process and with the housing search process;

iv. Identifying resources to cover expenses such as security deposit, furnishings, adaptive aids, environmental modifications, moving costs and other one-time expenses;

v. Ensuring that the living environment is safe and ready for move-in;

vi. Assisting in arranging for and supporting the details of the move; and

vii. Developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized.

b. Individual Housing and Tenancy Sustaining Services

i. Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment and other lease violations;

ii. Providing education and training on the roles, rights and responsibilities of the tenant and landlord;

iii. Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy;

iv. Providing assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action;

v. Providing advocacy and linkage with community resources to prevent eviction when housing is, or may potentially become jeopardized;

vi. Providing assistance with the housing recertification process;

vii. Coordinating with the tenant to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers; and

viii. Continuing training in being a good tenant and lease compliance, including ongoing support with activities related to household management.

5 A CB-CME housing navigator shall assist Members experiencing homelessness with the completion of the VI-SPDAT to determine risk and prioritization of housing services, as appropriate.

F. The Member's CB-CME, or CalOptima for a Member assigned to COD, shall accept referrals of potentially HHP-eligible Members from providers, which shall include the HHP eligibility criteria and the Member's interest in participating in HHP. For purpose of this section only, the term "provider" includes PCPs, Specialists, Community-Based Organizations, Whole-Person Care providers, and any other providers that are currently treating potentially HHP-eligible Members.

1. The CB-CME shall evaluate and provide verification of Member eligibility for the HHP to CalOptima's Case Management Department for final confirmation via facsimile or other means as directed by CalOptima.

a. CalOptima's Case Management Department shall provide final confirmation to the CB-CME via facsimile, CalOptima's medical management systems, or other means as directed by CalOptima regarding the Member's HHP eligibility within five (5) business days.

2. Members referred for the HHP, as well as the referring provider, shall be notified by the CB-CME of the Member's eligibility or ineligibility for the HHP within five (5) business days of receipt of final confirmation from CalOptima as described in Section III.F.1.a. of this Policy.

3. Members who are not eligible for the HHP will be offered other supportive programs available to them by the CB-CME.

G. Health Homes Program Care Management Oversight Responsibilities

1. CB-CME HHP Director shall have:

a. Overall responsibility for the management and operations of the HHP Care Team; and

b. Responsibility for quality measures and reporting for the HHP Care Team.

2. Upon completion of the HAP, the CB-CME clinical consultant shall review the HAP for:

a. Completeness and accuracy of information provided;

b. Clinical data;

c. Implementation progress and update as events unfold; and

d. Transmit the HNA, HAP, and care management level (Tier) to CalOptima.

3. A CalOptima clinical consultant shall review the CB-CME's returned completed HNA and HAP and shall evaluate:

a. Completeness and accuracy of information provided;

b. Clinical data; and

c. Implementation progress.

4. On a daily basis, a CalOptima clinical consultant shall communicate any deficiencies to the CB-CME.

5. The CalOptima clinical consultant shall perform regular monitoring to ensure that:

a. Case conferences occur;

b. HAP is updated as health care events unfolds; and

c. All other HHP care management requirements are completed.

6. On a monthly basis, CalOptima shall provide feedback in aggregate form to the CB-CME.

7. CalOptima shall ensure overall oversight of CB-CMEs in accordance with CalOptima Policy GG.1619: Delegation Oversight.

8. Clinical Support for Care Coordination

   a. A CB-CME clinical consultant or care coordinator shall:

      i. Be available as a clinical resource for care coordination, as needed; and

      ii. Facilitate access to primary care, including advising the Member's PCP of referrals to other agencies, including LTSS and behavioral health providers, in accordance with CalOptima Policy GG.1301: Comprehensive Care Management as needed to assist in care coordination.

IV. ATTACHMENT(S)

A. Multi-Disciplinary Care Team Qualifications and Roles
B. Community Based-Care Management Entity (CB-CME) Qualifications

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services
B. CalOptima Policy DD.2002: Cultural and Linguistic Services
C.
D. CalOptima Policy GG.1301: Comprehensive Care Management
E. CalOptima Policy GG.1308: Monitoring Health Network Compliance via Case Management Reports
F. CalOptima Policy GG.1350: Health Homes Program (HHP) Member Eligibility and Enrollment
G. CalOptima Policy GG.1505: Transportation: Emergency, Non-Emergency, and Non-Medical
H. CalOptima Policy GG.1508: Authorization and Processing of Referrals
I. CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
J. CalOptima Policy GG.1619: Delegation Oversight
K. Welfare and Institutions Code §§ 14127-14128
L. Health and Safety Code §§ 50675.2 and 50675.14
M. Department of Health Care Services All Plan Letter 18-012: Health Homes Program Requirements
N. Department of Health Care Services Medi-Cal Health Homes Program Guide (11/01/2019)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
03/04/2020	Department of Health Care Services (DHCS)	Approved as Submitted

None to Date

VII. BOARD ACTION(S)

Date	Meeting
12/05/2019	Regular Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2020	GG.1331	Health Homes Program (HHP) Services and Care Management	Medi-Cal
Program Sunset	12/31/2021	GG.1331	Health Homes Program (HHP) Services and Care Management	Medi-Cal
RETIRED	TBD	GG.1331	Health Homes Program (HHP) Services and Care Management	Medi-Cal

IX. GLOSSARY

Term	Definition
CalOptima Direct (COD):	A direct health care program operated by CalOptima that includes both COD-Administrative (COD-A) and CalOptima Community Network (CCN) and provides services to Members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
Chronically Homeless Member	A Member with a condition limiting the activities of daily living and who has been continually Homeless for one (1) year or more or had at least four (4) episodes of Homelessness in the past three (3) years. For the purposes of this policy, a Member who is currently residing in transitional housing (as defined in Health and Safety Code section 50675.2) or who has been residing in permanent supportive housing (as defined in Health and Safety Code section 50675.14) for less than two (2) years shall also be considered Chronically Homeless if the Member was Chronically Homeless prior to residence.
Community Based-Care Management Entities (CB-CME)	Providers within the community that have a contractual relationship with CalOptima, or CalOptima acting directly, to provide HHP services to HHP Members.
Finalized Engagement List (FEL)	The list to include the DHCS TEL and CalOptima Member data created by applying risk stratification criteria for CalOptima and CB-CMEs to utilize for Member engagement activities
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network
Health Action Plan (HAP)	A comprehensive individualized care plan with the inclusion of any elements specific to HHP.
Health Homes Program (HHP)	All of the California Medicaid State Plan amendments and relevant waivers that DHCS seeks and CMS approves for the provision of HHP services that provide supplemental services to HHP eligible and enrolled Members coordinating the full range of physical health, behavioral health, and community-based LTSS needed for chronic conditions.
HHP Care Team	The HHP Care Team includes Care Coordinators , a CB-CME HHP Director, Clinical Consultants, a housing navigator (for HHP enrolled Members experiencing Homelessness), and community health workers (recommended, but not required).
HHP Member	A Member who is enrolled, and continuously participating in the CalOptima Health Homes Program, and assigned to a Health Network or CalOptima Direct.
Health Needs Assessment	The assessment CalOptima uses as a health risk assessment for HHP-eligible Members.
Homeless	A Member who, as stated fully in 24 C.F.R. section 91.5, lacks a fixed, regular, and adequate nighttime residence, or who will imminently lose their primary nighttime residence; or are an unaccompanied Member under twenty-five (25) years of age; or a Member who is fleeing dangerous or life-threatening conditions, has no other residence, and lacks the resources to obtain permanent housing.
Individual Care Plan (ICP)	A written plan of care developed after an assessment of a Member's social and health care needs that reflects what services the Member will receive to reach and keep his or her best physical, mental, and social well-being.

Term	Definition
Individual Housing Transition Services	Services that support a Member's ability to prepare for and transition to housing and are further described in the Center for Medicaid & CHIP Services (CMCS) informational bulletin titled, "Coverage of Housing-Related Activities and Services for Individuals with Disabilities," dated June 26, 2015.
Individual Housing & Tenancy Sustaining Services	Services that support Members in being successful tenants in their housing arrangement, thus able to sustain tenancy, and are further described in the Center for Medicaid & CHIP Services (CMCS) informational bulletin titled "Coverage of Housing-Related Activities and Services for Individuals with Disabilities," dated June 26, 2015.
Long Term Services and Supports (LTSS)	A wide variety of services and supports that help Members meet their daily needs for assistance and improve the quality of their lives. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities. As described in Welfare and Institutions Code section 14186.1, Medi-Cal covered LTSS includes all the following: 1. Community-Based Adult Services (CBAS); 2. In-Home Supportive Services (IHSS); 3. Multipurpose Senior Services Program (MSSP) services; and 4. Skilled nursing facility services and subacute care services.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Notice of Action	Written notice informing a Member of an adverse benefit determination.
Palliative Care	Patient- and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering.
Targeted Case Management	Specialized case management services for Medi-Cal eligible individuals in a defined target population to gain access to needed medical, social, educational, and other services. In prescribed circumstances, TCM is available as a Medi-Cal benefit as a discrete service, as well as through State or local government entities and their contractors.
Targeted Engagement List (TEL)	The lists developed by DHCS of Medi-Cal Members who 1) appear to meet the HHP eligibility criteria based on Member characteristics identified in DHCS administrative data; and 2) are to be considered by CalOptima for engagement.
Well-Managed	Members with HHP chronic conditions that (a) do not have a pattern of utilization of negative health outcomes that are an indication of poor chronic disease management or patient activation or (b) are in an effective care management program. An assessment, which may include utilization data review or a clinical assessment, that determines that the Member's eligible chronic conditions are already Well-Managed – to the extent that HHP services are not medically necessary and will not significantly change the Member's health status. This includes participation in other CalOptima programs that are not Medicaid-funded that may be available and for which the Member is eligible.
Vulnerability Index - Service Prioritization Decision Assistance Tool (VI-SPDAT)	A survey administered both to individuals and families to determine risk and prioritization when providing assistance to Homeless and at-risk of Homelessness persons.

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Attachment A

Multi-Disciplinary Care Team Qualifications and Roles

Required Team Members	Qualifications	Role
Dedicated Care Coordinator (CB-CME or by contract)	Paraprofessional (with appropriate training) or licensed care coordinator, social worker, or nurse	• Oversee provision of HHP services and implementation of HAP • Offer services where the HHP member lives, seeks care, or finds most easily accessible and within CalOptima or CB-CME guidelines, as applicable • Connect HHP member to other social services and supports he/she may need • Advocate on behalf of members with health care professionals • Use motivational interviewing, trauma-informed care, and harm reduction practices • Work with hospital staff on discharge plan • Engage eligible HHP members • Accompany HHP member to office visits, as needed and according to CalOptima or CB-CME guidelines, as applicable • Monitor treatment adherence (including medication) • Provide health promotion and self-management training • Arrange transportation • Call HHP member to facilitate HHP member visit with the HHP care coordinator
HHP Director (CB-CME)	Ability to manage multi-disciplinary care teams	• Have overall responsibility for management and operations of the team • Have responsibility for quality measures and reporting for the team
Clinical Consultant (CB-CME or CalOptima)	Clinician consultant(s), who may be primary care physician, specialist physician, psychiatrist, psychologist, pharmacist, registered nurse, advanced practice nurse, nutritionist, licensed clinical social worker, or other behavioral health care professional	• Review and inform HAP • Act as clinical resource for care coordinator, as needed • Facilitate access to primary care and behavioral health providers, as needed to assist care coordinator

Attachment A

Required Team Members	Qualifications	Role
Community Health Workers (CB-CME or by contract) (Recommended but not required)	Paraprofessional or peer advocate Administrative support to care coordinator	• Engage eligible HHP members • Accompany HHP member to office visits, as needed, and in the most easily accessible setting, within CalOptima or CB-CME guidelines, as applicable • Health promotion and self-management training • Arrange transportation • Assist with linkage to social supports • Distribute health promotion materials • Call HHP member to facilitate HHP visit with care coordinator
For HHP Members Experiencing Homelessness: Housing Navigator (CB-CME or by contract)	Paraprofessional or other qualification based on experience and knowledge of the population and processes	• Form and foster relationships with housing agencies and permanent housing providers, including supportive housing providers • Partner with housing agencies and providers to offer the HHP member permanent, independent housing options, including supportive housing • Connect and assist the HHP member to get available permanent housing • Coordinate with HHP member in the most easily accessible setting, within MCP guidelines (e.g. could be a mobile unit that engages members on the street)

Attachment B

Community Based-Care Management Entity (CB-CME) Qualifications

HHP CB-CMEs must meet the following qualifications:

- Be experienced serving Medi-Cal members and, to comply with California Welfare and Institutions Code Health Homes Program (HHP) requirements, as appropriate for their assigned HHP member population, with high-risk members such as individuals who are experiencing homelessness;
- Comply with all program requirements;
- Have strong, engaged organizational leadership who agree to participate in learning activities, including in-person sessions and regularly scheduled calls;
- Have the capacity to provide appropriate and timely in-person care coordination activities, as needed;
- Have the capacity to accompany HHP members to critical appointments, when necessary, to assist in achieving HAP goals;
- Agree to accept any enrolled HHP members assigned by CalOptima, according to the CB-CME contract with CalOptima;
- Demonstrate engagement and cooperation with area hospitals, primary care practices and behavioral health providers, through the development of agreements and processes, to collaborate with the CB-CME on care coordination; and
- Use tracking processes to link HHP services and share relevant information between the CB-CME and CalOptima and other providers involved in the HHP member's care.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 7, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

10. Approve Modifications to CalOptima Policy GG.1513: Health Network Utilization Management Reporting and Monitoring Requirements

Contacts

Richard Pitts, D.O., Ph.D., Chief Medical Officer, (714) 246-8491
Kelly Giardina, Executive Director, Clinical Operations, (657) 900-1013

Recommended Action

Approval of modifications to the following Utilization Management Policy pursuant to CalOptima's policy review process:

1. Policy GG.1513: Health Network Utilization Management Reporting and Monitoring Requirements

Background/Discussion

CalOptima regularly reviews its Policies and Procedures to ensure they are up to date and aligned with Federal and State health care program requirements, contractual obligations, laws, and CalOptima Operations.

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

Policy GG.1513: Health Network Utilization Management Reporting and Monitoring Requirements outlines Utilization Management (UM) reporting requirements and the process for Monitoring a Health Network (HN)'s UM reports. This policy was reviewed to be aligned with requirements of:

- CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
- CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
- CalOptima Three-Way Contract with the CMS and the DHCS for Cal MediConnect

Policy Section	Change
I	Change oversight to monitoring, since that will be the UM function
II A - C	Changed to reflect reporting frequency and how the HN understands when the reports are due (attachment A). Removed frequency of reports in the Purpose statement.
III B.	Change to UM function. Identified that Over/Underutilization monitoring occurs on an ongoing basis via the Over/Underutilization dashboard.

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III F. & G.	Removed the annual policy and procedure review of HN policies as that will be retained in Audit & Oversight. Added who should attend the HN UM committee meetings.
III G.	Further outlined UM's functions and responsibilities.
III & IX	Removed the appeals requirement from the Procedure section and its definition as UM does not review appeals reports.

Fiscal Impact

The recommended action to modify CalOptima Policy GG.1513 is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Fiscal Year 2021-22 Operating Budget.

Rationale for Recommendation

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

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. GG.1513: Health Network Utilization Management Reporting and Monitoring Requirements (Redline and Clean)

/s/ Michael Hunn *03/31/2022*
Authorized Signature **Date**

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Policy:	GG.1513
Title:	**Health Network Utilization Management Reporting and Monitoring Requirements**
Department:	Medical Management
Section:	Utilization Management
CEO Approval:	
Effective Date:	03/01/1999
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines the Utilization Management (UM) reporting requirements and the process for ~~monitoring~~Monitoring a Health Network's ~~daily, quarterly, and annual~~ Utilization Management reports.

II. POLICY

A. A Health Network shall submit timely reports in accordance with CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting.

B. CalOptima shall delegate ~~Utilization Management (~~UM~~)~~ activities to a Health Network in accordance with the CalOptima Contract for Health ~~Network Service~~Care Services and the CalOptima Delegation Acknowledgement and Acceptance Agreement.

~~C.~~ If CalOptima delegates UM activities for Covered Services to a Health Network, for which CalOptima is financially responsible as set forth in the CalOptima Contract for Health ~~Network Service Agreement, CalOptima shall require~~Care Services, the Health Network ~~to~~shall report such activities to CalOptima, in accordance with CalOptima Policy FF.2001: Claims Processing for Covered Services for which CalOptima is Financially Responsible for purposes of~~:~~

~~1. **Oversight of delegated UM activities; and**~~

~~D.~~C. ~~Timely~~ timely and accurate adjudication of claims for Covered Services for which CalOptima is financially responsible.

III. PROCEDURE

A. ~~A~~CalOptima's UM Department shall review and Monitor the reports for compliance with CalOptima and Health Network UM Standards. CalOptima shall review elements including, but not limited to:

1. Bed days;

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2. Emergency room visits;

3. Referral denial rate;

4. Referral turn-around time;

5. Percentage of referrals that exceed the Health Network standard;~~shall report~~ and

6. UM activities.

B. CalOptima's UM Department shall track and trend the elements listed in Section III.A. of this policy for over and underutilization and adherence to UM Standards via the Over/Underutilization dashboard on an ongoing basis.

C. A Health Network that is delegated UM activities for Covered Services ~~for which CalOptima is financially responsible as follows~~shall report to CalOptima, for purposes of Monitoring and evaluating the Health Network's performance of such activities the following:

1. ~~All~~All requests for authorization of inpatient admissions that were approved, modified, partially approved, or denied ~~authorizations for Covered Services~~; and

2. All ~~services authorizations~~other request for authorization of Covered Services for which authorization is required that were approved, modified, partially approved, or denied ~~for Covered Services.~~.

D. The Health Network shall submit data ~~on a daily basis, no later than 11:59 p.m. of each calendar day,~~in accordance with CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting, covering all UM reporting requirements for UM activities that occurred during the ~~previous twenty-four (24) hours~~reporting period through a designated secure File Transfer Protocol (FTP) site ~~or through the Health Network Portal~~ as follows:

1. Submission through the secure FTP site of complete data files that meet layout specifications provided in the UM Specifications – UM Service Authorizations, UM Specifications – UM Admissions, and UM Specifications – UM Admission Length of Stay~~; or~~.

~~1. Manual entry of all fields in the Health Network Portal.~~

E. On a daily basis, the CalOptima Information Technology Services (~~IS~~ITS) Department shall download a Health Network's UM activities data from the secure FTP site~~, or Health Network Portal,~~ into CalOptima's internal data management systems.

~~E. A Health Network shall comply with all other UM reporting requirements as set forth in the CalOptima Health Network Service Agreement and CalOptima Policy HH.2003: Health Network Reporting.~~

F. A Health Network shall submit the following UM reports and documents:

1. Annual UM Program;

2. UM program review signature page;

3. Annual UM Evaluation;

4. Annual UM Work Plan;

5. Quarterly UM report; and

~~1. UM policies and procedures on an annual basis; and~~

6. Other resource documents as requested by CalOptima.

G. The CalOptima UM Manager, Monitoring or his or her designee shall ~~periodically~~ attend Health Network UM committee meetings to ~~monitor~~Monitor compliance with UM Standards~~.~~ whenever a specific issue is identified that requires discussion with UM leadership.

~~F. CalOptima shall offer technical assistance to~~ If a Health Network is found to be out of compliance with UM Standards, the CalOptima UM Monitoring staff shall issue a preliminary corrective action plan request to ~~assist in~~ the ~~reporting process~~Health Network and ~~in the analysis and correction of compliance issues identified by~~shall work with the Health Network ~~or CalOptima.~~

~~III.I. PROCEDURE~~

~~A. CalOptima's~~ to resolve the deficiency. If the Health Network does not adequately remediate the deficiency after three (3) consecutive months, the Audit ~~and~~& Oversight Department shall ~~review and monitor the reports for compliance with CalOptima and Health Network UM Standards. CalOptima shall review elements including, but not limited to:~~

~~1. Bed days;~~

~~2.1.Emergency room visits;~~

~~3.1.Referral denial rate;~~

~~4.1.Referral turn-around time;~~

~~5. Percentage of referrals that exceed the Health Network standard;~~

~~6. Number of Member and Provider Appeals upheld; and~~

~~7. UM activities.~~

~~B. CalOptima's Audit and Oversight Department shall track and trend the elements listed in Section III.A. of this policy for over and under utilization and adherence~~issue a Corrective Action Plan to ~~UM Standards.~~

~~C. If CalOptima's Audit and Oversight Department identifies elements that are out of compliance with UM Standards, it shall notify the~~ the Health Network for ~~analysis of justification, or correction.~~

H. those elements that remain out of compliance after the preliminary corrective action process. If the issue remains unresolved, CalOptima may conduct a Focused Review, require a Corrective Action Plan, and/or implement financial sanctions, in accordance with CalOptima Policies HH.2005Δ: Corrective Action Plan and GG.1619: Delegation Oversight.

IV. ATTACHMENT(S)

~~UM Reports – Audit and Oversight Timely and Appropriate Submission Grid~~
Not Applicable

V. REFERENCE(S)

A. CalOptima Contract for Health Care Services
B. CalOptima Delegation Acknowledgement and Acceptance Agreement
~~A.~~C. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
~~B.~~D. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
~~C. CalOptima Health Network Service Agreement~~
~~D.A. CalOptima Policy GG.1619: Delegation Oversight~~
~~E. CalOptima Policy HH.2003: Health Network Reporting~~
~~F.A. CalOptima Policy HH.2005Δ: Corrective Action Plan~~
~~G.~~E. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
F. CalOptima Policy FF.2001: Claims Processing for Covered Services for which CalOptima is Financially Responsible
G. CalOptima Policy GG.1619: Delegation Oversight
H. CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting
I. CalOptima Policy HH.2005Δ: Corrective Action Plan

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	03/01/1999	GG.1513	Utilization Management Monitoring of Quarterly and Annual Reports	Medi-Cal
Revised	01/01/2007	GG.1513	Utilization Management Monitoring of Quarterly and Annual Reports	Medi-Cal
Revised	11/01/2015	GG.1513	Health Network Utilization Management Reporting and Monitoring Requirements	Medi-Cal OneCare OneCare Connect
Revised	10/01/2016	GG.1513	Health Network Utilization Management Reporting and Monitoring Requirements	Medi-Cal OneCare OneCare Connect
Non-Substantive Edit	12/01/2016	GG.1513	Health Network Utilization Management Reporting and Monitoring Requirements	Medi-Cal OneCare OneCare Connect
Revised	08/01/2017	GG.1513	Health Network Utilization Management Reporting and Monitoring Requirements	Medi-Cal OneCare OneCare Connect

Action	Date	Policy	Policy Title	Program(s)
Revised	10/01/2017	GG.1513	Health Network Utilization Management Reporting and Monitoring Requirements	Medi-Cal OneCare OneCare Connect
Revised	01/01/2018	GG.1513	Health Network Utilization Management Reporting and Monitoring Requirements	Medi-Cal OneCare OneCare Connect
Revised	TBD	GG.1513	Health Network Utilization Management Reporting and Monitoring Requirements	Medi-Cal OneCare OneCare Connect

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IX. GLOSSARY

Term	Definition
~~Appeal~~	~~Medi-Cal: A request by the Member or the Member's Authorized Representative for review of any decision to deny, modify, or discontinue a Covered Service.~~ ~~OneCare and OneCare Connect: Any of the procedures that deal with the review of adverse Organization Determinations on a health care service a Member believes he or she is entitled to receive, including delay in providing, arranging for, or approving the Covered Service, or on any amounts the Member must pay for a service as defined in Title 42 of the Code of Federal Regulations, Section 422.566(b). An Appeal may include Reconsideration by CalOptima and if necessary, the Independent Review Entity, hearings before an Administrative Law Judge (ALJ), review by the Departmental Appeals Board (DAB), or a judicial review.~~
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 6840, which~~ section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), ~~and~~ speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), ~~which~~ 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 Board of Directors, which shall be covered for Members not~~-~~withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program. OneCare: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract. ~~One Care~~OneCare Connect: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the ~~three-way agreement~~Three-Way Contract with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS).
Focused Review	For the purposes of this policy, refers to an audit that specifically targets areas of potential deficiency.

Term	Definition
Health Network	For purposes of this policy, a Physician Hospital Consortium, Physician Medical Group (PMG) or a Shared Risk Group, under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Member	~~An enrollee~~ A beneficiary ~~of~~enrolled in a CalOptima program.
~~Provider~~Monitoring or Monitor	~~A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Health Network, Physician Medical Group, or other person or institution who furnishes Covered Services.~~Regular reviews directed by CalOptima management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.
Shared Risk Group (SRG)	A Health Network who accepts delegated clinical and financial responsibility for professional services for assigned Members, as defined by written contract and enters into a risk sharing agreement with CalOptima as the responsible partner for facility services.
UM Standards	Conforming to an established rule that is approved and monitored for compliance by an authoritative agency or professional.
Utilization Management (UM)	The evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities under the provisions of the applicable health benefits plan.
Utilization Management (UM) Program	A written document evaluated and revised on an annual basis, that describes the Utilization Management policies, procedures, processes, programs that are implemented organizationally to attain goals set forth by the health plan, to meet health plan, State, Federal, and accrediting agency requirements.
Utilization Management (UM) Workplan	A written document evaluated and revised on an annual basis that documents the progress of the initiatives, activities, results and analysis of the Utilization Management Program Description, State and Federal contractual obligations, and accrediting agency requirements.
Utilization Management Workplan Evaluation	A written document, updated and revised annually, that evaluates the overall effectiveness of the Utilization Management (UM) Program.

Policy:	GG.1513
Title:	**Health Network Utilization Management Reporting and Monitoring Requirements**
Department:	Medical Management
Section:	Utilization Management
CEO Approval:	
Effective Date:	03/01/1999
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines the Utilization Management (UM) reporting requirements and the process for Monitoring a Health Network's Utilization Management reports.

II. POLICY

A. A Health Network shall submit timely reports in accordance with CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting.

B. CalOptima shall delegate UM activities to a Health Network in accordance with the CalOptima Contract for Health Care Services and the CalOptima Delegation Acknowledgement and Acceptance Agreement.

C. If CalOptima delegates UM activities for Covered Services to a Health Network, for which CalOptima is financially responsible as set forth in the CalOptima Contract for Health Care Services, the Health Network shall report such activities to CalOptima, in accordance with CalOptima Policy FF.2001: Claims Processing for Covered Services for which CalOptima is Financially Responsible for purposes of timely and accurate adjudication of claims for Covered Services for which CalOptima is financially responsible.

III. PROCEDURE

A. CalOptima's UM Department shall review and Monitor the reports for compliance with CalOptima and Health Network UM Standards. CalOptima shall review elements including, but not limited to:

1. Bed days;
2. Emergency room visits;
3. Referral denial rate;
4. Referral turn-around time;
5. Percentage of referrals that exceed the Health Network standard; and

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6. UM activities.

B. CalOptima's UM Department shall track and trend the elements listed in Section III.A. of this policy for over and underutilization and adherence to UM Standards via the Over/Underutilization dashboard on an ongoing basis.

C. A Health Network that is delegated UM activities for Covered Services shall report to CalOptima, for purposes of Monitoring and evaluating the Health Network's performance of such activities the following:

1. All requests for authorization of inpatient admissions that were approved, modified, partially approved, or denied; and

2. All other request for authorization of Covered Services for which authorization is required that were approved, modified, partially approved, or denied.

D. The Health Network shall submit data in accordance with CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting, covering all UM reporting requirements for UM activities that occurred during the reporting period through a designated secure File Transfer Protocol (FTP) site as follows:

1. Submission through the secure FTP site of complete data files that meet layout specifications provided in the UM Specifications – UM Service Authorizations, UM Specifications – UM Admissions, and UM Specifications – UM Admission Length of Stay.

E. On a daily basis, the CalOptima Information Technology Services (ITS) Department shall download a Health Network's UM activities data from the secure FTP site into CalOptima's internal data management systems.

F. A Health Network shall submit the following UM reports and documents:

1. Annual UM Program;

2. UM program review signature page;

3. Annual UM Evaluation;

4. Annual UM Work Plan;

5. Quarterly UM report; and

6. Other resource documents as requested by CalOptima.

G. The CalOptima UM Manager, Monitoring or his or her designee shall attend Health Network UM committee meetings to Monitor compliance with UM Standards whenever a specific issue is identified that requires discussion with UM leadership.

H. If a Health Network is found to be out of compliance with UM Standards, the CalOptima UM Monitoring staff shall issue a preliminary corrective action plan request to the Health Network and shall work with the Health Network to resolve the deficiency. If the Health Network does not adequately remediate the deficiency after three (3) consecutive months, the Audit & Oversight Department shall issue a Corrective Action Plan to the Health Network for those elements that

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remain out of compliance after the preliminary corrective action process. If the issue remains unresolved, CalOptima may conduct a Focused Review, require a Corrective Action Plan, and/or implement financial sanctions, in accordance with CalOptima Policies HH.2005Δ: Corrective Action Plan and GG.1619: Delegation Oversight.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract for Health Care Services
B. CalOptima Delegation Acknowledgement and Acceptance Agreement
C. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
E. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
F. CalOptima Policy FF.2001: Claims Processing for Covered Services for which CalOptima is Financially Responsible
G. CalOptima Policy GG.1619: Delegation Oversight
H. CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting
I. CalOptima Policy HH.2005Δ: Corrective Action Plan

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

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Revised	01/01/2018	GG.1513	Health Network Utilization Management Reporting and Monitoring Requirements	Medi-Cal OneCare OneCare Connect
Revised	TBD	GG.1513	Health Network Utilization Management Reporting and Monitoring Requirements	Medi-Cal OneCare OneCare Connect

1

IX. GLOSSARY

Term	Definition
Covered Services	Medi-Cal: Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and 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 Board of Directors, which shall be covered for Members not-withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program. OneCare: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract. OneCare Connect: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Three-Way Contract with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS).
Focused Review	For the purposes of this policy, refers to an audit that specifically targets areas of potential deficiency.
Health Network	For purposes of this policy, a Physician Hospital Consortium, Physician Medical Group (PMG) or a Shared Risk Group, under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Member	A beneficiary enrolled in a CalOptima program.
Monitoring or Monitor	Regular reviews directed by CalOptima management and performed as part of normal operations to confirm ongoing compliance and to ensure that corrective actions are undertaken and effective.
Shared Risk Group (SRG)	A Health Network who accepts delegated clinical and financial responsibility for professional services for assigned Members, as defined by written contract and enters into a risk sharing agreement with CalOptima as the responsible partner for facility services.

Term	Definition
UM Standards	Conforming to an established rule that is approved and monitored for compliance by an authoritative agency or professional.
Utilization Management (UM)	The evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities under the provisions of the applicable health benefits plan.
Utilization Management (UM) Program	A written document evaluated and revised on an annual basis, that describes the Utilization Management policies, procedures, processes, programs that are implemented organizationally to attain goals set forth by the health plan, to meet health plan, State, Federal, and accrediting agency requirements.
Utilization Management (UM) Workplan	A written document evaluated and revised on an annual basis that documents the progress of the initiatives, activities, results and analysis of the Utilization Management Program Description, State and Federal contractual obligations, and accrediting agency requirements.
Utilization Management Workplan Evaluation	A written document, updated and revised annually, that evaluates the overall effectiveness of the Utilization Management (UM) Program.

Timely and Appropriate Submission Grid

Health networks and delegates are required to post reports to CalOptima's secure File Transfer Protocol (FTP) Site. Once the reports are received on the secure FTP Site, an automated program will immediately pull the reports, identify the naming convention, and route the reports to the appropriate areas within CalOptima. Please note: The report requirements, templates and/or instructions listed on this grid may change at any time, with 30 days notice to Health Networks.

Reports **MUST** have the correct naming convention or they will be **REJECTED**.

A. Submission Process

Health Networks FTP Site Administrators or Business Administrators are responsible for submitting reports to CalOptima's secure FTP Site, and ensuring the reports are submitted with:

1) The correct naming convention.
2) The **"DateRange"** is updated every time a report is submitted.
3) **Do not** include special characters such as **/ * # %,** in the naming conventions. This will cause reports to be rejected.
4) Reports are submitted to CalOptima's secure FTP Site to the folder indicated in the FTP FOLDER column below.

B. Timely Submission

Health Networks are responsible for ensuring timely and appropriate submission of all reports using the correct naming conventions to CalOptima's secure FTP Site:

- By the due date,
- Using the template provided (if available),
- Updating the **"DateRange"** area for each report prior to submission.

If a report due date falls on a holiday, the report is due the business day before.

C. Missing or Late Reports

If report(s) have not been received by the required due date or are invalid, the follow actions and timeframes for notification will apply:

Notification	Report Past Due
1st Notice	**24 hours after the due date of the report**
2nd Notice	**48 hours after the 1st Notice**
3rd Notice	**24 hours after the 2nd Notice**
Following the 3rd Notice, a referral will be made to the Office of Compliance requesting corrective action and/or sanction. Please refer to CalOptima policy HH.2003, Health Network Reporting for more information.	

D. Date Range

STANDARD DATE RANGE NAMING CONVENTION
Daily Reports: MMDDYYYY (e.g.; 071220XX)
Weekly Reports: MMDDYYYY (e.g.; 010820XX)
Monthly Reports: MMYYYY (e.g.; 1020XX)
Quarterly Reports: QTYYYY (e.g.; 0220XX)
Semi-Annual Reports: SemiAnnualYYYY (e.g.; SemiAnnual20XX)
Annual Reports: AnnualYYYY (e.g.; Annual20XX)
HN/Delegate Number: HN (Document Unique HN/Delegate ID number)

Timely and Appropriate Submission 2017

REPORT NAME	DESCRIPTION	MONITORING DEPARTMENT	REPORT FREQUENCY	NAMING CONVENTION	INSTRUCTIONS FOR NAMING CONVENTION	FTP FOLDER	FILE TYPE (PDF, EXCEL, etc…)	LINE OF BUSINESS
Claims XML Universe	Health Networks are required to report a complete Claims Universe for monthly review and auditing. CalOptima will select a subset of the universe and notify the Health Network of the case files required on a monthly basis.	Audit and Oversight	**Monthly** **2nd of every month**	1_XMLRPT_**HN**_CLM_**YYYYMM_##**.xml	HN = Health network # MM = 2 digit month YYYY= 4 digit year	hn_reporting	XML	All
Claims Universe Case Files	Health Networks are required to submit monthly Claims Universe Case Files for auditing. CalOptima will perform audits on the case files on a monthly basis and inform the Health Network of the results.	Audit and Oversight	**Monthly** **10th of every month**	1_AORPT_**HN_MMYYYY**_CLAIMS_**LB**_FILES	HN = Health network # MM = 2 digit month YYYY= 4 digit year LB = Line of Business (MC = Medi-Cal, OC = OneCare, DB = OneCare Connect)	hn_reporting	PDF	All
Credentialing Universe Monthly Case Files	Health Networks are required to submit Credentialing Universe Case Files for auditing. CalOptima will perform audits on the case files on a monthly basis and inform the Health Network of the results.	Audit and Oversight	**Monthly** **10th of every month**	1_AORPT_**HN_MMYYYY**_CRED_FILES	HN = Health network # MM = 2 digit month YYYY= 4 digit year	hn_reporting	PDF	All
Credentialing Annual Universe	Health Networks are required to report annual Credentialing universe of all contracted providers.	Audit and Oversight	**Annually** **January 15**	2_AORPT_QIRPT_**HN_YYYY**_CRED	HN = Health network # YYYY= 4 digit year	hn_reporting	Excel	All
Expedited Initial Organization Determination Log (OneCare & OneCare Connect)	Health Networks are required to report Expedited Initial Organization Determination requests for reporting and auditing. CalOptima will review the log weekly to monitor processing compliance and will notify the Health Network if there are any discrepancies or concerns.	Audit and Oversight	**Week y** **Every Friday between 12:00-2:00 p.m.**	1_AORPT _**HN**_EIOD_**MMDDYYYY**_LB	HN = Health network # MM = 2 digit month DD = 2 digit day YYYY= 4 digit year LB = Line of Business (OC = OneCare, DB = OneCare Connect)	hn_reporting	Excel	OneCare & OneCare Connect
NOMNC Log (OneCare & OneCare Connect)	Health Networks are required to report monthly NOMNC for reporting and auditing. CalOptima will select a subset of the universe and notify the Health Network of the case files required on a monthly basis.	Audit and Oversight	**Monthly** **2nd of every month**	1_AORPT_**HN_MMYYYY**_NOMNC_LB	HN = Health network # MM = 2 digit month YYYY= 4 digit year LB = Line of Business (OC = OneCare, DB = OneCare Connect)	hn_reporting	Word	OneCare, OneCare Connect
NOMNC Files (OneCare & OneCare Connect)	Health Networks are required to submit monthly NOMNC files for auditing. CalOptima will perform audits on the case files on a monthly basis and inform the Health Network of the results.	Audit and Oversight	**Monthly** **10th of every month**	1_AORPT_**HN_MMYYYY**_NOMNC_FILES_LB	HN = Health network # MM = 2 digit month YYYY= 4 digit year LB = Line of Business (OC = OneCare, DB = OneCare Connect)	hn_reporting	PDF	OneCare, OneCare Connect

REPORT NAME	DESCRIPTION	MONITORING DEPARTMENT	REPORT FREQUENCY	NAMING CONVENTION	INSTRUCTIONS FOR NAMING CONVENTION	FTP FOLDER	FILE TYPE (PDF, EXCEL, etc...)	LINE OF BUSINESS
PDR XML Universe	Health Networks are required to report a complete PDR Universe for monthly review and auditing. CalOptima will select a subset of the universe and notify the Health Network of the case files required on a monthly basis.	Audit and Oversight	**Monthly** **2nd of every month**	1_XMLRPT_**HN**_PDR_**YYYYMM**_##.xml	HN = Health network # MM = 2 digit month YYYY= 4 digit year	hn_reporting	XML	All
PDR Universe Case Files	Health Networks are required to submit monthly PDR Universe Case Files for auditing. CalOptima will perform audits on the case files on a monthly basis and inform the Health Network of the results.	Audit and Oversight	**Monthly** **10th of every month**	1_AORPT_**HN_MMYYYY**_PDR_**LB**_FILES	HN = Health network # CIN = Member CIN MM = 2 digit month YYYY = 4 digit year LB = Line of Business (MC = Medi-Cal, OC = OneCare, DB = OneCare	hn_reporting	PDF	All
UM XML Universe	Health Networks are required to report a complete UM Universe for monthly review and auditing. CalOptima will select a subset of the universe and notify the Health Network of the case files required on a monthly basis.	Audit and Oversight	**Monthly** **2nd of every month**	1_XMLRPT_**HN**_UM_**YYYYMM**_##.xml	HN = Health network # MM = 2 digit month YYYY= 4 digit year	hn_reporting	XML	All
UM Universe Case Files	Health Networks are required to submit monthly UM Universe Case Files for auditing. CalOptima will perform audits on the case files on a monthly basis and inform the Health Network of the results.	Audit and Oversight	**Monthly** **10th of every month**	1_AORPT_**HN_MMYYYY_LB**_Files	HN = Health network # CIN = Member CIN MM = 2 digit month YYYY= 4 digit year LB = Line of Business (MC = Medi-Cal, OC = OneCare, DB = OneCare Connect)	hn_reporting	PDF	All
HN Dashboard	Health Network performance results to support compilation of monthly Health Network Dashboard (deliverable to Audit and Oversight Committee)	Audit and Oversight	**Monthly** **15th of each month**	1_HMRPT_**HN_MMYYY**_Dashboard	HN = Health network # MM = 2 digit month YYYY= 4 digit year	hn_reporting	Excel	All
Provider Directory Universe	Health Networks are required to report a complete Provider Directory Universe for quarterly review and auditing. CalOptima will select a subset of the universe and notify the Health Network of the files selected on a quarterly basis.	Audit and Oversight	**Quarterly** **January 10, April 10, July 10 October 10**	1_AORPT_**HN_MMYYYY**_PD	HN = Health network # MM = 2 digit month YYYY= 4 digit year	hn_reporting	Excel	All
DHCS APL 17-005 Data Certification Statement	Per DHCS APL 17-005, Health Networks and delegates are required to certify that data submitted to CalOptima monthly is accurate, complete, and truthful.	Audit and Oversight	**Monthly ## of each month**	1_AORPT_**HN**_Data Certification_**MMYYYY**	HN = Health network #	hn_reporting	PDF	Medi-Cal only
Credentialing Monthly Universe	Health Networks are required to report a complete Credentialing Universe for monthly review and auditing. CalOptima will select a subset of the universe and notify the Health Network of the case files required on a monthly basis.	Audit and Oversight and Quality Improvement	**Monthly** **2nd of every month**	2_AORPT_QIRPT_**HN_MMYYYY**_CRED	MM = 2 digit month	hn_reporting	Excel	All
Mental Health Continuity of Care (Medi-Cal) - Kaiser	MCE DHCS Reporting	Behavioral Health	**Quarterly** **January 20, April 20, July 20, October 20**	Mental Health Reporting Template.xlsx Send via email to behavioralhealth@caloptima.org	YYYY= 4 digit year	Secure email	Excel	

REPORT NAME	DESCRIPTION	MONITORING DEPARTMENT	REPORT FREQUENCY	NAMING CONVENTION	INSTRUCTIONS FOR NAMING CONVENTION	FTP FOLDER	FILE TYPE (PDF, EXCEL, etc...)	LINE OF BUSINESS
Mental Health Grievances and Appeals (Medi-Cal) Kaiser	MCE DHCS Reporting	Behavioral Health	**Quarterly** **January 20, April 20, July 20, October 20**	Mental Health Reporting Template.xlsx Send via email to behavioralhealth@caloptima.org		Secure email	Excel	
Mental Health Referrals (Medi-Cal) - Kaiser	MCE DHCS Reporting	Behavioral Health	**Quarterly** **January 20, April 20, July 20, October 20**	Mental Health Reporting Template.xlsx Send via email to behavioralhealth@caloptima.org		Secure email	Excel	
Provider Payments By Place Of Service	Report includes all claims and amounts paid for the month, sorted by place of service. Details of the report include: place of service, provider name, procedure code, number of providers, total number of claims, unique utilizers, total hours, and amount paid. Note: this report is calculated from claims that have been submitted and paid at the time the report is run. Additional claims may be submitted for the report month within the filing limit of 180 calendar days from date of service.	Behavioral Health	**Monthly** **15th of every month**	MCE_CalOpt_M1_Provider_Payments_By_Place_Of_Service_MMCCYY		Incoming_tocal	Excel	Beacon Only
Paid Pended Denied Claims	List of all Paid, Pended, and Denied Claims for the month sorted by provider ID. Details include: provider ID, provider name, site name, site ID, member name, claims line ID, claim ID, procedure code, claim status, decision code, description of decision code, date received, date of service, submission days, closed mail date, lag days, allowed amount, paid amount, and co-pay amount. Note: this report is calculated from claims that have been submitted and paid at the time the report is run. Additional claims may be submitted for the report month within the filing limit of 180 calendar days from date of service.	Behavioral Health	**Monthly** **15th of every month**	MCE_CalOpt_M4_Paid_Pended_Denied_Claims_MMCCYY		Incoming_tocal	Excel	Beacon only
Cost Of Services Provided	Report includes the total cost of services provided for the month sorted by procedure code. Note: this report is calculated from claims that have been submitted and paid at the time the report is run. Additional claims may be submitted for the report month within the filing limit of 180 calendar days from date of service.	Behavioral Health	**Monthly** **15th of every month**	MCE_CalOpt_M5_ost_ Services_Provided_MMCCYY		Incoming_tocal	PDF	Beacon Only
Demographics Total Hours Of Service Provided By Age Group	Detailed breakdown by month of total hours of service provided by age group within the current fiscal year. Age groups include: 0-5, 6-17, 18-20, 21-59, 60+, and total. Each age group is broken down into number of unique utlizers and number of hours paid. Note: this report is calculated from claims that have been submitted and paid at the time the report is run. Additional claims may be submitted for the report month within the filing limit of 180 calendar days from date of service.	Behavioral Health	**Monthly** **15th of every month**	MCE_CalOpt_M6_Total_Hours_By_Age_Group_MMCCYY		Incoming_tocal	PDF	Beacon Only
Total Hours By Type Of Service	Detailed breakdown by month of total hours of services provided by type of service within the current fiscal year. Type of service includes: assessment, medication, individual therapy, attending, and total. Each type of service is broken down into unique utlizers, number of hours paid, and total amount paid. Note: this report is calculated from claims that have been submitted and paid at the time the report is un. Additional claims may be submitted for the repo t month within the filing limit of 180 calendar days from da of service.	Behav oral Health	**Monthly** **15th of every month**	MCE_CalOpt_M7_Total_Hours_By_Type_Of_Service_MMCCYY		Incoming_tocal	PDF	Beacon Only

REPORT NAME	DESCRIPTION	MONITORING DEPARTMENT	REPORT FREQUENCY	NAMING CONVENTION	INSTRUCTIONS FOR NAMING CONVENTION	FTP FOLDER	FILE TYPE (PDF, EXCEL, etc...)	LINE OF BUSINESS
High Volume Provider Report	Shows the break down of high volume providers from January 1st to the current month. 3 tabs are included on the report: YTD trend top groups (count of unique member visits per a month-includes line graph of trends), YTD trend top 10 individuals (count of unique member visits per a month-includes line graph of trends), and days claim count exceeding 32 (listed by individual). Note: this report is calculated from claims that have been submitted and paid at the time the report is run. Additional claims may be submitted for the report month within the filing limit of 180 calendar days from date of service.	Behavioral Health	**Monthly** **15th of every month**	MCE_CalOpt_M8_High_Volume_Provider_MMCCYY		Incoming_tocal	Excel	Beacon Only
Check Summary By Provider	Report includes checks issued for the month sorted by provider. Details include: check month/year, provider name, provider ID, check date, check number, check amount, payment amount, void amount (if applicable), and void reason (if applicable). Note: this report is calculated from claims that have been submitted and paid at the time the report is run. Additional claims may be submitted for the report month within the filing limit of 180 calendar days from date of service.	Behavioral Health	**Monthly** **15th of every month**	MCE_CalOpt_M10_Check_Summary_By_Provider_MMCCYY		Incoming_tocal	PDF	Beacon Only
Non Contracted Claims Threshold Report	Report includes non-contract claims for the month sorted by provider (if applicable). Details include: provider ID, provider name, service date, and total amount paid. Note: this report is calculated from claims that have been submitted and paid at the time the report is run. Additional claims may be submitted for the report month within the filing limit of 180 calendar days from date of service.	Behavioral Health	**Monthly** **15th of every month**	MCE_CalOpt_M11_Non_Contracted_Claims_Threshold_MMCCYY		Incoming_tocal	PDF	Beacon Only
Claims Lag With Member Months - Beacon	Claims lag with member months- utilized by accounting	Behavioral Health	**Monthly** **3rd of every month**	MCE_CalOpt_M13_Claims_Lag_With_Member_Months_012014-MMCCYY		Incoming_tocal	Excel	
Foster Standard Payments	Utilized by Accounting	Behavioral Health	**Monthly** **3rd of every month**	MCE_CalOpt_M14_Foster_Standard_Payments_MMCCYY		Incoming_tocal	Excel	Beacon Only
DHCS Monthly Reporting - Beacon	DHCS report	Behavioral Health	**Monthly** **9th of every month**	MCE_CalOpt_DHCS_Monthly_Provider_Report_MMCCYY		Incoming_tocal	Excel	Beacon Only
DHCS Provider Report - Beacon	DHCS report	Behavioral Health	**Monthly** **15th of every month**	MCE_CalOpt_Q3_Demographics_Of_Beneficiaries_MMCCYY-MMCCYY		Incoming_tocal	PDF	Beacon Only
Demographics Of Beneficiaries	Includes the demographics of members served both in-county services (orange county) and out of county services for the quarter. Details of the report include: County (in-county or out of county services), category (age group, aid code, ethnic group, gender, language, and provider), sub categories (of each category), type of services (assessment, medication, individual therapy, attending, and total). Each type of service is broken down into # of unique utlizers, # of hours billed, and # of hours paid.	Behavioral Health	**Quarterly** **January 15th, April 15th, July 15th, October 15th**	MCE_CalOpt_Q4_Auth_Of_Services_By_Provider_By_Diag_MMCCYY-MMCCYY		Incoming_tocal	Excel	Beacon Only
Demographics Unduplicated Client Count	Includes the unduplicated client count for the quarter. Report details include: membership group (in county, out of county, unknown and total), and # unduplicated client utilzers served.	Behavioral Health	**Quarterly** **January 15th, April 15th, July 15th, October 15th**	MCE_CalOpt_Q6_Demographics_Unduplicated_Client_Count_MMCCYY-MMCCYY		Incoming_tocal	PDF	Beacon Only

REPORT NAME	DESCRIPTION	MONITORING DEPARTMENT	REPORT FREQUENCY	NAMING CONVENTION	INSTRUCTIONS FOR NAMING CONVENTION	FTP FOLDER	FILE TYPE (PDF, EXCEL, etc...)	LINE OF BUSINESS
QI Provider Claims Appeals	Includes the claims provider appeals for the quarter. Report details include: provider ID, provider name, member ID, member last name, member first name, service date, procedure code, date received, date processed, determination (approved or denied), and decision reason. Note: this report is calculated from claims that have been submitted and paid at the time the report is run. Additional claims may be submitted for the report month within the filing limit of 180 calendar days from date of service.	Behavioral Health	**Quarterly January 15th, April 15th, July 15th, October 15th**	MCE_CalOpt_Q8_Provider_Claims_Appeals_MMCCYY-MMCCYY		Incoming_tocal	Excel	Beacon Only
MCE NOA Log	An Ad Hoc report that list all Notice of Action details for the quarter. Details include: member name/CIN #, NOA type, date of authorization, date of decision, and date denial letter was mailed.	Behavioral Health	**Quarterly January 15th, April 15th, July 15th, October 15th**	MCE_CalOpt_Q10_NOA_Log_MMCCYY-MMCCYY		Incoming_tocal or secure email	Excel	Beacon Only
837 File	Electronic submission of healthcare claim information. This format meets HIPPA requirements. The claim information includes: • Description of the patient • The patient condition for which treatment was provided • The services provided • The cost of treatment Note: this report is calculated from claims that have been submitted and paid at the time the report is run. Additional claims may be submitted for the report month within the filing limit of 180 calendar days from date of service.	Behavioral Health	**Monthly 20th of every month**	CH301YYJJJ##		Incoming_tocal	PDF	Beacon Only
Behavioral Health Access and Availability Report - Beacon	Access and availability report for behavioral Health providers in Beacon's network	Behavioral Health	**Yearly**	Behavioral Health Access and Availability Report		Secure email	PDF	
Behavioral Health Treatment /ABA open authorization	Report that outlines the total authorized hours for BHT vs utilized hours compiled from clams	Behavioral Health	**Monthly 1st of every month**	Behavioral Health Treatment/ABA open authorizations		Secure email	Excel	Beacon Only
DHCS BHT /ABA reporting	Compiled by BHT beacon team in format requested by DHCS	Behavioral Health	**Monthly - date varies**	DHCS BHT/ABA reporting		Secure email	Excel	Beacon Only
Reconciliation/Provider Network Survey	MCE DHCS Reporting	Behavioral Health	**Monthly, 1st Wednesday of each month**	Reconciliation template.xlsx Send via email to behavioralhealth@caloptima.org (Kaiser), Send via FTP		Via Email (Kaiser), Via FTP (Beacon)	Excel	Kaiser and Beacon Only
BHT Reporting Template - Kaiser	MCE DHCS Reporting	Behavioral Health	**Quarterly 28 days after the end of each quarter**	CalOptima.BHT.Mar.2016 Template.xlsx Send via email to behavioralhealth@caloptima.org		Secure email	Excel	
BHT Services Quarterly Report	MCE DHCS Reporting	Behavioral Health	**Quarterly, 6 days after the end of each quarter**	CalOptima.MentalHealth.QT.YYYY.xlsx Send via email to behavioralhealth@caloptima.org (Kaiser), Send via FTP (Beacon)	YYYY= 4 digit year QT = 2 digit Quarter #	Via Email (Kaiser), Via FTP (Beacon)	Excel	Kaiser and Beacon Only
Mental Health Continuity of Care (Medi-Cal) - Beacon	MCE DHCS Reporting	Behavioral Health	**Quarterly January 20, April 20, July 20, October 20**	Mental Health Reporting Template.xlsx		FTP FOLDER	Excel	
Mental Health Continuity of Care (Medi-Cal) - Magellan	MCE DHCS Reporting	Behavioral Health	**Quarterly January 20, April 20, July 20, October 20**	1_BHRPT_**HN_MMYYYY**_MC_COC	HN = Health network reporting # MM = 2 digit month DD - 2 digit day YYYY= 4 digit year	hn_reporting	Excel	Medi-Cal only
Mental Health Grievances and Appeals (Medi-Cal) Beacon	MCE DHCS Reporting	Behavioral Health	**Quarterly January 20, April 20, July 20, October 20**	Mental Health Reporting Template.xlsx		FTP FOLDER	Excel	
Mental Health Referrals (Medi-Cal) - Beacon	MCE DHCS Reporting	Behavioral Health	**Quarterly January 20, April 20, July 20, October 20**	Mental Health Reporting Template.xlsx		FTP FOLDER	Excel	

REPORT NAME	DESCRIPTION	MONITORING DEPARTMENT	REPORT FREQUENCY	NAMING CONVENTION	INSTRUCTIONS FOR NAMING CONVENTION	FTP FOLDER	FILE TYPE (PDF, EXCEL, etc...)	LINE OF BUSINESS
Mental Health Referrals (Medi-Cal) - Magellan	MCE DHCS Reporting	Behavioral Health	**Quarterly** **January 20, April 20, July 20, October 20**	1_BHRPT_**HN_MMYYYY**_MC_Referrals	HN = Health network reporting # MM = 2 digit month DD - 2 digit day YYYY= 4 digit year	hn_reporting	Excel	Medi-Cal only
BHT Reporting Template - Beacon	MCE DHCS Reporting	Behavioral Health	**Quarterly** **28 days after the end of each quarter**	CalOptima.BHT.Mar.2016 Template.xlsx		FTP FOLDER	Excel	
BHT Reporting Template - Magellan	MCE DHCS Reporting	Behavioral Health	**Quarterly** **28 days after the end of each quarter**	1_BHRPT_**HN_MMYYYY**_DHCS_BHT_TEMPLATE	HN = Health network reporting # MM = 2 digit month DD - 2 digit day YYYY= 4 digit year	hn_reporting	Excel	Medi-Cal only
DHCS Monthly Reporting - Magellan	DHCS report	Behavioral Health	**Monthly** **9th of every month**	1_BHRPT_**HN_MMYYYY**_DHCS_Monthly	HN = Health network reporting # MM = 2 digit month DD - 2 digit day YYYY= 4 digit year	hn_reporting	Excel	Medi-Cal only
DHCS Provider Report - Magellan	DHCS report	Behavioral Health	**Monthly** **15th of every month**	1_BHRPT_**HN_MMYYYY**_DHCS_Provider	HN = Health network reporting # MM = 2 digit month DD - 2 digit day YYYY= 4 digit year	hn_reporting	PDF	Medi-Cal only
MH Provider Supplemental Directory	Used to populate CalOptima's online and print provider directories.	Behavioral Health	**Monthly** **15th of every month**	1_BHRPT_**HN_MMYYYY**_Supplemental_Provider_Directory CalOpt_Monthly_Provider_Supplemental_Directory_MMDDYYYY	HN = Health network reporting # MM = 2 digit month DD - 2 digit day YYYY= 4 digit year	Email to Kenny Chhuor, Natalie Zavala, Edwin Poon	Excel	All
Claims Lag With Member Months - Magellan	Claims lag with member months	Behavioral Health	**Monthly** **3rd of every month**	1_BHRPT_**HN_MMYYYY**_M13	HN = Health network reporting # MM = 2 digit month YYYY= 4 digit year	hn_reporting	Excel	Medi-Cal only
Case Management Program Description	The case management program description is the description of the PMG and HN annual Case Management programs. It is a required submission as part of audit and oversight activities to ensure the respective case management programs are adhering to the standards required by our various governing agencies – CMS or DMHC – or for NCQA accreditation. The essential components of the case management program are specifically addressed in MA.6009 – Care Management and Coordination Process and GG.1301- Complex Case Management Process.	Case Mgmt	**Annually** **February 15th**	1_CMRPT_**HN**_Annual**YYYY**_CMPD	HN = Health network # YYYY = 4 digit year	hn_reporting	PDF or Word	Kaiser Only
Case Management Log	This log is required as a part of oversight activities for maintenance of NCQA accreditation and is for the Medi-Cal and OneCare Connect population only. Through the log, case management referral activities are tracked based on data and referral sources as are members in the various levels of care management from Complex to Service Coordination. "Add on" services are also noted and	Case Mgmt	**Monthly** **15th of every month**	1_CMRPT_**HN_MMYYYY**_CM	HN = Health network reporting # MM = 2 digit month YYYY= 4 digit year	hn_reporting	Excel	Medi-Cal and OneCare Connect
Birth Outcomes	Birth Outcomes reporting	Case Mgmt	**Quarterly** **January 30, April 30, July 30, October 30**	1_CMRPT_**HN_QTYYYY**_BOC	HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	Excel	Medi-Cal Only

REPORT NAME	DESCRIPTION	MONITORING DEPARTMENT	REPORT FREQUENCY	NAMING CONVENTION	INSTRUCTIONS FOR NAMING CONVENTION	FTP FOLDER	FILE TYPE (PDF, EXCEL, etc...)	LINE OF BUSINESS
Continuity of Care (OneCare Connect)	Continuity of Care reporting for OneCare Connect members	Case Mgmt	**Weekly** **Every Tuesday by 10 am for the prior week's activity**	1_CMRPT_**HN_MMDDYYYY**_COCDB	HN = Health network reporting # MM = 2 digit month DD - 2 digit day YYYY= 4 digit year	Managed_HN_Reporting	Excel	OneCare Connect Only
OneCare Connect Care Transition Log	As part of the program monitoring of OneCare Connect (OCC), the Centers for Medicare and Medicaid Services (CMS) and the Department of Health Care Services (DHCS) require CalOptima to report on transitions of member care.	Case Mgmt	**Monthly** **15th of the month**	1_CMRPT_**HN_MMYYYY**_Transitions	HN = Health network reporting # MM = 2 digit month DD - 2 digit day YYYY= 4 digit year	hn_reporting	Excel	OneCare Connect Only
OneCare Connect Care Transition Supporting Documentation	Supporting documentation for each transition of member care as reported in the OneCare Connect Care Transitions Log.	Case Mgmt	**Monthly** **15th of the month** **Ongoing, per process**	**HN_CIN**_Transition_**MMDDYYYY**	HN = Health network reporting # CIN = Member CIN MM = 2 digit month DD - 2 digit day YYYY= 4 digit year **MMDDYYYY is date of**	OCC/RevisedMOC/Inbound	PDF	OneCare Connect Only
Interdisciplinary Care Team (ICT) Bundle (OneCare)	Individual bundles with ICT minutes and ICP	Case Mgmt	**Ongoing, per process**	**HN_MEMBER CIN**_ICT_**MMDDYYYY**	HN = Health network reporting # MEMBER CIN = CIN # MM = 2 digit month DD = 2 digit day YYYY= 4 digit year	OneCare/RevisedMOC/Inbound	PDF	OneCare Only
Pediatric Interdisciplinary Care Team (ICT) Bundle (Medi-Cal)	Individual bundles with ICT minutes and ICP	Case Mgmt	**Ongoing, per process**	**HN_MEMBERCIN**_SPD_PEDS_ICT_**MMDDYYYY**	HN = Health network reporting # MEMBER CIN = CIN # MM = 2 digit month DD = 2 digit day YYYY= 4 digit year	SPD/RevisedMOC/Inbound	PDF	Medi-Cal Only
Interdisciplinary Care Team (ICT) Bundle (Medi-Cal)	Individual bundles with ICT minutes and ICP	Case Mgmt	**Ongoing, per process**	**HN_MEMBERCIN**_SPD_ICT_**MMDDYYYY**	HN = Health network reporting # MEMBER CIN = CIN # MM = 2 digit month DD = 2 digit day YYYY= 4 digit year	SPD/RevisedMOC/Inbound	PDF	Medi-Cal Only
Interdisciplinary Care Plan (ICP) Bundle (OneCare Connect)	Individual bundles with ICT minutes and ICP.	Case Mgmt	**Ongoing, per process**	**HN_MEMBERCIN**_ICP_**MMDDYYYY**	HN = Health network reporting # MEMBER CIN = CIN # MM = 2 digit month DD = 2 digit day YYYY= 4 digit year	OCC/RevisedMOC/Inbound	PDF	OneCare Connect Only
LTC Interdisciplinary Care Plan (ICP) Bundle (OneCare Connect)	Individual bundles with ICT minutes and ICP.	Case Mgmt	**Ongoing, per process**	**HN_MEMBERCIN_**LTC_ICP_**MMDDYYYY**	HN = Health network reporting # MEMBER CIN = CIN # MM = 2 digit month DD = 2 digit day YYYY= 4 digit year	OCC/RevisedMOC/Inbound	PDF	OneCare Connect Only
MOC Tracking Log (OneCare)	Report with OneCare PCC assignments and Care Management Levels	Case Mgmt	**Monthly** **6th of the month**	**HN**571**CCYYMMDD**	HN = Health network reporting # CCYY= 4 digit year MM = 2 digit month DD = 2 digit day	OneCare/RevisedMOC/Inbound	Pipe delimited text file	OneCare Only
MOC SPD Tracking Log (Medi-Cal)	Report with indicated SPD member PCC assignments and Care Management Levels	Case Mgmt	**Monthly** **6th of the month**	**HN**271**CCYYMMDD**	HN = Health network reporting # CCYY= 4 digit year MM = 2 digit month DD = 2 digit day	SPD Revised MOC/Inbound	Pipe delimited text file	Medi-Cal Only
MOC Tracking Log (OneCare Connect)	Report with OneCare Connect PCC assignments and Care Management Levels	Case Mgmt	**Monthly** **6th of the month**	**HN**871**CCYYMMDD**	HN = Health network reporting # CCYY= 4 digit year MM = 2 digit month	OCC/RevisedMOC/Inbound	Pipe delimited text file	OneCare Connect Only

REPORT NAME	DESCRIPTION	MONITORING DEPARTMENT	REPORT FREQUENCY	NAMING CONVENTION	INSTRUCTIONS FOR NAMING CONVENTION	FTP FOLDER	FILE TYPE (PDF, EXCEL, etc...)	LINE OF BUSINESS
Organ Transplant	Report of members with organ transplant	Case Mgmt	**Monthly** **15th of every month**	1_CMRPT_04_**MMYYYY**_OT	MM = 2 digit month YYYY= 4 digit year	hn_reporting	Excel	Kaiser Only
Network Staff Legend File	Report PCC and other care coordinator staff names, training status, manager and percentage of time working on Medi-Cal, OneCare and OneCare Connect	Case Mgmt	**Monthly** **6th of every month**	**HN**429**YYYYMMDD**	HN = Health network reporting # YYYY = 4 digit year MM = 2 digit month DD = 2 digit day	/RevisedMOC/Inbound	Text File	All
Claims Third Party Liability	Networks report their potential TPL data to CalOptima and we submit to DHCS	Claims	**Monthly** **30th of every month**	1_CLMRPT_**HN_MMYYYY**_TPL	HN = Health network reporting # MM = 2 digit month YYYY= 4 digit year	hn_reporting	Excel & PDF	Medi-Cal Only
Claims Third Party Liability (OneCare Connect)	Networks report their potential TPL data to CalOptima and we submit to DHCS	Claims	**Monthly** **30th of every month**	1_CLMRPT_**HN_MMYYYY**_TPL_DB	HN = Health network reporting # MM = 2 digit month YYYY= 4 digit year	hn_reporting	Excel & PDF	OneCare Connect Only
Claims Timeliness Reports (Medi-Cal)	Health Networks shall submit claims payment summary reports to DHCS on a quarterly basis as specified in Exhibit A, Attachment 2, Provision2. Financial Audit Reports Paragraph B. 2).	Compliance	**Monthly** **15th of every month** **Quarterly** **January 30, April 30, July 30, October 30**	1_HNRPT_**HN_MMYYYY**_MTRMC (Monthly) 1_HNRPT_**HN_QTYYYY**_MTRMC (Quarterly)	HN = Health network reporting # MM = 2 digit month QT = 2 digit quarter # YYYY= 4 digit year	hn_reporting	Excel	Medi-Cal Only
Provider Disputes (Medi-Cal)	Health networks are required to report quarterly Provider Dispute Resolution data. CalOptima compiles the data and reports to Regulatory affairs.	Compliance	**Quarterly** **January 30, April 30, July 30, October 30**	1_HNRPT_**HN_QTYYYY**_PDMC	HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	Excel	Kaiser Only
Call Center Statistics	Per the Medicare Marketing Guidelines, Call Center Requirements includes: • Limit average hold time to two (2) minutes. The average hold time is defined as the time spent on hold by the caller following the interactive voice response (IVR) system, touch tone response system, or recorded greeting and before reaching a live person. • Answer eighty (80) percent of incoming calls within thirty (30) seconds • Limit the disconnect rate of all incoming calls to five (5 percent Health Networks must report: • Calls by Language • Abandonment Rate • Average Speed of Answer, Average Length of Call, Number of Auth/Referral Calls, Number of Claims Calls, Number of Member Cost Calls	Customer Service	**Quarterly** **January 30, April 30, July 30, October 30**	2_CSRPT_QIRPT_**HN_QTYYYY**_CCS	HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	Excel	All

REPORT NAME	DESCRIPTION	MONITORING DEPARTMENT	REPORT FREQUENCY	NAMING CONVENTION	INSTRUCTIONS FOR NAMING CONVENTION	FTP FOLDER	FILE TYPE (PDF, EXCEL, etc...)	LINE OF BUSINESS
Annual Audited Financial Statements	Annual audited financial statements of the organization (PHC and SRG only).	Finance	**Annual submission due 120 days after organization's fiscal year ends**	1_FINRPT_**HN**_Annual**YYYY**_AAFS	HN = Health network reporting # YYYY = 4 digit year	hn_reporting	PDF or Excel	All
IBNR Documentation	**Can be included in Annual Audited Financial Statements, or submitted as a separate report.** 'Written policies and procedures or any related documentation of the methodology used to estimate the liability for incurred but not reported (IBNR) claims, and supporting documentation for the IBNR calculation.	Finance	**Annual submission due 120 days after organization's fiscal year ends**	1_FINRPT_**HN**_Annual**YYYY**_IBNR or submitted with Annual Audited Financial Statements	HN = Health network reporting # YYYY = 4 digit year	hn_reporting	PDF or Excel	All
Medical Loss Ratio	Reporting of the Health Network Medical Loss Ratio. Medi-Cal Expansion reported separately from Medi-Cal (classic). SRG completes only the "P" tabs. PHC completes the "P"	Finance	**Interim: Waived** **Final: Annual submission of all 12 months due June 30.**	1_FINRPT_**HN_Final**YYYY_MLR	HN = Health network reporting # YYYY= 4 digit year	hn_reporting	Excel (using most current AFRF)	Medi-Cal and OneCare Connect
Risk Bearing Organization (RBO) Report	Quarterly and annual financial data submitted by networks to DMHC (PHC and SRG only)	Finance	**Annual submission due 150 days after the fiscal year ends.** **Quarterly submissions due: February 15, May 15, August 15, November 15**	1_FINRPT_**HN_Annual**YYYY_DMHC (Annual) 1_FINRPT_**HN_QTYYYY**_DMHC (Quarterly)	HN = Health network reporting # YYYY= 4 digit year QT = 2 digit Quarter #	hn_reporting	PDF or Excel	All
Total Business Reports	Quarterly unaudited financial statements of the PHC and SRG organization including balance sheet, income statement, statement of cash flows and related disclosures (PHC and SRG only).	Finance	**Quarterly submissions due: February 15, May 15, August 15, November 15**	1_FINRPT_**HN_QTYYYY**_TBFS	HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	PDF or Excel	All
Member All Grievance Log	DHCS: Quarterly log containing details of each case included in the Member All Grievances Summary	GARS	**Quarterly** **February 9, May 9, August 9, November 9**	1_GARSRPT_04_**QT_YYY**_GrievLog	HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	Excel	Kaiser Only
Member All Grievances Summary	DHCS: Quarterly report of grievances and appeals closed within the quarter; tracking volume and types of cases	GARS	**Quarterly** **February 9, May 9, August 9, November 9**	1_GARSRPT_04_**QTYYYY**_AllMbr	HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	Excel	Kaiser Only
Member CBAS Summary	DHCS: Quarterly report of grievances related to Community Based Adult Services closed within the quarter	GARS	**Quarterly** **January 23, April 23, July 23, October 23**	1_GARSRPT_04_**QTYYYY**_CBAS	HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	Excel	Kaiser Only
DHCS Quarterly Report	Quarterly report of grievances and appeals received within the quarter; tracks grievance types	GARS	**Quarterly** **January 23, April 23, July 23, October 23**	1_GARSRPT_04_**QTYYYY**_DHCS	HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	Excel	Kaiser Only
Member SPD Grievances Summary	DHCS: Quarterly report of grievances and appeals closed within the quarter, filed by SPD members; tracking volume and types of cases (subset of Member All Grievances Summary)	GARS	**Quarterly** **February 9, May 9, August 9, November 9**	1_GARSRPT_04_**QTYYYY**_SPD	HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	Excel	Kaiser Only
Disease Management Evaluation	The organization must identify a minimum of two chronic condition for which it has implemented a DM program. The conditions should be relevant to the organization s population (including high-risk pregnancy); however, primary prevention may not be included as a disease management condition. The components of the DM program should meet the requirements set forth by NCQA for QI8	Health Education and Disease Management	**Annually** **1st Quarter**	1_DMRPT_04_Annual**YYYY**_DM	YYYY= 4 digit year	hn_reporting	Excel or Word or PDF	Kaiser Only
Health Education Calendar		Health Education and Disease Management	**Semi-Annually** **January 31 and July 31**	1_DMRPT_04_**MMYYYY**_HECALENDAR	HN = Health network reporting # MM = 2 digit month YYYY= 4 digit year	hn_reporting	Excel	Kaiser Only

REPORT NAME	DESCRIPTION	MONITORING DEPARTMENT	REPORT FREQUENCY	NAMING CONVENTION	INSTRUCTIONS FOR NAMING CONVENTION	FTP FOLDER	FILE TYPE (PDF, EXCEL, etc...)	LINE OF BUSINESS
Health Education Individual Encounters		Health Education and Disease Management	**Semi-Annually** **January 31 and July 31**	1_DMRPT_04_**MMYYYY**_HEIE	HN = Health network reporting # MM = 2 digit month YYYY= 4 digit year	hn_reporting	Word	Kaiser Only
Health Education Other Encounters		Health Education and Disease Management	**Semi-Annually** **January 31 and July 31**	1_DMRPT_04_**MMYYYY**_HEOE	HN = Health netwo k reporting # MM 2 digi mon h YYYY= 4 digit year	hn_reporting	Word	Kaiser Only
Hep C Pharmacy Data File		IS	**Monthly** **15th of every month**	04269**CCYYMMDD**	N = Health network reporting # CCYY= 4 digit year MM = 2 digit month DD = 2 digit day	Incoming	Text File	Kaiser Only
CBAS Report		Long Term Support Services	**Monthly** **20th of every month**	KaiserPermanente_PRD_HCBShighind_CalOptima_**yyyymm**.txt	YYYY= 4 digit year MM = 2 digit month	Incoming	Text File	Kaiser only
Health Network Newly Contracted Provider Training Report	Health Networks shall initiate, provide, and complete all educational training to **all Provider's** within ten (10) working days from the Provider s placement on active status. Health Networks shall obtain a signed acknowledgment	PN	**Quarterly** **January 25, April 25, July 25, October 25**	1_HMRPT_**HN_QTYYYY**_NCT	HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	Excel	All
Out of Network Requests	Health Networks report out-of-network requests from all enrolled members and approvals by specialty type.	Quality Analytics	**Quarterly** **January 25, April 25, July 25, October 25**	1_MDMRPT_**HN_Q_YYYY**_OON	HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	Excel	Medi-Cal Only
Access and Availability Report	Annual analysis of data to measure performance against standards for access. Report must also include BH access standards.	Quality Analytics	**Annually** **February 15**	1_MDMRPT_04_Annual**YYYY**_Access	YYYY = 4 digit year	hn_reporting	Excel or Word or PDF	Kaiser Only
QI Program	Health Networks shall develop an annual quality improvement report and submit to CalOptima for review.	Quality Improvement	**Annually** **February 15 h**	1_QIRPT_**HN**_Annual**YYYY**_QIP	HN = Health network # YYYY = 4 digit year	hn_reporting	PDF or Word	All
QI Evaluation (Previous Year)	Health Networks shall perform an annual evaluation of their quality improvement work plan/program and submit to CalOptima for review.	Quality Improvement	**Annually** **February 15th**	1_QIRPT_**HN**_Annual**YYYY**_QIE	HN = Health network # YYYY = 4 digit year	hn_reporting	PDF or Word	All
QI Work Plan Current Year (Initial)	Health Networks must develop an annual quality improvement work plan that outlines goals and initiatives for the new year. The initial work plan must be submitted to CalOptima for review.	Quality Improvemen	**Annually** **February 15th (for new year)**	1_QIRPT_**HN**_Annual**YYYY**_QICY	HN = Health network # YYYY = 4 digit year	hn_reporting	Excel	All
QI Work Plan (ICE)	Health Networks must report progress towards quality improvement program goals semi-annually.	uali y Improvement	**Semi-Annually** **February 15th and August 15th**	1_QIRPT_**HN**_SemiAnnual**YYYY**_QI	HN = Health network # YYYY = 4 digit year	hn_reporting	Excel	All
Authorization Utilization Report	Health Networks report open authorizations, if a claim was received and the date the claim was paid (if applicable).	Quality Improvement	**Quarterly** **Q3 2016 - February 15** **Q4 2016 - May 15** **Q1 2017 - August 15** **Q2 2017 - November 15**	1_QIRPT_**HN_QTYYYY**_AUTH	HN = Health network reporting # QT = 2 digit quarter YYYY= 4 digit year	hn_reporting	Excel	Medi-Cal Only

REPORT NAME	DESCRIPTION	MONITORING DEPARTMENT	REPORT FREQUENCY	NAMING CONVENTION	INSTRUCTIONS FOR NAMING CONVENTION	FTP FOLDER	FILE TYPE (PDF, EXCEL, etc...)	LINE OF BUSINESS
UM Program	Health Networks shall develop a utilization management program description and submit to CalOptima for review.	Utilization Management	**Annually** **February 15th**	1_UMRPT_**HN**_Annual**YYYY**_UMP	HN = Health network # YYYY = 4 digit year	hn_reporting	PDF or Word	All
UM Evaluation (Previous Year)	Health Networks shall perform an annual evaluation on their utilization management work plan/program and submit to CalOptima for review.	Utilization Management	**Annually** **February 15th**	1_UMRPT_**HN**_Annual**YYYY**_UME	HN = Health network # YYYY = 4 digit year	hn_reporting	PDF or Word	All
UM Work Plan Current Year (Initial)	Health Networks must develop an annual utilization management work plan that outlines goals and initiatives for the new year. The initial work plan must be submitted to CalOptima for review.	Utilization Management	**Annually** **February 15th (for new year)**	1_UMRPT_**HN**_Annual**YYYY**_UMCY	HN = Health network # YYYY = 4 digit year	hn_reporting	Excel	All
UM Work Plan (ICE)	Health Networks must report progress towards utilization management program goals semi-annually.	Utilization Management	**Semi-Annually** **February 15th and August 15**	1_UMRPT_**HN**_SemiAnnual**YYYY**_UMCY	HN = Health network # YYYY = 4 digit year	hn_reporting	Excel	All
UM Committee Meeting Minutes	Health Networks must keep record of utilization management committee meetings through minutes	Utilization Management	**Semi- Annually** **February 15th and August 15th**	1_UMRPT_**HN**_SemiAnnuall**YYYY**_Minutes	HN = Health network # YYYY = 4 digit year	hn_reporting	PDF or Word	All
Dental Anesthesia Report	The Department of Health Care Services (DHCS) now requires reporting of dental general anesthesia services. The health networks will report quarterly the monthly totals of dental general anesthesia requests, approvals and denials for adults and children with and without developmental disability.	Utilization Management	**Quarterly** **15th after the end of the quarter**	1_UMRPT_**HN_QTYYYY**_DA	HN = Health network reporting # QT = 2 digit Quarter # YYYY = 4 digit year	hn_reporting	Excel	Medi-Cal Only
Nurse Advice Line Call Log	Each week on Monday, the health networks will submit the completed Nurse Advice Line Call Log for the previous week s activity	Utilization Management	**Weekly** **Every Monday for the previous weeks activity**	1_NARPT_**HN_MMDDYY**_**YY**	HN = Health network reporting # YYYY= 4 digit year MM = 2 digit month DD = 2 digit day Use date of submission	hn_reporting	Excel	All

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 7, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

11. Adopt Board Resolution No. 22-0407-01, Authorizing Remote Teleconference Meetings for the CalOptima Board of Directors and its Advisory Committees in Accordance with California Government Code section 54953, subdivision (e)

Contact

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

Recommended Action

Adopt Board Resolution No. 22-0407-01, authorizing remote teleconference meetings for the CalOptima Board of Directors and its advisory committees in accordance with Government Code section 54953, subdivision (e).

Background

Under the Ralph M. Brown Act, California Government Code Section 54950 *et seq.*, (Brown Act) meetings of California local public bodies must be open and public. Prior to the COVID-19 pandemic, the Brown Act has generally allowed a local agency to use teleconferencing for public meetings, subject to specific agenda, posting, physical access, and quorum requirements. On March 4, 2020, pursuant to Government Code section 8625, Governor Gavin Newsom declared a state of emergency related to the COVID-19 pandemic. On November 10, 2021, Governor Newsom issued Executive Order N-21-21, extending the state of emergency through March 31, 2022, and the declaration of emergency continues in effect and has not been lifted or rescinded.

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

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

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

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

Discussion

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

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

Given the continued active declaration of emergency arising from the COVID-19 pandemic and the Governor's extension of the declaration of a state of emergency through March 31, 2022, there is an ongoing need for holding teleconference meetings for the CalOptima Board of Directors and its advisory committees. In addition, the County of Orange Health Officer issued "Orders and Strong Recommendations," updated as of January 14, 2022, to strongly recommend preventative measures such as avoiding gathering and practicing social distancing. For CalOptima to continue the teleconference meetings, the required finding are set forth in the attached Resolution No. 22-0407-01.

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

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

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

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

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

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Board Resolution No. 22-0407-01, 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. November 10, 2021, Extension of the State of Emergency
4. January 14, 2022, Orange County Health Officer's Orders and Strong Recommendations
5. Government Code section 54953, as amended by AB 361

/s/ Michael Hunn *03/31/2022*
Authorized Signature **Date**

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RESOLUTION NO. 22-0407-01

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

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

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

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

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

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; and

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; and

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; and

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; and

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; and

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

WHEREAS, on November 10, 2021, the Governor extended the state of emergency through March 31, 2022; and

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; and

WHEREAS, on January 14, 2022, the County of Orange Health Officer issued a revised "Orders and Strong Recommendations," which includes strong recommendations for preventative measures, such as avoiding gathering and practicing social distancing; and

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

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

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

NOW, THEREFORE, BE IT RESOLVED:

I. That the CalOptima Board of Directors has duly considered the active status of the current state of emergency through March 31, 2022, along with the County of Orange Health Officer's strong recommendation to continue implementing COVID-19 preventative measures, such as social distancing, and has found that the state of emergency continues to directly impact the ability of the CalOptima Board of Directors and its advisory committees to meet safely in person,

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

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

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

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a. CalOptima, this 7th day of April, 2022.

AYES: _____

NOES: _____

ABSENT: _____

ABSTAIN: _____

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

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

EXECUTIVE DEPARTMENT
STATE OF CALIFORNIA

PROCLAMATION OF A STATE OF EMERGENCY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

IT IS HEREBY ORDERED THAT:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

GAVIN NEWSOM
Governor of California

ATTEST:

ALEX PADILLA
Secretary of State

EXECUTIVE DEPARTMENT
STATE OF CALIFORNIA

EXECUTIVE ORDER N-21-21

WHEREAS on March 4, 2020, I proclaimed a State of Emergency to exist in California as a result of the threat of COVID-19; and

WHEREAS in response to the ongoing COVID-19 pandemic and increased spread of the Delta variant, on August 16, 2021, I issued Executive Order N-12-21 to ensure the State's health care facilities continue to have the staffing and resources needed to prevent potential strain on the State's health care delivery system; and

WHEREAS on October 4, 2021, I issued Executive Order N-17-21 to extend flexibilities allowing the State to increase health care capacity to support ongoing testing and vaccination efforts and minimize the threat of COVID-19 to Californians; and

WHEREAS California has stopped recording week-over-week declines in COVID-19 cases and hospitalizations, which demonstrates a plateau and the potential beginning of a new surge in COVID-19 cases; and

WHEREAS as flu season approaches, it is critical that California's health care facilities, already short-staffed and backlogged from the Delta variant and with high-levels of non-COVID-19 admissions, have the flexibilities that they need for additional capacity and to prevent staffing shortages; and

WHEREAS California continues to prioritize efforts to vaccinate all eligible individuals against COVID-19, including ensuring access to boosters and vaccines for newly eligible populations; and

WHEREAS supporting robust COVID-19 testing capacity remains critical in the efforts to protect public health and mitigate the impacts of the pandemic; and

WHEREAS continued flexibility in non-hospital settings remains necessary to support these ongoing testing and vaccination efforts and to minimize the threat of COVID-19 to vulnerable Californians; and

WHEREAS under the provisions of Government Code section 8571, I find that strict compliance with various statutes, regulations, and certain

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IT IS HEREBY ORDERED THAT:

1. The timeframes set forth in Executive Order N-12-21, paragraphs 1 through 6, are hereby extended through March 31, 2022.

2. The timeframe set forth in Executive Order N-17-21, Paragraph 1, is hereby extended through March 31, 2022.

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

This Order is not intended to, and does not, create any rights or benefits, substantive or procedural, enforceable at law or in equity, against the State of California, its agencies, departments, entities, officers, employees, or any other person.

IN WITNESS WHEREOF I have hereunto set my hand and caused the Great Seal of the State of California to be affixed this 10th day of November 2021.

GAVIN NEWSOM
Governor of California

ATTEST:

SHIRLEY WEBER, PH.D.
Secretary of State

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CLAYTON CHAU, MD PhD
DIRECTOR/COUNTY HEALTH OFFICER

REGINA CHINSIO-KWONG, DO
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COUNTY OF ORANGE HEALTH OFFICER'S ORDERS AND STRONG RECOMMENDATIONS

(Revised January 14, 2022)

In light of the recent quarantine and isolation guidelines announced/issued by Centers for Disease Control and Preventions (CDC) and California Department of Public Health (CDPH), 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 January 4, 2022. The Orders and Strong Recommendations issued on January 4, 2022, are no longer in effect as of January 14, 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 and Self-Quarantine Orders

NOTE: Refer to the Definition Section below for the meaning of terms used in this isolation and quarantine orders, e.g., exposure to COVID-19, symptoms, etc.

A. Self-isolation of Persons with COVID-19

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 test positive for COVID-19. Persons who test positive for COVID-19 shall immediately isolate themselves in their home or another suitable place for at least 5 days. They may discontinue self-isolation after day 5 from the date they test positive IF:

    - COVID-19 symptoms are not present and a diagnostic specimen collected on day 5 or later tests negative.

        - An antigen test, nucleic acid amplification test (NAAT), or LAMP test are acceptable, however, if it is recommended that persons use an antigen test for ending isolation. Use of Over-the-Counter tests are also acceptable to end isolation.

    - If unable to test, choose not to test, or test positive by repeat testing, and symptoms are not present or not resolving, isolation shall continue through day 10 and may end after 10 days regardless of whether symptoms are present or resolving.

    - They should continue to wear a well-fitting mask at all times around other people through at least day 10.

2. Persons who have symptoms. Persons who have COVID-19 symptomatic shall immediately isolate themselves in their home or another suitable place for 5 days from the date of their symptom onset. They may end isolation IF:

    - A diagnostic specimen collected as early as the onset of their symptoms or later tests negative.

        - An antigen test, nucleic acid amplification test (NAAT), or LAMP test are acceptable, however, if it is recommended that persons use an antigen test for ending isolation. Use of Over-the-Counter tests are also acceptable to end isolation.

- If fever is present, isolation shall continue until fever resolves without the use of fever-reducing medications.
- If symptoms other than fever are not resolving, isolation shall continue (i) until symptoms are resolving or (ii) for 10 days regardless of whether symptoms are resolving or not.
- If unable to test, choose not to test, or test positive by repeat testing, and symptoms are not present or not resolving, isolation shall continue through day 10 and may end after 10 days regardless of whether symptoms are present or resolving.
- They 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.

B. Exemption from Isolation

- Health care providers who (i) work at general acute care hospitals, acute psychiatric hospitals, and skilled nursing facilities; (ii) have tested positive for COVID-19; and (iii) do not have any symptoms are not required to isolate per this Order. This exemption is effective through February 1, 2022. They shall wear an N95 respirator for source control. Facilities implementing this exemption (i) must have made every attempt to bring in additional registry or contract staff and must have considered

modifications to non-essential procedures; and (ii) should preferably assign them to work with COVID-19 positive patients.

C. Self-Quarantine of Persons Exposed to COVID-19

NOTE: The self-quarantine orders and exemptions below DO NOT in any way restrict access by first responders to a quarantine site during an emergency.

1. Not-up-to-date personas. Persons who (i) do not have symptoms; (ii) are not-up-to-date with COVID-19 vaccination; and (iii) know they have been exposed to COVID-19 shall quarantine for at least 5 days after their most recent exposure to COVID-19. Self-quarantine may end after day 5 IF:

   - Person has not developed any symptoms and a diagnostic specimen collected on day 5 or later tests negative.
     - Use of Over-the-Counter tests are acceptable to end quarantine.
   - If the person is unable to test or chooses not to test, s/he shall quarantine for 10 days after most recent exposure to COVID-19.
   - Additionally, the person should continue to wear a well-fitting mask around other people through at least day 10 after most recent exposure to COVID-19.

D. Exemptions from Quarantine

1. Asymptomatic up-to-date persons. Persons who (i) are up-to-date with COVID-19 vaccinations prior to their exposure to COVID-19; and (ii) have not developed any symptoms since their exposure to COVID-19 are not required to quarantine.

   - They should test on day 5 from date of exposure to COVID-19. If they test positive, they shall immediately self-isolate, as ordered above, and contact their healthcare provider with any questions regarding their care.
   - They should continue to wear a well-fitting mask at all times around other people through at least day 10 after their exposure to COVID-19.

2. Asymptomatic persons previously infected. Persons who (i) are exposed to COVIV-19; (ii) test positive for COVID-19 before their new, recent exposure to COVID-19; and (iii) it has been less than 3 months since they started having

symptoms from that previous infection (or since their first positive COVID-19 test if asymptomatic), are not required to quarantine per this Order, as long as they have not had any new symptoms since their recent exposure to COVID-19.

3. Exposed Asymptomatic Emergency Responders and Health Care Workers. During critical staffing shortages, exposed emergency responders and health care workers who do not have any symptoms are not required to quarantine. They should wear a well-fitting mask at all times when around others for at least 10 days after their most recent exposure to COVID-19 and monitor for symptoms of COVID-19.

4. Non-health care provider and non-emergency workers. All non-health care provider and non-emergency responder workers (i) who are fully vaccinated and eligible for a booster shot but have not yet obtained their booster shot; and (ii) who do not have symptoms are not required to quarantine per this Order if:

   - A diagnostic specimen collected on day 5 or later tests negative (use of Over-the-Counter tests are acceptable); and
   - The worker wears a well-fitting mask around others for 10 days from date of last exposure to COVID-19; and
   - The worker does not develop any symptoms.

5. Quarantine of Students in both Private and Public Transitional Kindergarten through Grade 12. Schools/school districts may choose from between the following two models for students who are exposed to COVID-19:

   Option 1. Individual Management – Students in both private and public transitional kindergarten through grade 12 shall follow the isolation and self-quarantine orders above with the following Modified Quarantine exemption:

   Modified Quarantine. If a not-up-to-date student is exposed to COVID-19 and both were wearing mask then the exposed student may continue to attend school for in-person instruction during the duration of his or her quarantine period if the following conditions are met:

   - The exposed student does not develop any symptoms; AND

- The exposed student continues to appropriately wear well-fitting mask; AND
- The exposed student undergoes testing for COVID-19 at least twice during the 5 days quarantine period (use of Over-the-Counter tests are acceptable); AND
- The exposed student refrains from participation in all extracurricular activities at school, including sports, and activities within the community setting for the duration of his or her quarantine period. The exposed student may participate in all required instructional components of the school day, except activities where a mask cannot be worn, such as while playing certain musical instruments. The exposed student may also eat meals on campus.
- If the exposed student is unable to test or chooses not to test, s/he shall quarantine for 10 days after most recent exposure to COVID-19.

Option 2. Group Tracing Approach – For this option, schools will notify groups of students. Groups of students mean those students who spent more than 15 minutes (over a 24-hour period) in the same indoor airspace (e.g., classroom) with someone who has COVID-19, regardless of their vaccination status or previous COVID-19 disease. Notification would be to groups of exposed students (e.g., classmates, teammates, cohorts) rather than the individual students identified in Option 1 (Individual Management), above. The notification will provide the following information:

- Exposure to COVID-19;
- Last known date of exposure to COVID-19;
- The option to continue to attend school so long as they are free of any symptoms (those who develop symptoms shall isolate per the isolation order, above);

- Recommendation to undergo testing 3 to 5 days after most recent exposure to COVID-19;
- Shall wear a well-fitting mask;
- If unable to wear a mask due to a documented exemption the student must quarantine at home until the student has obtained a negative result for the test administered on day 3 to 5 after most recent exposure to COVID-19.
- Students so notified who participate in activities where it is not practicable to participate with a mask on will refrain from that activity until negative results is obtained from the test administered on day 3 to -5 after most recent last exposure to COVID-19. If they are participating in routine testing program, at least once per week they may continue with all activities, so long as they remain asymptomatic and test negative.

In the event of wide-scale and or repeated exposures, broader (grade-wide or campus-wide) once weekly testing for COVID-19 may be chosen in lieu of group notification until such time as exposure events become less frequent.

E. Definitions

The following definitions shall govern the meaning of terms in the isolation and quarantine orders, above.

1. *Symptom(s)*. Whenever the term "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.

2. *Up-to-date with COVID-19 vaccination*. Persons 12 years and older are considered up-to-date with their COVID-19 vaccination if they have completed a primary series of COVID-19 vaccine and have either received a booster shot or are not yet recommended to receive a booster dose according to current CDC guidance. Those less than 12 years of age are considered up-to-date with their COVID-19 Vaccinations if they have completed their primary series according to CDC guidance:

   CDC COVID-19 Primary Vaccine Series Guidance

   CDC COVID-19 Vaccine Booster Shot Guidance

3. *Not-up-to-date with COVID-19 vaccination*. All persons who do not meet the criteria under up-to-date with COVID-19 vaccination, as defined above, are considered not-up-to-date with their COVID-19 vaccination.

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

5. *Emergency responder*. This term includes 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.

6. *Health care provider*. This term includes 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.

II. Face-Covering Order:

- **Wear a Cloth Face-Covering**. To help prevent the spread of droplets containing COVID-19, all County residents and visitors shall wear face coverings in accordance with and as required by the Guidance for the Use of Face Coverings issued by CDPH, effective December 15, 2021. The Guidance is attached herein as Attachment "**A**" and can be found at:

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

The Guidance orders, as follows:

Masking Requirements.

Masks are required for all individuals in all indoor public settings, regardless of vaccination status from December 15, 2021, through February 15, 2022. Full guidance can be found at: https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Get-the-Most-out-of-Masking.aspx.

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

See State Health Officer Order, issued on July 26, 2021 (https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Order-of-the-State-Public-Health-Officer-Unvaccinated-Workers-In-High-Risk-Settings.aspx), for a full list of high-risk congregate and other healthcare settings where surgical masks are required for unvaccinated workers, and recommendations for respirator use for unvaccinated workers in healthcare and long-term care facilities in situations or settings not covered by Cal OSHA ETS or ATD.

No person can 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 wearing masks at all times:

- Persons younger than two years old. Very young children must not wear a mask because of the risk of suffocation.
- 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.

The County Health Officer strongly recommends that all mask wearers consistently and correctly wear a mask that offers good filtration to get the best protection. To improve efficacy, the mask should fit to minimize gaps between the face and mask. The mask should also fully cover the nose and mouth. If wearing a fabric face covering, three layers should be worn to offer better filtration.

The County Health Officer also strongly recommends wearing a face shield for members of the public who cannot wear a face covering due to a medical condition or other exemption (except for children younger than 2 years old), although they may not work as well as face coverings in their ability to prevent the spread of COVID-19 to others. A cloth “drape” should be attached to the bottom edge of the face shield and tucked into the shirt to minimize gaps between the face and face shield.

III. Vaccination and Testing for COVID-19 Orders:

1. **COVID-19 Vaccination for Workers and Service Providers of Certain Facilities**.
To help prevent transmission of COVID-19, all workers who provide services or work in facilities described below shall comply with the COVID-19 vaccination and booster dose requirements as set forth in the December 22, 2021, 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:

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 December 22, 2021. *See* https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Order-of-the-State-Public-Health-Officer-Health-Care-Worker-Vaccine-Requirement.aspx

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

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

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

Facilities covered by this order include:

Acute Health Care and Long-Term Care Settings:

- General Acute Care Hospitals
- Skilled Nursing Facilities (including Subacute Facilities)
- Intermediate Care Facilities

High-Risk Congregate Settings:

- Adult and Senior Care Facilities
- Homeless Shelters
- State and Local Correctional Facilities and Detention Centers

Other Health Care Settings:

- Acute Psychiatric Hospitals
- Adult Day Health Care Centers
- Adult Day Programs Licensed by the California Department of Social Services
- Program of All-Inclusive Care for the Elderly (PACE) and PACE Centers
- Ambulatory Surgery Centers
- Chemical Dependency Recovery Hospitals
- Clinics & Doctor Offices (including behavioral health, surgical)
- Congregate Living Health Facilities

- Dental Offices
- Dialysis Centers
- Hospice Facilities
- Pediatric Day Health and Respite Care Facilities
- Residential Substance Use Treatment and Mental Health Treatment Facilities

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

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

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

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

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

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

5. **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 does requirements as set forth in the December 22, 2021, State Health Officer Order. A copy of the State Health Officer Order is attached herein as Attachment "**F**" and can be found at the following link:

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. Visiting Acute Health Care and Long-Term Care Setting Order:

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

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

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

V. Seasonal Flu Vaccination Order:

Seasonal Flu Vaccination for Certain County Residents.

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

- *Emergency responder* shall mean military or national guard; law enforcement officers; correctional institution personnel; fire fighters; emergency medical services personnel; physicians; nurses; public health personnel; emergency medical technicians; paramedics; emergency management personnel; 911 operators; child welfare workers and service providers; public works personnel; and persons with skills or training in operating specialized equipment or other skills needed to provide aid in a declared emergency; as well as individuals who work for such

facilities employing these individuals and whose work is necessary to maintain the operation of the facility.

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

STRONG RECOMMENDATIONS

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

1. **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.

2. **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 unless a medical contraindication applies. 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.

3. **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.

4. **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) are fully vaccinated by September 30, 2021.

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

GENERAL PROVISIONS

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

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

REASONS FOR THE ORDERS AND STRONG RECOMMENDATIONS

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

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

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

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

5. As of January 14, 2022, the County has reported a total of 430,675 recorded confirmed COVID-19 cases and 5,921 of COVID-19 related deaths.

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

7. CDC requires face coverings on planes, buses, trains, and other forms of public transportation traveling into, within, or out of the United States and in U.S. transportation

hubs such as airports and stations. See https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/about-face-coverings.html.

8. The CDPH issued a revised Guidance for the Use of Face Coverings, effective December 15, 2021, available at: https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/guidance-for-face-coverings.aspx

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

10. The Orders and the Strong Recommendations contained in this document are based on the following facts, in addition to the facts stated under the foregoing paragraphs: (i) Safe and effective FDA authorized COVID-19 vaccines have become widely available, but many Orange County residents have not yet had the opportunity to be vaccinated, or have not completed their vaccination series to be fully vaccinated; (ii) there are currently limited therapeutic options proven effective that consistently prevents the severe illness associated with COVID-19; (iii) the current consensus among public health officials for slowing down the transmission of and avoiding contracting COVID-19 is for unvaccinated persons to avoid gathering and practice social distancing, frequently wash hands with soap, wearing face covering and get vaccinated; (iv) some individuals who contract COVID-19 have no symptoms or have only mild symptoms and so are unaware that they carry the virus and are transmitting it to others; (v) current evidence shows that the novel coronavirus can survive on surfaces and can be indirectly transmitted between individuals; (vi) older adults and individuals with medical conditions are at higher risk of severe illness; (vii) sustained COVID-19 community transmission continues to occur; (viii) the age, condition, and health of a significant portion of Orange County's residents place them at risk for serious health complications, including hospitalization and death, from COVID-19; (ix) younger and otherwise healthy people are also at risk for serious negative health outcomes and for transmitting the novel coronavirus to others.

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

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

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

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

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

IT IS SO ORDERED:

Date: January 12, 2022

Clayton Chau MD, PhD
County Health Officer
County of Orange

GOVERNMENT CODE - GOV

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

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

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

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

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

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

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

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

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

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

(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

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.)

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 7, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

12. Authorize Extension of Contract to Secure Transportation for CalOptima Program of All-Inclusive Care for the Elderly (PACE)

Contacts

Richard Pitts, D.O., Ph.D., Chief Medical Officer, (714) 246-8491
Monica Macias, LCSW, PACE Director, (714) 468-1077

Recommended Actions

1. Authorize the Chief Executive Officer (CEO) to execute an amendment to extend the current agreement for PACE transportation services and extending the contact four additional months, effective June 1, 2022, to September 30, 2022.
2. Authorize payment to support fees to secure transportation vendor through the dates and up to the amounts indicated below.

Background

PACE is a Medicare and Medicaid managed care service delivery model for the frail elderly that integrates acute, chronic, and long-term care for nursing home certified seniors. The goals of PACE are to prevent unnecessary institutionalization and maintain or improve the functional status of the program's participants. CalOptima currently serves approximately 420 participants. Transportation to and from the PACE center, alternative care settings, and medically necessary appointments in the community is an integral benefit of the PACE program. In 2021, more than 30,000 one-way trips were completed by Secure Transportation for CalOptima PACE participants. Secure Transportation was selected as the initial PACE transportation vendor for CalOptima PACE in a 2012 RFP process and renewed for two 1-year contract extensions. In 2017, a new RFP was released, with Secure Transportation being selected as the primary vendor for PACE transportation services. Secure Transportation has a 40-year history serving frail and elderly with non-emergency medical transportation. To serve the participants of CalOptima PACE, Secure Transportation operates a fleet of 17 Ford Transit Extended Vans, supplemented by subcontracted wheelchair-lift vans and sedans.

Discussion

Secure Transport has been providing transportation services to our participants since 2012. The contract expires May 31, 2022. Doing an RFP in a very short time would require substantial time commitment as well as significant disruptions to operations. Secures contract is expiring and due to the complications of COVID-19 pandemic, staff need additional time to complete the RFP process and selection. Extending the contract will allow staff sufficient time for RFP completion, selection and implementation and avoid potential gap in services to our participants.

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Fiscal Impact

The recommended action to extend the contract under the same terms and conditions with Secure Transportation for the CalOptima PACE program for four months has a total anticipated impact of approximately $496,000. The anticipated fiscal impact in Fiscal Year (FY) 2021-22 for the month of June is approximately $124,000 and is a budgeted item. Staff will include forecasted PACE transportation service expenses in the CalOptima FY 2022-23 Operating Budget.

Rationale for Recommendation

Extension of the contract will ensure no disruption in services provided to our participants allowing continuation of transportation to medical appointments.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Secure Transportation Contract
2. Amendment II

/s/ Michael Hunn *03/31/2022*
Authorized Signature **Date**

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ANCILLARY SERVICES CONTRACT

This Ancillary Services Contract (the "Contract") is entered into by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and **Secure Transportation Company, Inc.** ("Provider"), a California Corporation, with respect to the following:

RECITALS

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

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

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

D. CalOptima has entered into a participation contract with the State of California, acting by and through the Department of Health Care Services ("DHCS" or "State"), and the Department of Health and Human Services ("HHS"), acting by and through the Centers for Medicare & Medicaid Services ("CMS"), to furnish health care services to Medicare/Medi-Cal enrollees who are enrolled in CalOptima's Cal MediConnect program ("DHCS/CMS Cal MediConnect Contract"). This program will begin operation, subject to final approval of DHCS and CMS, no sooner than July 1, 2015.

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

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

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

NOW, THEREFORE, the parties agree as follows:

ARTICLE 1
DEFINITIONS

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

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

1.2. "California Children Services Program" or "CCS" means a public health program, which assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (21) years who have CCS eligible conditions, as defined in Title 22, California Code of Regulations (CCR), and Section 41800.

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

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

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

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

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

1.6. "CalOptima's Regulators" means those government agencies that regulate and oversee CalOptima's and its first tier downstream and/or related entity's ("FDR's") activities and

obligations under this Contract including, without limitation, the Department of Health and Human Services, the Centers for Medicare and Medicaid Services, the California Department of Health Care Services, and the California Department of Managed Health Care and other government agencies that have authority to set standards and oversee the performance of the parties to this Contract.

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

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

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

1.10. "Compliance Program" means the program (including, without limitation, the compliance manual, code of conduct and CalOptima Policies) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of the members of its Board of Directors, employees, contractors and providers comply with applicable law and ethical standards. The Compliance Program includes CalOptima's Fraud, Waste and Abuse ("FWA") plan.

1.11. "Coordination of Benefits" or "COB" refers to the determination of order of financial responsibility which applies when two or more health benefit plans provide coverage of items and services for an individual.

1.12. "Covered Services" means those Medically Necessary items and services available to Members under the applicable CalOptima Program benefits.

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

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

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

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

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

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

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

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

1.21. "Medically Necessary" or "Medical Necessity" means when addressing Covered Services: (i) under Medicare, reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. Section 1395y; and (ii) under Medi-Cal, reasonable and necessary to protect life, to prevent significant illness or significant disability or to alleviate sever pain through the diagnosis or treatment of disease, illness or injury under Welfare & Institutions Code Section 14059.5.

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

1.23. "Medicare Secondary Payer" or "MSP" means the Medicare coordination of benefits requirements as incorporated in MA regulations.

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

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

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

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

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

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

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

ARTICLE 2
FUNCTIONS AND DUTIES OF PROVIDER

2.1 Provision of Covered Services.

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

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

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

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

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

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

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

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

2.7 Disclosure of Provider Ownership. Provider shall provide CalOptima with the following information: (a) names of all officers of Provider's governing board; (b) names of all owners of Provider; and (c) names of stockholders owning more than ten percent (10%) of the stock issued by Provider.

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

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

2.9 Utilization & Resource Management Program. Provider acknowledges and agrees that CalOptima has implemented and maintains a Utilization & Resource Management Program ("UM Program") that addresses evaluations of medical necessity and processes to review and approve the provision of items and services, including Covered Services, to Members. Provider shall comply with the requirements of the UM Program including,

without limitation, those criteria applicable to the Covered Services as described in this Contract.

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

2.11 Transfer of Care. Upon request by a CalOptima Member, Provider shall assist the CalOptima Member in the orderly transfer of such CalOptima Member's medical care. In doing so, Provider shall make available to the new provider of care for the Member, copies of the medical records, patient files, and other pertinent information, including information maintained by any Subcontractor, necessary for efficient medical case management of Member. In no circumstance shall a CalOptima Member be billed for this service.

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

2.13 Provision of Interpreters. Provider, in conjunction with PACE, shall ensure that CalOptima Members are provided with linguistic interpreter services and interpreter services for Members who are deaf and hard of hearing as necessary to ensure effective communication.

Interpreters shall be used where needed. Provider shall not require a Member to use friends or family as interpreters. However, a family member may be used when the use of the family member or friend: (a) is requested by a Member; (b) will not compromise

the effectiveness of service; (c) will not violate a Member's confidentiality; and (d) Member is advised that an interpreter is available at no cost to the Member.

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

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

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

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

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

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

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

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

Provider and its Subcontractors may request in writing to DHCS, who, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

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

2.17 No Discrimination/Harassment (Employees). During the performance of this Contract, Provider and its Subcontractors shall not unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of race, religion, creed, color, national origin, ancestry, physical disability (including Human Immunodeficiency Virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS)), mental disability, medical condition, marital status, age (over 40), gender or the use of family and medical care leave and pregnancy disability leave. Provider and Subcontractors shall ensure that the evaluation and treatment of their employees and applicants for employment are free of such discrimination and harassment. Provider and Subcontractors shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900 et seq.) and the applicable regulations promulgated thereunder, (Title 2, CCR, Section 7285.0 et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990, set forth in Chapter 5 of Division 4 of Title 2 of the CCR are incorporated into this Contract by reference and made a part hereof as if set forth in full. Provider and its Subcontractors shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement.

2.18 No Discrimination (Member). Provider shall not discriminate against Members because of race, color, creed, religion, ancestry, marital status, sexual orientation, national origin, age, sex, or physical or mental handicap in accordance with Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d (race, color, national origin); Section 504 of the Rehabilitation Act of 1973 (29 USC §794) (nondiscrimination under Federal grants and programs); Title 45 CFR Part 84 (nondiscrimination on the basis of handicap in programs or activities receiving Federal financial assistance); Title 28 CFR Part 36 (nondiscrimination on the basis of disability by public accommodations and in commercial facilities); Title IX of the Education Amendments of 1973 (regarding

education programs and activities); Title 45 CFR Part 91 and the Age Discrimination Act of 1975 (nondiscrimination based on age); as well as Government Code Section 11135 (ethnic group identification, religion, age, sex, color, physical or mental handicap); Civil Code Section 51 (all types of arbitrary discrimination); and all rules and regulations promulgated pursuant thereto, and all other laws regarding privacy and confidentiality.

For the purpose of this Contract, if based on any of the foregoing criteria, the following constitute unlawful discriminations: (a) denying any Member any Covered Services or availability of a Provider, (b) providing to a Member any Covered Service which is different or is provided in a different name or at a different time from that provided to other similarly situated Members under this Contract, except where medically indicated, (c) subjecting a Member to segregation or separate treatment in any manner related to the receipt of any Covered Service, (d) restricting a Member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service, (e) treating a Member differently than others similarly situated in determining compliance with admission, enrollment, quota, eligibility, or other requirements or conditions that individuals must meet in order to be provided any Covered Service, or in assigning the times or places for the provision of such services.

Provider agrees to render Covered Services to Members in the same manner, in accordance with the same standards, and within the same time availability as offered to non-CalOptima patients. Provider shall take affirmative action to ensure that all Members are provided Covered Services without discrimination, except where medically necessary. For the purposes of this section, physical handicap includes the carrying of a gene which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genetic handicap shall include, but not be limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia.

Provider shall act upon all complaints alleging discrimination against Members in accordance with CalOptima's Policies. Provider shall include the nondiscrimination and compliance provisions of this clause in all Subcontracts.

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

2.20 Subcontract Requirements. If permitted by the terms of this Contract, Provider may subcontract for certain functions covered by this Contract, subject to the requirements of this Contract. Subcontracts shall not terminate the legal liability of Provider under this Contract. Provider must ensure that all Subcontracts are in writing and include any and all provisions required by this Contract or applicable Government Programs to be incorporated into Subcontracts. Provider shall make all Subcontracts available to CalOptima or its regulators upon request. Provider is required to inform CalOptima of the name and business addresses of all Subcontractors. Additionally, Provider shall require that all Subcontracts relating to the provision of Covered Services include, without limitation, the following provisions:

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

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

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

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

2.20.5 An agreement to comply with all provisions of this Contract and applicable law with respect to providing and paying for Emergency Services.

2.20.6 An agreement that Subcontractors shall notify Provider of any investigations into Subcontractors' professional conduct, or any suspension of or comment on a Subcontractor's professional licensure, whether temporary or permanent.

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

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

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

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

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

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

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

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

2.23 Credentialing and Recredentialing. Prior to providing any Covered Services under, and throughout the duration of, this Contract, Provider, and all Subcontractors, shall be credentialed and periodically recredentialed by CalOptima in the manner and to the extent required by CalOptima Policy.

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

2.25 Smoke Free Workplace. Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible party. By signing this Contract, Provider certifies that it will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The prohibitions herein are effective December 26, 1994. Provider further agrees that it will insert this certification into any subcontracts entered into that provide for children's services as described in the Act.

2.26 CLIA Laboratories. Provider shall only use laboratories with a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. Those laboratories with certificates of waiver shall provide only the types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

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

2.30. Electronic Transactions. Provider shall use best efforts to participate in the exchange of electronic transactions with CalOptima, including but not limited to electronic claims

submission (EDI), verification of eligibility and enrollment through electronic means and submission of electronic prior authorization transactions in accordance with CalOptima Policy and Procedure.

2.31. Advanced Directives. Provider shall maintain written Policies and Procedures related to Advanced Directives in compliance with State and Federal laws and regulations. Provider shall document patient records with respect to the existence of an Advanced Directive in accordance with applicable law. Provider shall not discriminate against any Member on the basis of that Member's Advanced Directive status. Nothing in this Contract shall be interpreted to require a Member to execute an Advance Directive or agree to orders regarding the provision of life-sustaining treatment as a condition of receipt of services.

ARTICLE 3
FUNCTIONS AND DUTIES OF CALOPTIMA

3.1. Payment. CalOptima shall pay Provider for Covered Services provided to CalOptima Members. Provider agrees to accept the compensation set forth in Attachment C as payment in full from CalOptima for such Covered Services. Upon submission of a Clean Claim, CalOptima shall pay Provider pursuant to CalOptima Policies and Attachment C. Notwithstanding the foregoing, Provider may also collect other amounts (e.g., copayments, deductibles, OHC and/or third party liability payments) where expressly authorized to do so under the CalOptima Program(s) and applicable law. Provider agrees that Members will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts and that the provider will (A) accept the plan payment as payment in full, or (B) bill the appropriate State source as required at 42 CFR §422.504(g)(1)(iii).

3.2. Service Authorization. CalOptima shall provide a written authorization process for Covered Services pursuant to CalOptima Policies.

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

ARTICLE 4
PAYMENT PROCEDURES

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

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

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

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

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

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

4.5.2 In no event, including, but not limited to, non-payment by CalOptima, CalOptima's or Provider's insolvency, or breach of this contract by CalOptima, shall Provider, or any of its Subcontractors, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against the State of California or any Member or person acting on behalf of a Member for Covered Services pursuant to this Contract. Notwithstanding the foregoing, Provider may collect SOC, co-payments, and deductibles if, and to the extent, required under a specific CalOptima Program and applicable law.

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

4.5.4 Upon receiving notice of Provider invoicing or balance billing a Member for the difference between the Provider's billed charges and the reimbursement paid by CalOptima for any Covered Services, CalOptima may sanction the Provider or take other action as provided in this Contract.

4.5.5 This section shall survive the termination of this Contract for Covered Services furnished to CalOptima Members prior to the termination of this Contract, regardless of the cause giving rise to termination, and shall be construed to be for the benefit of Members. This section shall supersede any oral or written contrary agreement now existing or hereafter entered into between the Provider and its

Subcontractors. Language to ensure the foregoing shall be included in all of Provider's Subcontracts related to provision of Covered Services to CalOptima Members.

4.6 Recoupment. CalOptima shall recoup payments made to Provider when DHCS or CMS has determined that an individual was not eligible for services under this contract and retroactively terminates the individual, including, without limitation, recouping any payments made for a deceased Member. CalOptima may also recoup overpayments to Provider, as well as unpaid *Conlan* reimbursements owed by Provider to CalOptima Members, including offsetting any such amounts owed against Provider's claims submissions, in accordance with CalOptima Policies. This clause shall not be construed to limit CalOptima's right to recoup payment made to Provider on any other basis for which recoupment is appropriate.

ARTICLE 5
INSURANCE AND INDEMNIFICATION

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

5.2 Provider Professional Liability. Provider, at its sole cost and expense, shall ensure that it and Subcontractors providing professional services under this Contract shall maintain professional liability insurance coverage with minimum per incident and annual aggregate amounts which are at least equal to the community minimum amounts in Orange County, California, for the specialty or type of service which Provider provides, with a minimum of $1,000,000 per incident/$3,000,000 aggregate per year.

5.3 Provider Comprehensive General Liability ("CGL")/Automobile Liability. Provider at its sole cost and expense shall maintain such policies of comprehensive general liability and automobile liability insurance and other insurance as shall be necessary to insure it and its business addresses, customers (including Members), employees, agents, and representatives against any claim or claims for damages arising by reason of a) personal injuries or death occasioned in connection with the furnishing of any Covered Services hereunder, b) the use of any property of the Provider, and c) activities performed in connection with the Contract, with minimum coverage of $1,000,000 per incident/$3,000,000 aggregate per year.

5.4 Workers Compensation Insurance. Provider at its sole cost and expense shall maintain workers compensation insurance within the limits established and required by the State of

California and employers liability insurance with minimum limits of liability of $1,000,000 per occurrence/$1,000,000 aggregate per year.

5.5 Insurer Ratings. All above insurance shall be provided by an insurer:

5.5.1 rated by Best's with a rating of B or better; and

5.5.2 "admitted" to do business in California or an insurer approved to do business in California by the California Department of Insurance and listed on the Surplus Lines Association of California List of Eligible Surplus Lines Insurers (LESLI) or licensed by the California Department of Corporations as an Unincorporated Interindemnity Trust Arrangement as authorized by the California Insurance Code 12180.7.

5.6 Captive Risk Retention Group/Self Insured. Where any of the insurances mentioned above are provided by a Captive Risk Retention Group or are self insured, such above provisions may be waived at the sole discretion of CalOptima, but only after CalOptima reviews the Captive Risk Retention Group's or self-insured's audited financial statements and approves the waiver.

5.7 Cancellation or Material Change. The Provider shall not of its own initiative cause such insurances as addressed in this Article to be canceled or materially changed during the term of this Contract.

5.8 Certificates of Insurance. Prior to execution of this Contract, Provider shall provide Certificates of Insurance to CalOptima showing the required insurance coverage and further providing that CalOptima is named as an additional insured on the Comprehensive General Liability Insurance and Automobile Liability Insurance with respect to the performance hereunder and coverage is primary and non-contributory as to any other insurance with respect to performance hereunder.

ARTICLE 6
RECORDS, AUDITS AND REPORTS

6.1 Access to and Audit of Contract Records. For the purpose of review of items and services furnished under the terms of this Contract and duplication of any books and records, Provider shall allow CalOptima, its regulators and/or their duly authorized agents and representatives access to said books and records, including medical records, for the purpose of direct physical examination of the records by CalOptima or its regulators and/or their duly authorized agents and representatives at the Provider's premises. Provider shall be given advance notice of such visit in accordance with CalOptima Policies. Such access shall include the right to directly observe all aspects of Provider's operations and to inspect, audit and reproduce all records and materials and to verify Claims and reports required according to the provisions of this Contract. Provider shall maintain records in chronological sequence, and in an immediately retrievable form in accordance with the laws and regulations applicable to such record keeping. Provider

shall also comply with any audit and access requirements set for in the CalOptima Program Addenda, as applicable.

6.2 Medical Records. Provider and its Subcontractors shall establish and maintain for each Member who has obtained Covered Services, medical records which are organized in a manner which contain such demographic and clinical information as is necessary to provide and ensure accurate and timely documentation as to the medical problems and Covered Services provided to the Member. Such medical records shall be consistent with State and Federal laws and CalOptima Program requirements and shall include a historical record of diagnostic and therapeutic services recommended or provided by, or under the direction of, the Provider. Such medical records shall be in such a form as to allow trained health professionals, other than the Provider, to readily determine the nature and extent of the Member's medical problem and the services provided, and to permit peer review of the care furnished to the Member.

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

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

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

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

6.5.2 Members Receiving State Assistance. Notwithstanding any other provision of this Contract, names and identification numbers of Members receiving public assistance are confidential and are to be protected from unauthorized disclosure in accordance with applicable State and Federal laws and regulations. For the purpose of this Contract, Provider shall protect from unauthorized disclosure all

information, records, data and data elements collected and maintained for the operation of the Contract and pertaining to Members.

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

ARTICLE 7
TERM AND TERMINATION

7.1 Term. This Contract shall be effective for a three (3) year term, commencing on June 1, 2017 and ending on May 31, 2020. This Contract may be extended for two additional one-year terms upon formal approval by the CalOptima Board of Directors, unless earlier terminated by either party as provided for in this Contract.

7.2 Termination for Default. CalOptima may, in its sole discretion, terminate this Contract whenever CalOptima determines that the Provider or any Subcontractor (a) has repeatedly and inappropriately withheld Covered Services to a CalOptima Member(s), (b) has failed to perform its contracted duties and responsibilities in a timely and proper manner including, without limitation, service procedures and standards identified in this Contract, (c) has committed acts that discriminate against CalOptima Members on the basis of their health status or requirements for health care services; (d) has not provided Covered Services in the scope or manner required under the provisions of this Contract; (e) has engaged in prohibited marketing activities; (f) has failed to comply with CalOptima's Compliance Program, including Participation Status requirements; (g) has committed fraud or abuse relating to Covered Services or any and all obligations, duties and responsibilities under this Contract; or (h) has materially breached any covenant, condition, or term of this Contract. A termination as described above shall be referred to herein as "Termination for Default." In the event of a Termination for Default, CalOptima shall give Provider prior written notice of its intent to terminate with a thirty (30)-day cure period if the Termination for Default is curable, in the sole discretion of CalOptima. In the event the default is not cured within the thirty (30)-day period, CalOptima may terminate the Contract immediately following such thirty (30)-day period. The rights and remedies of CalOptima provided in this clause are not exclusive and are in addition to any other rights and remedies provided by law or under the Contract. The Provider shall not be relieved of its liability to CalOptima for damages sustained by virtue of breach of the Contract by the Provider or any Subcontractor.

7.3 Immediate Termination. CalOptima may terminate this Contract immediately upon the occurrence of any of the following events and delivery of written notice: (i) the suspension or revocation of any license, certification or accreditation required by Provider and/or Provider Agents; (ii) the determination by CalOptima that the health, safety, or welfare of Members is jeopardized by continuation of this Contract; (iii) the

imposition of sanctions or disciplinary action against Provider or against Provider Agents in their capacities with the Provider by any Federal or State licensing agency; (iv) termination or non-renewal of any Government Contract; (v) the withdrawal of DHHS's approval of the waiver granted to the CalOptima under Section 1915(b) of the Social Security Act. If CalOptima receives notice of termination from any of the Government Agencies or termination of the Section 1915(b) waiver, CalOptima shall immediately transmit such notice to Provider.

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

7.5 Modifications or Termination to Comply with Law. CalOptima reserves the right to modify or terminate the Contract at any time when modifications or terminations are (a) mandated by changes in Federal or State laws, (b) required by Government Contracts, or (c) required by changes in any requirements and conditions with which CalOptima must comply pursuant to its Federally-approved Section 1915(b) waiver. CalOptima may also modify the Contract at any time if such a change would be in the best interest of Members. CalOptima shall notify Provider in writing of such modification or termination immediately and in accordance with applicable Federal and/or State requirements.

7.6 Termination Without Cause. Either party may terminate this Contract, without cause, upon one hundred twenty (120) days prior written notice to the other party as provided herein.

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

7.8 Obligations Upon Termination. Upon termination of this Contract, it is understood and agreed that Provider shall continue to provide authorized Covered Services to Members who retain eligibility and who are under the care of Provider at the time of such termination, until the services being rendered to Members are completed, unless CalOptima, in its sole discretion, makes reasonable and medically appropriate provisions for the assumption of such services. Payment for services under this paragraph shall be at the contracted rates. Prior to the termination or expiration of this Contract, and upon request by CalOptima or one of its regulatory agencies to assist in the orderly transfer of Members' medical care, Provider shall make available to CalOptima and/or such regulatory agency, copies of any pertinent information, including information maintained by Provider and any Subcontractor necessary for efficient case management of Members. Costs of reproduction shall be borne by CalOptima or the government agency, as

applicable. For purposes of this section only, "under the care of Provider" shall mean that a Member has an authorization from CalOptima to receive services from the Provider issued prior to the Termination, all of the services authorized under that authorization have not yet been completed, and the time period covered by the authorization has not yet expired.

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

ARTICLE 8
GRIEVANCES AND APPEALS

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

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

ARTICLE 9
GENERAL PROVISIONS

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

governing body of Provider (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

9.2 Documents Constituting Contract. This Contract and its attachments, schedules, addenda and exhibits and all CalOptima Policies applicable to Covered Services and CalOptima Members (and any amendments thereto) shall constitute the entire agreement between the parties. It is the express intention of Provider and CalOptima that any and all prior or contemporaneous agreements, promises, negotiations or representations, either oral or written, relating to the subject matter and period governed by this Contract which are not expressly set forth herein shall be of no further force, effect or legal consequence after the effective date hereunder.

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

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

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

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

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

9.8 No Waiver. No delay or failure by either party hereto to exercise any right or power accruing upon noncompliance or default by the other party with respect to any of the terms of this Contract shall impair such right or power or be construed to be a waiver

thereof. A waiver by either of the parties hereto of a breach of any of the covenants, conditions, or agreements to be performed by the other shall not be construed to be a waiver of any succeeding breach thereof or of any other covenant, condition, or agreement herein contained. Any information delivered, exchanged or otherwise provided hereunder shall be delivered, exchanged or otherwise provided in a manner which does not constitute a waiver of immunity or privilege under applicable law.

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

If to CalOptima:

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

If to Provider:

Gerard Linsmeier
Name
Regional VP of Sales, Secure Transportation
Title
434 E Broadway
Address
Long Beach CA 90802

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

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

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

9.13 Authority to Execute. The persons executing this Contract on behalf of the parties warrant that they are duly authorized to execute this Contract, and that by executing this Contract, the parties are formally bound.

9.14 Severability. In the event any provision of this Contract is rendered invalid or unenforceable by Act of Congress, by statute of the State of California, by any regulation duly promulgated by the United States or the State of California in accordance with law or is declared null and void by any court of competent jurisdiction, the remainder of the provisions hereof shall remain in full force and effect.

ARTICLE 10
EXECUTION

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

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

Provider	**CalOptima**
Signature	Signature
Gerard Linsmeier	Ladan Khamseh
Print Name	Print Name
Regional VP of Sales	Chief Operating Officer
Title	Title
5/31/17	6/2/17
Date	Date

ATTACHMENT A

COVERED SERVICES

ARTICLE 1
CALOPTIMA PROGRAMS

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

_____ Medi-Cal Program

_____ Medicare Advantage Program (OneCare)

__X__ PACE Program

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

ARTICLE 2
SCOPE OFSERVICES

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

The Provider shall provide transportation services for the CalOptima PACE program and all of its PACE Centers located throughout Orange County. In general, the transportation services entail door-to-door, pick-up and drop-off round trips of CalOptima PACE Members: (1) to and from participants' homes and the PACE Center, (2) to and from the PACE Center and outside medical appointments, (3) to and from field trip destinations, and (4) to and from other destinations approved by the PACE interdisciplinary team. Transport services may also occasionally include transporting participants' caregivers and/or CalOptima staff if approved by the PACE interdisciplinary team.

In certain circumstances, participants may require "through the door" service based on individual need (e.g., ambulatory assistance to seat inside home, etc.).

Additional Requirements:

- If applicable, must meet all Medicare and Medi-Cal requirements applicable to transportation services
- Cannot employ or contract with any individual or organization:

    - Who has been excluded from Medicare or Medicaid participation;
    - Who has been convicted of criminal offenses related to their involvement in Medicaid, Medicare, other health insurance or health care programs, or Social services programs under Title XX of the SSA; or
    - In any capacity where an individual's contact with participants would pose a potential risk because the individual has been convicted of physical, sexual, drug, or alcohol abuse.
- Implement a system for its staff, or a representative, to participate in IDT meetings, as required, and for drivers to be able to communicate with the IDT regarding participant care plan needs, including changes
- Provide a designated staff member to be stationed on a regularly scheduled basis to satisfy needs at the PACE Center for dispatch and who will serve as point person between drivers and center-based staff
- Standard practice of "on-time" performance of scheduled pick-ups – "On time" means at the scheduled pick up time or up to fifteen (15) minutes before or after stated pick-up time.. Provider must have systems in place to track performance of on-time pick-up's and process to correct performance as necessary
- Be able to provide transportation services between the hours of 7:00am and 7:00pm every weekday, and, on occasion, have personnel and vehicles available for after-hours service for participants (i.e., late hospital discharges)

Provider must also satisfy the requirements in the following

areas: Participant Care and Safety

- Wheelchair hydraulic lifts, with failsafe safety systems, and safety restraint systems on vehicles in sufficient capacity to serve assigned population and all drivers trained on their proper use
- Provider must have or implement a vehicle management program that promotes the safe use of equipment and minimizes safety risks and hazards both for its staff and for participants.
- All vehicles shall meet Americans with Disabilities Act (ADA) Accessibility Specifications for Transportation, Federal Transit Administration (FTA) regulations, Title 22 requirements and any other federal, state or local requirements as applicable.

Driver Competency and Training

- Written policies and procedures that specify personnel qualifications, training, experience, and continuing education requirements consistent with the services it provides to PACE participants, including compliance with Department of Transportation and Title 22 of the California Code of Regulations, as applicable. Written policies and procedures for the training and monitoring of drivers, including:

    - Proper transfer techniques, including nonambulatory and wheelchair users
    - Proper body mechanics
    - Proper use of equipment needed to transfer and secure participants during transit
    - Proper use of restraints and seat belts to secure participants during transport
    - Emergency procedures during transfer, transport, and arrival of participants
    - Attendance at all CalOptima PACE required training, including managing special needs of participants and handling emergency situations
- Driving personnel shall receive nationwide background checks before employment and be enrolled in the California Department of Motor Vehicles (DMV) Employer Pull Notice (EPN) Program.
- Provider shall have a Drug and Alcohol Screening Program and National Sex Offenders Registry Background Check in place for all drivers.
- Written procedures to check or audit for the following information on each driver:
    - Current driver's license
    - Verifications of licenses, registrations, certifications, and competency assessments
    - Record of any traffic violations or accidents that may constitute a potential hazard for the transport of participants
    - Background checks
    - Orientation completion and ongoing competency training
    - PPD screening
    - CPR certification
    - First Aid certification
- Demonstrate competency and sensitivity to communication and health care issues common with an elderly population, such as:
    - Hearing loss
    - Cognitive impairment
    - Sensory impairment
    - Limited mobility and physical disability
    - Use of assistive devices
    - Denial of need for assistance
- Cultural sensitivity, including how to meet the needs of non-English speaking clients
- Superlative customer service approach – most days, the PACE driver will be the first and last point of contact that participants will have with the program

Operational Efficiency

- Provider shall have communications systems on all vehicles for communication with a base station. Provider shall utilize a Computer Aided Dispatch (CAD) system and have a mechanism for dispatch audio recordings.
- All vehicles must be equipped to communicate with the PACE Center in real time during transportation activities, including ability to communicate with IDT members regarding participant needs as they arise during transport
- All vehicles must be equipped with GPS devices
- Provider must have or implement a contingency plan for emergencies and disasters, or to have arrangements with alternative providers in the event that Provider is unable to perform transportations services due to emergency or disaster
- Provider shall maintain vehicle fleet as back-up. Provider shall have a system to dispatch replacement vehicles immediately in the event of vehicle mechanical breakdown.

Quality Assurance and Improvement

- Provider shall have a Quality Management and Improvement Program that measures, conducts improvement activities and documents key performance standards. At a minimum, Provider must be able to monitor and report to CalOptima on the following performance standards:

    - Participant and/or Caregiver complaints
    - Transportation performance standards (maintaining above 90% on-time pick ups)
    - Ensuring one-way rides are no longer than one hour in duration
    - Participant satisfaction with service and drivers

- Written policies and procedures for monitoring and tracking the performance of all drivers, including standard performance measurements to support improvement
- Written policies and procedures for accident and incident reporting
- Assist and cooperate with PACE staff for internal and external audits, including providing all transportation logs, vehicle records, and driver personnel files
- Written procedures to notify CalOptima in a timely manner regarding any changes of driver personnel or driver status who are assigned to CalOptima PACE
- If quality metrics are not met for three consecutive months, CalOptima PACE may reduce the scope of services and utilize an alternative vendor to provide specialty care trips, equating up to 20% of the scope of work. CalOptima reserves the right to reduce allocated Secure Transportation

dollars for a alternative transportation vendor. Criteria for a alternate vendor are as follows:

- Did not meet the on-time performance metric for 3 consecutive months
- Has 5 or more 1-hour transportation violations in 3 consecutive months

- CalOptima reserves the right to use an alternate vendor for up to 80% of the scope of work if performance metrics are continually violated

Vehicle Maintenance

- All fleet vehicles used for the PACE program must be maintained in accordance with the manufacturer's recommendations
- All fleet vehicles used for the PACE program must be equipped to communicate with the PACE Center
- Written policies and procedures on the maintenance of vehicles used for the PACE program, including a plan for identifying, monitoring, and reporting (where indicated) vehicle malfunctions and repairs needed
- Ability to provide evidence of appropriate state vehicle inspections
- Maintain comprehensive first aid, emergency, and accident kits that are fully stocked on vehicles at all times

ATTACHMENT B

PROCEDURES FOR REQUESTING INTERPRETATION SERVICES

ARTICLE 1
PACE PARTICIPANTS

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

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

a. Member name and ID, date of birth and telephone number;

b. Name and phone number of the care taker, if applicable;

c. Language or sign language needed;

d. Date and time of the appointment;

e. Address and telephone number of the facility where the appointment is to take place;

f. Estimated amount of time the interpretation service will be needed; and

g. Type of appointment: assessment, fitting/delivery or other.

1.3 Provider's Responsibilities.

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

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

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

ATTACHMENT C

COMPENSATION

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

I. Medi-Cal Program Reimbursement

N/A

II. Medicare Advantage Program Reimbursement

N/A

III. PACE Program Reimbursement

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

1. For Services provided by Provider for PACE members, CalOptima shall reimburse Provider, and Provider shall accept as payment in full from CalOptima, the lesser of billed charges, or:

   Transportation Coordinator - A flat rate of $6,000 per month for a Transportation Coordinator to manage all aspects of the transportation program at the PACE Center. This employee will work 8 hours a day, 5 days per week.

   Dedicated Driver and ADA Wheelchair Accessible Lift Van – A flat rate of $6,550 per month per vehicle. Vehicles include 8 Ford Extended Transits, 1 dedicated driver and 1 CalOptima logoed Lift Van to work 8 hours per day, 5 days per week. Transportation will be door-to-door, pick-up and drop-off round trips of PACE Members. Flat monthly rate includes (1) to and from Members homes and the PACE Center, (2) to and from the PACE Center and outside medical appointments, (3) to and from field trip destinations, and (4) to and from other destinations approved by the PACE Interdisciplinary Team. Transport services may also occasionally include transporting participants' care givers and/or CalOptima staff if approved by the PACE.

   Provider will manage all the logistics of fuel/maintenance activity and submit detailed monthly invoices to PACE for payment on non-markup straight pass-through cost.

   Subcontractor Fees – A flat rate of $16,892 per month for Secure Transportation Sub Contracted partners to include but not limited to:

1. Ambulatory Transportation: $17.00 origination fee each way/$1.75 per mile
2. Wheelchair Transportation: $25.00 origination fee each way/$1.75 per mile
3. Cancelation and or No show fee- Full fare if not cancelled day prior
4. Wait fee - $45.00 per hour. First 15 minutes are free.

Supplemental Vehicle Services on a Pick-up per Mile Rate in Lieu of Monthly Flat Fee

Gurney Transportation:
1. $140.00 per pick up and $4.00 per mile
2. Wait time: $80.00 per hour billable in 5 minute increments.
3. Cancellation Charge: $80.00

16 Passenger ADA Wheelchair Accessible Shuttle Transportation
1. $65.00 per hour with a 3 hour minimum
2. Cancellation charge: $180.00
3. Rate charges start once vehicle arrives at CalOptima PACE site and ends at last Participant return of vehicle to PACE site.

Full Size ADA Wheelchair Accessible Van Transportation:
1. $55.00 per hour with a 3 hour minimum
2. Cancellation charge $150.00
3. Rate charges start once vehicle arrives at CalOptima PACE site and ends at last Participant return vehicle to PACE site.

Sedan or ADA Wheelchair Accessible Minivan Transportation:
1. $43.00 per hour with a 3 hour minimum
2. Cancellation charge: $129.00
3. Rate charges start once vehicle arrives at CalOptima PACE site and ends at last Participant return of vehicle to PACE site

Misc Supplemental Vehicles:
1. $50.00 per pick up, $4.00 per mile
2. Wait time: $50.00 per hour billable in 5 minute increments.
3. Cancellation Charge: $50.00.

PACE Management may authorize supplemental vehicle services at the rates listed above by mutual agreement.

2. If quality metrics are continuallynot met for three (3) consecutive months, CalOptima PACE may reduce the scope of services and utilize an alternative vendor to provide specialty care trips, equating up to 20% of the scope of work. CalOptima reserves the right to reduce allocated Secure Transportation dollars for the alternative transportation vendor. Criteria for an alternate vendor are as follows:

- Did not meet the on-time performance metric for 3 consecutive months
- Has 5 or more 1-hour transportation violations in 3 consecutive months

3. A 1% penalty fee reduction will be calculated from monthly invoice if either quality metric is not met for the month.

4. Provider shall be capable of providing a monthly detailed invoice for services provided to the PACE Center and the detailed invoice will include but not limited to Member name, identification number and dates/times of transportation.

5. PACE authorization rules apply for payment of services.

IV. Cal MediConnect/OneCare Connect Program Reimbursement

N/A

ADDENDUM 1
MEDI-CAL PROGRAM

NOT APPLICABLE

Addendum 1--Attachment 1

NOT APPLICABLE

ADDENDUM 2
MEDICARE ADVANTAGE PROGRAM
(ONECARE)

NOT APPLICABLE

ADDENDUM 3
PACE PROGRAM REQUIREMENTS

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

1. State Approval and Termination.

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

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

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

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

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

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

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

   2.4. Interdisciplinary Team Meeting Participation. If necessary for the benefit of a CalOptima PACE participant's care delivery or planning, Provider shall participate in CalOptima PACE Interdisciplinary Team meetings as required.

Such participation may be by telephone, unless in-person attendance at such meetings is reasonably warranted under the circumstances.

2.5. Payment in Full. Provider shall accept CalOptima's payment as payment in full, and shall not seek any reimbursement for services directly from the CalOptima PACE member, Medi-Cal, Medicare or other insurance carrier or provider. Provider shall not seek any type of copayment from PACE member for Covered Services. CalOptima PACE participants shall not be liable to Provider for any sum owed by CalOptima, and Provider agrees not to maintain any action at law or in equity against CalOptima PACE participants to collect sums that are owed by CalOptima. Surcharges to CalOptima PACE participants by Provider are prohibited. Whenever CalOptima receives notice of any such surcharge, CalOptima shall take appropriate action, and Contractor shall reimburse the participant as appropriate.

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

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

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

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

2.10. Provision of Direct Care Services to PACE Participants. Provider hereby represents and warrants that Provider and all employees of Provider providing direct care to CalOptima PACE participant shall, at all time covered by this Contract, meet the requirements set forth in this Section. Provider agrees to cooperate with CalOptima PACE's competency evaluation program and direct

participant care requirements, and to notify CalOptima immediately if Provider or any employee of Provider providing services to CalOptima PACE participants no longer meets any of these requirements. All providers of direct care services to CalOptima PACE Members shall meet the following requirements:

2.10.1 Comply with any State or Federal requirements for direct patient care staff in their respective settings;

2.10.2 Meet Medicare, Medi-Cal and CalOptima requirements applicable to the services Provider furnishes;

2.10.3 Have verified current certifications or licenses for their respective positions;

2.10.4 Have not been excluded from participation in Medicare, Medicaid or Medi-Cal;

2.10.5 Have not been convicted of criminal offenses related to their involvements with Medicare, Medicaid, Medi-Cal, or other health insurance or health care programs, or any social service programs under Title XX of the Act;

2.10.6 Not pose a potential risk to CalOptima PACE participants because of a conviction for physical, sexual, drug or alcohol abuse;

2.10.7 Be free of communicable diseases, and up to date with immunizations, before performing direct patient care; and

2.10.8 Participate in an orientation to the PACE program presented by CalOptima PACE, and agree to abide by the philosophy, practices and protocols of CalOptima PACE.

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

3. Records Retention. Provider and its Subcontractors shall maintain and retain all records, including encounter data, of all items and services provided Members for ten (10) years from the close of the latest DHCS fiscal year in which the date of service occurred, in which the records or data were created or applied, and for which the financial record was completed. Records involving matters which are the subject of litigation shall be retained for a period of not less than ten (10) years following the termination of litigation. Provider's and its Subcontractors' books and records shall be maintained within, or be otherwise accessible within the State of California and pursuant to Section 1381(b) of the Health and Safety Code. Such records shall be maintained and retained on Provider's State licensed premises for such period as may be required by applicable laws and regulations related to the particular records. Such records shall be maintained in chronological sequence and in an immediately retrievable form that allows CalOptima,

and/or representatives of any regulatory or law enforcement agencies, immediate and direct access and inspection of all such records at the time of any onsite audit or review.

Microfilm copies of the documents contemplated herein may be substituted for the originals with the prior written consent of CalOptima, provided that the microfilming procedures are approved by CalOptima as reliable, and are supported by an effective retrieval system. If CalOptima is concerned about the availability of such records in connection with the continuity of care to a Member, Provider shall, upon request, transfer copies of such records to CalOptima's possession.
This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise.

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

   Provider and its Subcontractors shall cooperate in the audit process by signing any consent forms or documents required to effectuate the release of any records or documentation Provider may possess in order to verify Provider's records when requested by regulatory or oversight organizations, including, but not limited to; DHCS, DMHC, Department of Justice, Attorney General, Federal Bureau of Investigation and Bureau of Medi-Cal Fraud and/or CalOptima.
   This provision shall survive the expiration or termination of this Contract, whether with or without cause, by rescission or otherwise.

5. Medical Records. All medical records shall meet the requirements of Section 1300.80(b)(4) of Title 28 of the California Code of Regulations, and Section 1396a(w) of Title 42 of the United States Code. Such records shall be available to health care providers at each encounter, in accordance with Section 1300.67.1(c) of Title 28 of the California Code of Regulations. Provider shall ensure that an individual is delegated the responsibility of securing and maintaining medical records at each Participating Provider or Subcontractor site.

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

7. Assignment and Delegation. This Contract is not assignable, nor are the duties hereunder delegable, by the Provider, either in whole or in part, without the prior written consent of

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13.1.3 Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in Subprovision 13.1.2 herein; and

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

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

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

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

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

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

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

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

16. Lobbying Restrictions and Disclosure Certification. Provider shall complete and submit the lobbying disclosure form required by federal law, when applicable, as set forth in this Addendum 3.

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

16.2 Certification and Disclosure Requirements

16.2.1 Each person (or recipient) who requests or receives a contract, subcontract, grant, or subgrant, which is subject to Section 1352 of the 31, U.S.C., and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in Attachment 1 to this Addendum 3, consisting of one page, entitled "Certification Regarding Lobbying") that the recipient has not made, and will not make, any payment prohibited by Paragraph 16.3 of this provision.

16.2.2 Each recipient shall file a disclosure (in the form set forth in Attachment 2 to Addendum 3, entitled "Standard Form-LLL 'disclosure of Lobbying Activities'") if such recipient has made or has agreed to make any payment using nonappropriated funds (to include profits from any covered federal action) in connection with a contract or grant or any extension or amendment of that contract or grant, which would be prohibited under Paragraph 16.3 of this provision if paid for with appropriated funds.

16.2.3 Each recipient shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure, or that materially affects the accuracy of the information contained in any disclosure form previously filed by such person under Paragraph 16.2.2 herein. An event that materially affects the accuracy of the information reported includes:

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

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

16.2.3.3 A change in the officer(s), employee(s), or member(s) contacted for the purpose of influencing or attempting to influence a covered federal action.

16.2.4 Each person (or recipient) who requests or receives from a person referred to in Paragraph 16.2.1 of this provision a contract, subcontract, grant or subgrant exceeding $100,000 at any tier under a contract or grant shall file a certification, and a disclosure form, if required, to the next tier above.

16.2.5 All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in Paragraph 16.2.1 of this provision. That person shall forward all disclosure forms to DHCS program contract manager.

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

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

Addendum 3--Attachment 1

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES

CERTIFICATION REGARDING LOBBYING

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

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

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

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontractors, subgrants, and contracts under grants and cooperative agreements) of $100,000 or more, and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Secure Transportation	Gerard Linsmeier
Name of Contractor	Printed Name of Person Signing for Contractor
Cal Optima Pace Program	Gerard Linsmeier
Contract / Grant Number	Signature of Person Signing for Contractor
5/31/17	Regional VP of Sales
Date	Title

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

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

Addendum 3--Attachment 2

CERTIFICATION REGARDING LOBBYING

Approved by OMB
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

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

4. Name and Address of Reporting Entity: Prime Subawardee Tier, if known: Congressional District, If known:	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District, If known:
6. Federal Department/Agency:	Federal Program Name/Description: CDFA Number, if applicable:
8. Federal Action Number, if known:	9. Award Amount, if known:
10. a. Name and Address of Lobbying Entity (If individual, last name, first name, MI): (attach Continuation Sheets(s)	b. Name and Address of Lobbying Entity (If individual, last name, first name, MI): SF-LLL-A, If necessary)
Amount of Payment (check all that apply): $ actual planned Form of Payment (check all that apply): a. cash b. in-kind, specify: Nature Value	13. Type of Payment (check all that apply): a. retainer b. one-time fee c. commission d. contingent fee e. deferred f. other, specify:

14. Brief Description of Services Performed or to be Performed and Dates(s) of Service, including Officer(s), Employee(s), or Member(s) Contracted for Payment indicated in item 11:

15. Continuation Sheet(s) SF-LLL-A Attached: Yes No

16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $19,000 and not more than $100,000 for each such failure.	Signature: Print Name: Title: Telephone No.: Date:

Federal Use Only	Authorized for Local Reproduction Standard Form-LLL

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

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

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

Identify the status of the covered federal action.

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

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

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

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

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

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

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

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

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

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

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

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

Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

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

ADDENDUM 4
CAL MEDICONNECT PROGRAM REQUIREMENTS

NOT APPLICABLE

Addendum 4--Attachment 1

NOT APPLICABLE

AMENDMENT II TO
ANCILLARY SERVICES CONTRACT

THIS AMENDMENT II TO THE ANCILLARY SERVICES CONTRACT FOR HEALTH CARE SERVICES ("Amendment") by and between CalOptima, the county organized health system for the County of Orange, California ("CalOptima"), and **Secure Transportation Company, Inc.** ("Provider"), with respect to the following facts:

RECITALS

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

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

NOW, THEREFORE, the parties agree as follows:

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

"Term. Contract shall become effective following execution by both parties commencing on June 1, 2020 (the "Effective Date") and remaining in effect up to and through May 31st, 2022."

2. ATTACHMENT A "COVERED SERVICES" Shall be deleted in its entirety and replaced with a new ATTACHCMENT A "COVERED SERVICES", attached hereto.

3. ATTACHMENT C "COMPENSATION, ARTICLE III "Subcontractor Fees" shall be deleted in its entirety and replaced with the following:

"**Subcontractor Fees** Secure Transportation Subcontractors shall not be paid more than 30% of Secure Transportations total billed charges per month. Subcontractor services shall include but are not limited to:

1. Ambulatory Transportation: $17.00 origination fee each way/ $1.75 per mile
2. Wheelchair Transportation $25.00 origination fee each way/ $1.75 per mile
3. Cancelation and or No Show fee: Full fare if not cancelled day prior
4. Wait fee: $45.00 per hour. First 15 minutes are free."

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

IN WITNESS WHEREOF, CalOptima and **Secure Transportation Company, Inc.** have executed this Amendment. This Amendment shall become effective June 1, 2020 ("Effective Date").

FOR PROVIDER:

SIGNATURE

Jeff Bosheers
PRINT NAME

Chief Financial Officer
TITLE

April 27, 2020
DATE

FOR CALOPTIMA:

SIGNATURE

Ladan Khamseh
PRINT NAME

Chief Operating Officer
TITLE

4/30/2020
DATE

ATTACHMENT A

COVERED SERVICES

ARTICLE 1
CALOPTIMA PROGRAMS

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

_____ Medi-Cal Program

_____ Medicare Advantage Program (OneCare)

__X__ PACE Program

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

ARTICLE 2
SCOPE OFSERVICES

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

The Provider shall provide transportation services for the CalOptima PACE program and all its PACE alternative care settings located throughout Orange County. In general, the transportation services entail door-to-door, pick-up and drop-off round trips of CalOptima PACE Members: (1) to and from participants' homes and the PACE Center, (2) to and from the PACE Center and outside medical appointments, (3) to and from field trip destinations, and (4) to and from other destinations approved by the PACE interdisciplinary team. Transport services may also occasionally include transporting participants' caregivers and/or CalOptima staff if approved by the PACE interdisciplinary team.

In certain circumstances, participants may require "through the door" service based on individual need (e.g., ambulatory assistance to seat inside home, etc.).

Additional Requirements:

- If applicable, must meet all Medicare and Medi-Cal requirements applicable to transportation services.
- Cannot employ or contract with any individual or organization:
  - Who has been excluded from Medicare or Medicaid participation;
  - Who has been convicted of criminal offenses related to their involvement in Medicaid, Medicare, other health insurance or health care programs, or

Social services programs under Title XX of the SSA; or
    - In any capacity where an individual's contact with participants would pose a potential risk because the individual has been convicted of physical, sexual, drug, or alcohol abuse.
- Implement a system for its staff, or a representative, to participate in IDT meetings, as required, and for drivers to be able to communicate with the IDT regarding participant care plan needs, including changes.
- Provide a designated staff member to be stationed on a regularly scheduled basis to satisfy needs at the PACE Center for dispatch and who will serve as point person between drivers and center-based staff.
- Standard practice of "on-time" performance of scheduled pick-ups – "On time" means at the scheduled pick up time or up to fifteen (15) minutes before or after stated pick-up time. Provider must have systems in place to track performance of on-time pick-up's and process to correct performance as necessary.
- Be able to provide transportation services between the hours of 7:00am and 7:00pm every weekday, and, have personnel and vehicles available for weekend and after-hours service for participants (i.e., late hospital discharges, dialysis, PACE center weekend operating hours).

Provider must also satisfy the requirements in the following areas:

Participant Care and Safety

- Wheelchair hydraulic lifts, with failsafe safety systems, and safety restraint systems on vehicles in sufficient capacity to serve assigned population and all drivers trained on their proper use.
- Provider must have or implement a vehicle management program that promotes the safe use of equipment and minimizes safety risks and hazards both for its staff and for participants.
- All vehicles shall meet Americans with Disabilities Act (ADA) Accessibility Specifications for Transportation, Federal Transit Administration (FTA) regulations, Title 22 requirements and any other federal, state or local requirements as applicable.

Driver Competency and Training

- Written policies and procedures that specify personnel qualifications, training, experience, and continuing education requirements consistent with the services it provides to PACE participants, including compliance with Department of Transportation and Title 22 of the California Code of Regulations, as applicable. Written policies and procedures for the training and monitoring of drivers, including:
    - Proper transfer techniques, including nonambulatory and wheelchair users
    - Proper body mechanics
    - Proper use of equipment needed to transfer and secure participants during transit
    - Proper use of restraints and seat belts to secure participants during transport

- Emergency procedures during transfer, transport, and arrival of participants
- Attendance at all CalOptima PACE required training, including managing special needs of participants and handling emergency situations

- Driving personnel shall receive nationwide background checks before employment and be enrolled in the California Department of Motor Vehicles (DMV) Employer Pull Notice (EPN) Program.
- Provider shall have a Drug and Alcohol Screening Program and National Sex Offenders Registry Background Check in place for all drivers.
- Written procedures to check or audit for the following information on each driver:
  - Current driver's license
  - Verifications of licenses, registrations, certifications, and competency assessments
  - Record of any traffic violations or accidents that may constitute a potential hazard for the transport of participants
  - Background checks
  - Orientation completion and ongoing competency training
  - PPD screening
  - CPR certification
  - First Aid certification
- Demonstrate competency and sensitivity to communication and health care issues common with an elderly population, such as:
  - Hearing loss
  - Cognitive impairment
  - Sensory impairment
  - Limited mobility and physical disability
  - Use of assistive devices
  - Denial of need for assistance
- Cultural sensitivity, including how to meet the needs of non-English speaking clients.
- Superlative customer service approach – most days, the PACE driver will be the first and last point of contact that participants will have with the program.

Operational Efficiency

- Provider shall have communications systems on all vehicles for communication with a base station. Provider shall utilize a Computer Aided Dispatch (CAD) system and have a mechanism for dispatch audio recordings.
- All vehicles must be equipped to communicate with the PACE Center in real time during transportation activities, including ability to communicate with IDT members regarding participant needs as they arise during transport.
- All vehicles must be equipped with GPS devices.
- Provider must have or implement a contingency plan for emergencies and disasters, or to have arrangements with alternative providers in the event that Provider is unable to perform transportations services due to emergency or disaster.
- Provider shall maintain vehicle fleet as back-up. Provider shall have a system to

dispatch replacement vehicles immediately in the event of vehicle mechanical breakdown.

Quality Assurance and Improvement

- Provider shall have a Quality Management and Improvement Program that measures, conducts improvement activities and documents key performance standards. At a minimum, Provider must be able to monitor and report to CalOptima on the following performance standards:

    - Participant and/or Caregiver complaints
    - Transportation performance standards (maintaining above 90% on-time pick-ups)
    - Ensuring one-way rides are no longer than one hour in duration
    - Participant satisfaction with service and drivers

- Written policies and procedures for monitoring and tracking the performance of all drivers, including standard performance measurements to support improvement.
- Written policies and procedures for accident and incident reporting.
- Assist and cooperate with PACE staff for internal and external audits, including providing all transportation logs, vehicle records, and driver personnel files.
- Written procedures to notify CalOptima in a timely manner regarding any changes of driver personnel or driver status who are assigned to CalOptima PACE.
- If quality metrics are not met for three consecutive months, CalOptima PACE may reduce the scope of services and utilize an alternative vendor to provide specialty care trips, equating up to 20% of the scope of work. CalOptima reserves the right to reduce allocated Secure Transportation dollars for an alternative transportation vendor. Criteria for an alternate vendor are as follows:

    - Did not meet the on-time performance metric for 3 consecutive months
    - Has 5 or more 1-hour transportation violations in 3 consecutive months

- CalOptima reserves the right to use an alternate vendor for up to 80% of the scope of work if performance metrics are continually violated.

Vehicle Maintenance

- All fleet vehicles used for the PACE program must be maintained in accordance with the manufacturer's recommendations.
- All fleet vehicles used for the PACE program must be equipped to communicate with the PACE Center.
- Written policies and procedures on the maintenance of vehicles used for the PACE program, including a plan for identifying, monitoring, and reporting (where

indicated) vehicle malfunctions and repairs needed.

- Ability to provide evidence of appropriate state vehicles inspections.
- Maintain comprehensive first aid, emergency, and accident kits that are fully stocked on vehicles at all times.

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Financial Summary

February 28, 2022

Board of Directors Meeting

April 7, 2022

Nancy Huang, Chief Financial Officer

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Financial Highlights: February 2022

February					July-February			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
882,001	841,510	40,491	4.8%	Member Months	6,916,613	6,737,351	179,262	2.7%
320,696,961	279,078,034	41,618,927	14.9%	Revenues	2,909,864,119	2,546,546,952	363,317,167	14.3%
265,972,166	258,503,077	(7,469,089)	(2.9%)	Medical Expenses	2,679,783,753	2,478,822,209	(200,961,544)	(8.1%)
11,473,577	14,777,374	3,303,797	22.4%	Administrative Expenses	97,152,972	117,482,460	20,329,488	17.3%
43,251,218	**5,797,583**	**37,453,635**	**646.0%**	**Operating Margin**	**132,927,395**	**(49,757,717)**	**182,685,112**	**367.1%**
(5,953,542)	833,333	(6,786,875)	(814.4%)	Non Operating Income (Loss)	(9,223,448)	6,666,666	(15,890,114)	(238.4%)
37,297,676	**6,630,916**	**30,666,760**	**462.5%**	**Change in Net Assets**	**123,703,947**	**(43,091,051)**	**166,794,998**	**387.1%**
82.9%	92.6%	9.7%		Medical Loss Ratio	92.1%	97.3%	5.2%	
3.6%	5.3%	1.7%		Administrative Loss Ratio	3.3%	4.6%	1.3%	
13.5%	2.1%	11.4%		Operating Margin Ratio	4.6%	(2.0%)	6.5%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
82.9%	92.6%	9.7%		*MLR (excluding Directed Payments)	91.7%	97.3%	5.6%	
3.6%	5.3%	1.7%		*ALR (excluding Directed Payments)	3.5%	4.6%	1.1%	

*CalOptima updated the category of Directed Payments per Department of Health Care Services instructions

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Consolidated Performance: February 2022 (in millions)

February				July-February		
Actual	Budget	Variance		Actual	Budget	Variance
39.8	4.9	34.9	Medi-Cal	121.4	(47.2)	168.6
3.2	0.6	2.6	OCC	9.4	(3.0)	12.3
(0.0)	0.0	(0.1)	OneCare	(0.8)	(0.8)	(0.0)
0.3	0.3	0.0	PACE	2.9	1.2	1.7
(0.0)	(0.0)	0.0	MSSP	(0.0)	(0.0)	0.0
43.3	**5.8**	**37.5**	**Operating**	**132.9**	**(49.8)**	**182.7**
(6.0)	0.8	(6.8)	Inv./Rental Inc, MCO tax	(9.2)	6.7	(15.9)
(6.0)	**0.8**	**(6.8)**	**Non-Operating**	**(9.2)**	**6.7**	**(15.9)**
37.3	**6.6**	**30.7**	**TOTAL**	**123.7**	**(43.1)**	**166.8**

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FY 2021–22: Management Summary

- Change in Net Assets Surplus or (Deficit)
  - MTD (Feb 2022): $37.3 million, favorable to budget $30.7 million or 462.5%, primarily due to higher than anticipated Calendar Year (CY) 2022 Medi-Cal rates and deferred and delayed services
  - YTD (Jul 2021 – Feb 2022): $123.7 million, favorable to budget $166.8 million or 387.1%
- Enrollment
  - MTD: 882,001 members, favorable to budget 40,491 or 4.8%
  - YTD: 6,916,613 members, favorable to budget 179,262 or 2.7%
- Revenue
  - MTD: $320.7 million, favorable to budget $41.6 million or 14.9% driven by Medi-Cal (MC) line of business (LOB):
    - $41.0 million due to CY 2022 rate update and favorable enrollment
    - Offset by $2.1 million due to the net change in COVID-19 and Proposition 56 risk corridor estimates
  - YTD: $2.9 billion, favorable to budget $363.3 million or 14.3% driven by MC LOB:
    - $132.6 million of Fiscal Year (FY) 2020 hospital Directed Payments (DP)
    - $209.3 million due to CY 2022 rate update, favorable enrollment, prior year retroactive eligibility changes, and Proposition 56 estimates
    - $50.1 million increase in Long-Term Care (LTC), pharmacy funding from Department of Health Care Services (DHCS), Intergovernmental Transfer (IGT) 10 and Coordinated Care Initiative (CCI)
    - Offset by $32.7 million due to COVID-19 risk corridor

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FY 2021–22: Management Summary (cont.)

- Medical Expenses
  - MTD: $266.0 million, unfavorable to budget $7.5 million or 2.9% driven by MC LOB:
    - Provider Capitation expense unfavorable variance of $15.7 million due primarily to the extension of Proposition 56 and short-term supplemental rate increase due to COVID-19
    - Offset by net favorable variance from all other expenses of $9.2 million
  - YTD: $2.7 billion, unfavorable to budget $201.0 million or 8.1% driven by MC LOB:
    - Reinsurance & Other expense unfavorable variance of $138.8 million due to FY 2020 hospital DP
    - Provider Capitation expense unfavorable variance of $120.5 million due primarily to the extension of Proposition 56 and short-term supplemental rate increase due to COVID-19
    - Offset by net favorable variance from all other expenses of $52.9 million
- Administrative Expenses
  - MTD: $11.5 million, favorable to budget $3.3 million or 22.4%
  - YTD: $97.2 million, favorable to budget $20.3 million or 17.3%
- Non-Operating Income (Loss)
  - MTD: ($5.9) million, unfavorable to budget $6.8 million or 814.4%
    - Unfavorable variance is due to Managed Care Organization Tax expense and unrealized losses in bond value due to higher than anticipated interest rate increase by the Federal Reserve
  - YTD: ($9.6) million, unfavorable to budget $16.2 million or 243.5%

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FY 2021–22: Key Financial Ratios

- Medical Loss Ratio (MLR)
  - MTD: Actual 82.9%, Budget 92.6%
  - YTD: Actual 92.1% (91.7% excluding DP), Budget 97.3%
- Administrative Loss Ratio (ALR)
  - MTD: Actual 3.6% , Budget 5.3%
  - YTD: Actual 3.3% (3.5% excluding DP), Budget 4.6%
- Balance Sheet Ratios
  - *Current ratio: 1.75
  - Board-designated reserve funds level: 1.68
  - Net position: $1.4 billion, including required Tangible Net Equity (TNE) of $105.4 million

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

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Enrollment Summary: February 2022

February					July-February			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
119,764	117,616	2,148	1.8%	SPD	950,951	938,042	12,909	1.4%
302,823	295,348	7,475	2.5%	TANF Child	2,403,044	2,372,892	30,152	1.3%
116,984	106,682	10,302	9.7%	TANF Adult	901,733	854,491	47,242	5.5%
2,957	3,191	(234)	(7.3%)	LTC	25,028	25,528	(500)	(2.0%)
310,781	290,122	20,659	7.1%	MCE	2,402,382	2,318,881	83,501	3.6%
11,300	11,159	141	1.3%	WCM	94,096	89,272	4,824	5.4%
864,609	**824,118**	**40,491**	**4.9%**	**Medi-Cal Total**	**6,777,234**	**6,599,106**	**178,128**	**2.7%**
14,579	**15,186**	**(607)**	**(4.0%)**	**OneCare Connect**	**118,232**	**120,816**	**(2,584)**	**(2.1%)**
2,395	**1,789**	**606**	**33.9%**	**OneCare**	**17,831**	**14,200**	**3,631**	**25.6%**
418	**417**	**1**	**0.2%**	**PACE**	**3,316**	**3,229**	**87**	**2.7%**
457	**455**	**2**	**0.4%**	**MSSP**	**909**	**910**	**(1)**	**(0.1%)**
882,001	**841,510**	**40,491**	**4.8%**	**CalOptima Total***	**6,916,613**	**6,737,351**	**179,262**	**2.7%**

*Note: CalOptima Total does not include MSSP

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Consolidated Revenue & Expenses: February 2022 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS	542,528	310,781	11,300	864,609	14,579	2,395	418	457	882,001
REVENUES									
Capitation Revenue	148,845,109	$ 113,631,446	$ 20,392,989	$ 282,869,544	$ 31,294,584	$ 2,898,909	$ 3,441,891	$ 192,032	$ 320,696,961
Total Operating Revenue	148,845,109	113,631,446	20,392,989	282,869,544	31,294,584	2,898,909	3,441,891	192,032	320,696,961
MEDICAL EXPENSES									
Provider Capitation	46,151,351	49,229,274	7,881,006	103,261,631	13,090,493	819,583			117,171,707
Facilities	23,564,686	24,473,022	4,426,756	52,464,464	4,108,426	865,620	935,678		58,374,188
Professional Claims	22,429,064	12,086,348	1,444,184	35,959,596	1,003,995	88,165	742,467		37,794,223
Prescription Drugs	(555,464)	(451,885)	97,269	(910,080)	5,713,796	938,516	340,387		6,082,619
MLTSS	31,529,881	3,350,260	1,079,093	35,959,234	1,482,160	4,297	2,711	26,337	37,474,738
Medical Management	2,309,922	1,452,285	306,237	4,068,443	1,006,774	35,560	848,526	107,386	6,066,689
Qualtiy Insurance	1,178,161	795,957	29,900	2,004,018	219,570		5,225		2,228,813
Reinsurance & Other	339,323	174,885	10,347	524,554	117,726	100	136,809		779,189
Total Medical Expenses	126,946,922	91,110,146	15,274,792	233,331,860	26,742,940	2,751,841	3,011,802	133,723	265,972,166
Medical Loss Ratio	85.3%	80.2%	74.9%	82.5%	85.5%	94.9%	87.5%	69.6%	82.9%
GROSS MARGIN	**21,898,187**	**22,521,300**	**5,118,197**	**49,537,684**	**4,551,644**	**147,068**	**430,089**	**58,310**	**54,724,795**
ADMINISTRATIVE EXPENSES									
Salaries & Benefits				6,711,549	585,389	74,935	74,957	46,348	7,493,178
Professional fees				517,204	313	29,167		2,207	548,890
Purchased services				580,373	107,147	11,449	54,662		753,631
Printing & Postage				380,932	110,243	3,131	5,794		500,099
Depreciation & Amortization				344,248			370		344,618
Other expenses				1,435,512	556		10,421	6,016	1,452,505
Indirect cost allocation & Occupancy				(246,004)	552,533	58,503	11,506	4,119	380,656
Total Administrative Expenses				9,723,814	1,356,178	177,184	157,711	58,690	11,473,577
Admin Loss Ratio				3.4%	4.3%	6.1%	4.6%	30.6%	3.6%
INCOME (LOSS) FROM OPERATIONS				39,813,871	3,195,466	(30,116)	272,378	(380)	43,251,218
INVESTMENT INCOME									(2,818,355)
TOTAL MCO TAX				(3,135,194)					(3,135,194)
OTHER INCOME				7					7
CHANGE IN NET ASSETS				**$ 36,678,684**	**$ 3,195,466**	**$ (30,116)**	**$ 272,378**	**$ (380)**	**$ 37,297,676**
BUDGETED CHANGE IN NET ASSETS				4,872,810	643,468	33,883	259,867	(12,445)	6,630,916
VARIANCE TO BUDGET - FAV (UNFAV)				$ 31,805,874	$ 2,551,998	$ (63,999)	$ 12,511	$ 12,065	$ 30,666,760

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Consolidated Revenue & Expenses: February 2022 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total MC	OneCare Connect	OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS	4,280,756	2,402,382	94,096	6,777,234	118,232	17,831	3,316	909	6,916,613
REVENUES									
Capitation Revenue	1,350,793,299	$ 1,098,847,458	$ 188,152,724	2,637,793,481	$ 222,014,739	$ 22,759,057	$ 26,885,676	411,166	$ 2,909,864,119
Total Operating Revenue	1,350,793,299	1,098,847,458	188,152,724	2,637,793,481	222,014,739	22,759,057	26,885,676	411,166	2,909,864,119
MEDICAL EXPENSES									
Provider Capitation	364,696,904	395,021,941	73,245,746	832,964,590	88,362,691	6,245,672			927,572,952
Facilities	201,270,468	201,085,700	42,239,876	444,596,044	32,022,581	6,991,147	5,784,628		489,394,400
Professional Claims	171,812,442	87,752,260	11,359,271	270,923,972	8,743,531	815,440	6,378,918		286,861,860
Prescription Drugs	128,472,664	176,115,126	40,503,155	345,090,945	48,656,271	7,296,628	2,565,193		403,609,037
MLTSS	288,450,343	31,604,067	14,260,500	334,314,909	11,508,660	388,442	358,968	54,773	346,625,753
Medical Management	20,088,080	12,036,638	2,581,236	34,705,954	8,199,485	295,488	6,616,444	231,008	50,048,380
Quality Insurance	13,605,823	7,672,477	563,178	21,841,478	1,788,750		41,450		23,671,678
Reinsurance & Other	93,485,233	55,972,567	92,466	149,550,266	1,449,583	24,819	975,024		151,999,692
Total Medical Expenses	1,281,881,957	967,260,774	184,845,427	2,433,988,158	200,731,552	22,057,636	22,720,626	285,781	2,679,783,753
Medical Loss Ratio	94.9%	88.0%	98.2%	92.3%	90.4%	96.9%	84.5%	69.5%	92.1%
GROSS MARGIN	**68,911,342**	**131,586,684**	**3,307,297**	**203,805,323**	**21,283,187**	**701,421**	**4,165,050**	**125,385**	**230,080,367**
ADMINISTRATIVE EXPENSES									
Salaries & Benefits				56,397,586	5,686,191	609,965	866,079	102,271	63,662,092
Professional fees				2,325,318	174,469	240,099	7,251	2,916	2,750,053
Purchased services				7,517,828	863,287	89,256	152,821		8,623,192
Printing & Postage				2,655,328	759,634	70,635	101,409		3,587,006
Depreciation & Amortization				3,009,472			6,773		3,016,245
Other expenses				12,362,071	7,746	1,076	52,991	12,170	12,436,054
Indirect cost allocation & Occupancy				(1,895,324)	4,420,261	468,020	77,136	8,238	3,078,331
Total Administrative Expenses				82,372,278	11,911,588	1,479,051	1,264,460	125,595	97,152,972
Admin Loss Ratio				3.1%	5.4%	6.5%	4.7%	30.5%	3.3%
INCOME (LOSS) FROM OPERATIONS				121,433,045	9,371,599	(777,630)	2,900,591	(211)	132,927,395
INVESTMENT INCOME									(9,568,231)
TOTAL MCO TAX				335,975					335,975
OTHER INCOME				8,808					8,808
CHANGE IN NET ASSETS				**$ 121,777,828**	**$ 9,371,599**	**$ (777,630)**	**$ 2,900,591**	**$ (211)**	**$ 123,703,947**
BUDGETED CHANGE IN NET ASSETS				(47,187,195)	(2,962,837)	(765,783)	1,183,795	(25,697)	(43,091,051)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 168,965,023	$ 12,334,436	$ (11,847)	$ 1,716,796	$ 25,486	$ 166,794,998

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Balance Sheet: As of February 2022

ASSETS		LIABILITIES & NET POSITION	
Current Assets		**Current Liabilities**	
Operating Cash	$737,165,482	Accounts Payable	$40,865,830
Short-term Investments	909,524,503	Medical Claims liability	830,507,863
Capitation receivable	165,221,848	Accrued Payroll Liabilities	13,884,845
Receivables - Other	44,320,597	Deferred Revenue	10,167,080
Prepaid expenses	13,292,098	Deferred Lease Obligations	107,023
		Capitation and Withholds	171,987,145
Total Current Assets	**1,869,524,529**	**Total Current Liabilities**	**1,067,519,786**
Capital Assets			
Furniture & Equipment	46,251,085		
Building/Leasehold Improvements	8,298,842		
505 City Parkway West	52,168,012		
	106,717,939		
Less: accumulated depreciation	(62,096,115)		
Capital assets, net	44,621,824		
		Other (than pensions) post employment benefits liability	31,971,165
Other Assets		Net Pension Liabilities	30,757,228
Restricted Deposit & Other	300,000	Bldg 505 Development Rights	-
Homeless Health Reserve	56,798,913		
Board-designated assets:		**TOTAL LIABILITIES**	**1,130,248,179**
Cash and Cash Equivalents	8,762,902		
Investments	572,095,597	**Deferred Inflows**	
Total Board-designated Assets	580,858,499	Excess Earnings	344,198
		OPEB 75 Difference in Experience	536,000
Total Other Assets	637,957,412	Change in Assumptions	2,709,945
		OPEB Changes in Assumptions	773,000
		Net Position	
TOTAL ASSETS	**2,552,103,765**	TNE	105,416,625
		Funds in Excess of TNE	1,327,068,115
Deferred Outflows		**TOTAL NET POSITION**	1,432,484,740
Contributions	1,508,025		
Difference in Experience	3,236,721		
Excess Earning	2,104,780		
Changes in Assumptions	3,692,771		
OPEB 75 Changes in Assumptions	3,906,000		
Pension Contributions	544,000		
TOTAL ASSETS & DEFERRED OUTFLOWS	**2,567,096,062**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**2,567,096,062**

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Board Designated Reserve and TNE Analysis: As of February 2022

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	235,688,440				
	Tier 1 - MetLife	234,535,255				
Board-designated Reserve		470,223,696	377,815,995	584,915,690	92,407,700	(114,691,994)
	Tier 2 - Payden & Rygel	55,334,415				
	Tier 2 - MetLife	55,300,389				
TNE Requirement		110,634,804	105,416,625	105,416,625	5,218,179	5,218,179
	Consolidated:	**580,858,499**	**483,232,620**	**690,332,314**	**97,625,879**	**(109,473,815)**
	Current reserve level	*1.68*	*1.40*	*2.00*		

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Our Mission

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

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UNAUDITED FINANCIAL STATEMENTS

February 2022

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CalOptima - Consolidated
Financial Highlights
For the Eight Months Ended February 28, 2022

February					July-February			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
882,001	841,510	40,491	4.8%	Member Months	6,916,613	6,737,351	179,262	2.7%
320,696,961	279,078,034	41,618,927	14.9%	Revenues	2,909,864,119	2,546,546,952	363,317,167	14.3%
265,972,166	258,503,077	(7,469,089)	(2.9%)	Medical Expenses	2,679,783,753	2,478,822,209	(200,961,544)	(8.1%)
11,473,577	14,777,374	3,303,797	22.4%	Administrative Expenses	97,152,972	117,482,460	20,329,488	17.3%
43,251,218	**5,797,583**	**37,453,635**	**646.0%**	**Operating Margin**	**132,927,395**	**(49,757,717)**	**182,685,112**	**367.1%**
(5,953,542)	833,333	(6,786,875)	(814.4%)	Non Operating Income (Loss)	(9,223,448)	6,666,666	(15,890,114)	(238.4%)
37,297,676	**6,630,916**	**30,666,760**	**462.5%**	**Change in Net Assets**	**123,703,947**	**(43,091,051)**	**166,794,998**	**387.1%**
82.9%	92.6%	9.7%		Medical Loss Ratio	92.1%	97.3%	5.2%	
3.6%	5.3%	1.7%		Administrative Loss Ratio	3.3%	4.6%	1.3%	
13.5%	2.1%	11.4%		Operating Margin Ratio	4.6%	(2.0%)	6.5%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
82.9%	92.6%	9.7%		*MLR (excluding Directed Payments)	91.7%	97.3%	5.6%	
3.6%	5.3%	1.7%		*ALR (excluding Directed Payments)	3.5%	4.6%	1.1%	

*CalOptima updated the category of Directed Payments per Department of Health Care Services instructions

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CalOptima
Financial Dashboard
For the Eight Months Ended February 28, 2022

February

Enrollment	Actual	Budget	Fav / (Unfav)	
Medi-Cal	864,609	824,118	40,491	4.9%
OneCare Connect	14,579	15,186	(607)	(4.0%)
OneCare	2,395	1,789	606	33.9%
PACE	418	417	1	0.2%
MSSP	457	455	2	0.4%
Total*	882,001	841,510	40,491	4.8%

Change in Net Assets (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 36,679	$ 4,873	$ 31,806	652.7%
OneCare Connect	3,195	643	2,552	396.9%
OneCare	(30)	34	(64)	(188.2%)
PACE	272	260	12	4.6%
MSSP	-	(12)	12	100.0%
505 Bldg.	-	-	-	0.0%
Investment Income	(2,818)	833	(3,651)	(438.3%)
Total	$ 37,298	$ 6,631	$ 30,667	462.5%

MLR	Actual	Budget	% Point Var
Medi-Cal	82.5%	92.9%	10.4
OneCare Connect	85.5%	91.4%	6.0
OneCare	94.9%	90.3%	(4.6)

Administrative Cost (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 9,724	$ 12,439	$ 2,715	21.8%
OneCare Connect	1,356	1,851	495	26.7%
OneCare	177	178	1	0.7%
PACE	158	237	80	33.5%
MSSP	59	71	13	17.7%
Total	$ 11,474	$ 14,777	$ 3,304	22.4%

Total FTE's Month	Actual	Budget	Fav / (Unfav)
Medi-Cal	1,074	1,205	131
OneCare Connect	174	210	36
OneCare	10	9	(1)
PACE	95	117	22
MSSP	17	18	1
Total	1,370	1,558	189

MM per FTE	Actual	Budget	Fav / (Unfav)
Medi-Cal	805	684	121
OneCare Connect	84	72	11
OneCare	241	192	49
PACE	4	4	1
MSSP	27	25	2
Total	1,161	978	184

July-February

Year To Date Enrollment	Actual	Budget	Fav / (Unfav)	
Medi-Cal	6,777,234	6,599,106	178,128	2.7%
OneCare Connect	118,232	120,816	(2,584)	(2.1%)
OneCare	17,831	14,200	3,631	25.6%
PACE	3,316	3,229	87	2.7%
MSSP	909	910	(1)	(0.1%)
Total*	6,916,613	6,737,351	179,262	2.7%

Change in Net Assets (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 121,778	$ (47,187)	$ 168,965	358.1%
OneCare Connect	9,372	(2,963)	12,335	416.3%
OneCare	(778)	(766)	(12)	(1.6%)
PACE	2,901	1,184	1,717	145.0%
MSSP	-	(26)	26	100.0%
505 Bldg.	-	-	-	0.0%
Investment Income	(9,568)	6,667	(16,235)	(243.5%)
Total	$ 123,705	$ (43,091)	$ 166,796	387.1%

MLR	Actual	Budget	% Point Var
Medi-Cal	92.3%	97.7%	5.5
OneCare Connect	90.4%	94.6%	4.2
OneCare	96.9%	96.0%	(0.9)

Administrative Cost (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 82,372	$ 99,108	$ 16,736	16.9%
OneCare Connect	11,912	14,980	3,069	20.5%
OneCare	1,479	1,434	(45)	(3.1%)
PACE	1,264	1,817	552	30.4%
MSSP	126	143	17	11.9%
Total	$ 97,153	$ 117,482	$ 20,329	17.3%

Total FTE's YTD	Actual	Budget	Fav / (Unfav)
Medi-Cal	8,536	9,607	1,071
OneCare Connect	1,491	1,676	185
OneCare	79	74	(5)
PACE	736	911	175
MSSP	138	144	6
Total	10,980	12,413	1,433

MM per FTE	Actual	Budget	Fav / (Unfav)
Medi-Cal	794	687	107
OneCare Connect	79	72	7
OneCare	225	191	34
PACE	5	4	1
MSSP	7	6	0
Total	1,109	960	149

Note:* Total membership does not include MSSP

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CalOptima - Consolidated
Statement of Revenues and Expenses
For the One Month Ended February 28, 2022

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	882,001		841,510		40,491	
REVENUE						
Medi-Cal	$ 282,869,544	$ 327.16	$ 244,100,526	$ 296.20	$ 38,769,018	$ 30.96
OneCare Connect	31,294,584	2,146.55	29,176,641	1,921.29	2,117,943	225.26
OneCare	2,898,909	1,210.40	2,197,886	1,228.56	701,023	(18.16)
PACE	3,441,891	8,234.19	3,399,892	8,153.22	41,999	80.97
MSSP	192,032	420.20	203,089	446.35	(11,057)	(26.15)
Total Operating Revenue	320,696,961	363.60	279,078,034	331.64	41,618,927	31.96
MEDICAL EXPENSES						
Medi-Cal	233,331,860	269.87	226,788,605	275.19	(6,543,255)	5.32
OneCare Connect	26,742,940	1,834.35	26,681,859	1,757.00	(61,081)	(77.35)
OneCare	2,751,841	1,148.99	1,985,626	1,109.91	(766,215)	(39.08)
PACE	3,011,802	7,205.27	2,902,761	6,961.06	(109,041)	(244.21)
MSSP	133,723	292.61	144,226	316.98	10,503	24.37
Total Medical Expenses	265,972,166	301.56	258,503,077	307.19	(7,469,089)	5.63
GROSS MARGIN	54,724,795	62.04	20,574,957	24.45	34,149,838	37.59
ADMINISTRATIVE EXPENSES						
Salaries and benefits	7,493,178	8.50	9,290,625	11.04	1,797,447	2.54
Professional fees	548,890	0.62	785,396	0.93	236,506	0.31
Purchased services	753,631	0.85	1,147,039	1.36	393,408	0.51
Printing & Postage	500,099	0.57	556,998	0.66	56,899	0.09
Depreciation & Amortization	344,618	0.39	492,900	0.59	148,282	0.20
Other expenses	1,452,505	1.65	2,065,482	2.45	612,977	0.80
Indirect cost allocation & Occupancy expense	380,656	0.43	438,934	0.52	58,278	0.09
Total Administrative Expenses	11,473,577	13.01	14,777,374	17.56	3,303,797	4.55
INCOME (LOSS) FROM OPERATIONS	43,251,218	49.04	5,797,583	6.89	37,453,635	42.15
INVESTMENT INCOME						
Interest income	677,342	0.77	833,333	0.99	(155,991)	(0.22)
Realized gain/(loss) on investments	(637,235)	(0.72)	-	-	(637,235)	(0.72)
Unrealized gain/(loss) on investments	(2,858,462)	(3.24)	-	-	(2,858,462)	(3.24)
Total Investment Income	(2,818,355)	(3.20)	833,333	0.99	(3,651,688)	(4.19)
TOTAL MCO TAX	(3,135,194)	(3.55)	-	-	(3,135,194)	(3.55)
OTHER INCOME	7	-	-	-	7	-
CHANGE IN NET ASSETS	**37,297,676**	**42.29**	**6,630,916**	**7.88**	**30,666,760**	**34.41**
MEDICAL LOSS RATIO	**82.9%**		**92.6%**		**9.7%**	
ADMINISTRATIVE LOSS RATIO	**3.6%**		**5.3%**		**1.7%**	

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CalOptima - Consolidated
Statement of Revenues and Expenses
For the Eight Months Ended February 28, 2022

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	6,916,613		6,737,351		179,262	
REVENUE						
Medi-Cal	$ 2,637,793,481	$ 389.21	$ 2,279,514,501	$ 345.43	$ 358,278,980	$ 43.78
OneCare Connect	222,014,739	1,877.79	223,814,450	1,852.52	(1,799,711)	25.27
OneCare	22,759,057	1,276.38	16,598,266	1,168.89	6,160,791	107.49
PACE	26,885,676	8,107.86	26,213,556	8,118.17	672,120	(10.31)
MSSP	411,166	452.33	406,179	446.35	4,987	5.98
Total Operating Revenue	2,909,864,119	420.71	2,546,546,952	377.97	363,317,167	42.74
MEDICAL EXPENSES						
Medi-Cal	2,433,988,158	359.14	2,227,593,216	337.56	(206,394,942)	(21.58)
OneCare Connect	200,731,552	1,697.78	211,796,933	1,753.05	11,065,381	55.27
OneCare	22,057,636	1,237.04	15,929,702	1,121.81	(6,127,934)	(115.23)
PACE	22,720,626	6,851.82	23,213,259	7,188.99	492,633	337.17
MSSP	285,781	314.39	289,099	317.69	3,318	3.30
Total Medical Expenses	2,679,783,753	387.44	2,478,822,209	367.92	(200,961,544)	(19.52)
GROSS MARGIN	230,080,367	33.27	67,724,743	10.05	162,355,624	23.22
ADMINISTRATIVE EXPENSES						
Salaries and benefits	63,662,092	9.20	74,576,146	11.07	10,914,054	1.87
Professional fees	2,750,053	0.40	5,624,680	0.83	2,874,627	0.43
Purchased services	8,623,192	1.25	10,214,847	1.52	1,591,655	0.27
Printing & Postage	3,587,006	0.52	4,455,984	0.66	868,978	0.14
Depreciation & Amortization	3,016,245	0.44	3,943,200	0.59	926,955	0.15
Other expenses	12,436,054	1.80	15,156,131	2.25	2,720,077	0.45
Indirect cost allocation & Occupancy expense	3,078,331	0.45	3,511,472	0.52	433,141	0.07
Total Administrative Expenses	97,152,972	14.05	117,482,460	17.44	20,329,488	3.39
INCOME (LOSS) FROM OPERATIONS	132,927,395	19.22	(49,757,717)	(7.39)	182,685,112	26.61
INVESTMENT INCOME						
Interest income	4,948,830	0.72	6,666,666	0.99	(1,717,836)	(0.27)
Realized gain/(loss) on investments	(888,183)	(0.13)	-	-	(888,183)	(0.13)
Unrealized gain/(loss) on investments	(13,628,878)	(1.97)	-	-	(13,628,878)	(1.97)
Total Investment Income	(9,568,231)	(1.38)	6,666,666	0.99	(16,234,897)	(2.37)
TOTAL MCO TAX	335,975	0.05	-	-	335,975	0.05
OTHER INCOME	8,808	-	-	-	8,808	-
CHANGE IN NET ASSETS	**123,703,947**	**17.89**	**(43,091,051)**	**(6.40)**	**166,794,998**	**24.29**
MEDICAL LOSS RATIO	**92.1%**		**97.3%**		**5.2%**	
ADMINISTRATIVE LOSS RATIO	**3.3%**		**4.6%**		**1.3%**	

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CalOptima - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ended February 28, 2022

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS	542,528	310,781	11,300	864,609	14,579	2,395	418	457	882,001
REVENUES									
Capitation Revenue	148,845,109	$ 113,631,446	$ 20,392,989	$ 282,869,544	$ 31,294,584	$ 2,898,909	$ 3,441,891	$ 192,032	$ 320,696,961
Total Operating Revenue	148,845,109	113,631,446	20,392,989	282,869,544	31,294,584	2,898,909	3,441,891	192,032	320,696,961
MEDICAL EXPENSES									
Provider Capitation	46,151,351	49,229,274	7,881,006	103,261,631	13,090,493	819,583			117,171,707
Facilities	23,564,686	24,473,022	4,426,756	52,464,464	4,108,426	865,620	935,678		58,374,188
Professional Claims	22,429,064	12,086,348	1,444,184	35,959,596	1,003,995	88,165	742,467		37,794,223
Prescription Drugs	(555,464)	(451,885)	97,269	(910,080)	5,713,796	938,516	340,387		6,082,619
MLTSS	31,529,881	3,350,260	1,079,093	35,959,234	1,482,160	4,297	2,711	26,337	37,474,738
Medical Management	2,309,922	1,452,285	306,237	4,068,443	1,006,774	35,560	848,526	107,386	6,066,689
Quality Incentives	1,178,161	795,957	29,900	2,004,018	219,570		5,225		2,228,813
Reinsurance & Other	339,323	174,885	10,347	524,554	117,726	100	136,809	-	779,189
Total Medical Expenses	126,946,922	91,110,146	15,274,792	233,331,860	26,742,940	2,751,841	3,011,802	133,723	265,972,166
Medical Loss Ratio	85.3%	80.2%	74.9%	82.5%	85.5%	94.9%	87.5%	69.6%	82.9%
GROSS MARGIN	**21,898,187**	**22,521,300**	**5,118,197**	**49,537,684**	**4,551,644**	**147,068**	**430,089**	**58,310**	**54,724,795**
ADMINISTRATIVE EXPENSES									
Salaries & Benefits				6,711,549	585,389	74,935	74,957	46,348	7,493,178
Professional fees				517,204	313	29,167		2,207	548,890
Purchased services				580,373	107,147	11,449	54,662		753,631
Printing & Postage				380,932	110,243	3,131	5,794		500,099
Depreciation & Amortization				344,248			370		344,618
Other expenses				1,435,512	556		10,421	6,016	1,452,505
Indirect cost allocation & Occupancy				(246,004)	552,533	58,503	11,506	4,119	380,656
Total Administrative Expenses				9,723,814	1,356,178	177,184	157,711	58,690	11,473,577
Admin Loss Ratio				3.4%	4.3%	6.1%	4.6%	30.6%	3.6%
INCOME (LOSS) FROM OPERATIONS				39,813,871	3,195,466	(30,116)	272,378	(380)	43,251,218
INVESTMENT INCOME									(2,818,355)
TOTAL MCO TAX				(3,135,194)					(3,135,194)
OTHER INCOME				7					7
CHANGE IN NET ASSETS				**$ 36,678,684**	**$ 3,195,466**	**$ (30,116)**	**$ 272,378**	**$ (380)**	**$ 37,297,676**
BUDGETED CHANGE IN NET ASSETS				4,872,810	643,468	33,883	259,867	(12,445)	6,630,916
VARIANCE TO BUDGET - FAV (UNFAV)				$ 31,805,874	$ 2,551,998	$ (63,999)	$ 12,511	$ 12,065	$ 30,666,760

Note:* Total membership does not include MSSP

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CalOptima - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Eight Months Ended February 28, 2022

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total MC	OneCare Connect	OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS	4,280,756	2,402,382	94,096	6,777,234	118,232	17,831	3,316	909	6,916,613
REVENUES									
Capitation Revenue	1,350,793,299	$ 1,098,847,458	$ 188,152,724	2,637,793,481	$ 222,014,739	$ 22,759,057	$ 26,885,676	411,166	$ 2,909,864,119
Total Operating Revenue	1,350,793,299	1,098,847,458	188,152,724	2,637,793,481	222,014,739	22,759,057	26,885,676	411,166	2,909,864,119
MEDICAL EXPENSES									
Provider Capitation	364,696,904	395,021,941	73,245,746	832,964,590	88,362,691	6,245,672			927,572,952
Facilities	201,270,468	201,085,700	42,239,876	444,596,044	32,022,581	6,991,147	5,784,628		489,394,400
Professional Claims	171,812,442	87,752,260	11,359,271	270,923,972	8,743,531	815,440	6,378,918		286,861,860
Prescription Drugs	128,472,664	176,115,126	40,503,155	345,090,945	48,656,271	7,296,628	2,565,193		403,609,037
MLTSS	288,450,343	31,604,067	14,260,500	334,314,909	11,508,660	388,442	358,968	54,773	346,625,753
Medical Management	20,088,080	12,036,638	2,581,236	34,705,954	8,199,485	295,488	6,616,444	231,008	50,048,380
Quality Incentives	13,605,823	7,672,477	563,178	21,841,478	1,788,750		41,450		23,671,678
Reinsurance & Other	93,485,233	55,972,567	92,466	149,550,266	1,449,583	24,819	975,024		151,999,692
Total Medical Expenses	1,281,881,957	967,260,774	184,845,427	2,433,988,158	200,731,552	22,057,636	22,720,626	285,781	2,679,783,753
Medical Loss Ratio	94.9%	88.0%	98.2%	92.3%	90.4%	96.9%	84.5%	69.5%	92.1%
GROSS MARGIN	**68,911,342**	**131,586,684**	**3,307,297**	**203,805,323**	**21,283,187**	**701,421**	**4,165,050**	**125,385**	**230,080,367**
ADMINISTRATIVE EXPENSES									
Salaries & Benefits				56,397,586	5,686,191	609,965	866,079	102,271	63,662,092
Professional fees				2,325,318	174,469	240,099	7,251	2,916	2,750,053
Purchased services				7,517,828	863,287	89,256	152,821		8,623,192
Printing & Postage				2,655,328	759,634	70,635	101,409		3,587,006
Depreciation & Amortization				3,009,472			6,773		3,016,245
Other expenses				12,362,071	7,746	1,076	52,991	12,170	12,436,054
Indirect cost allocation & Occupancy				(1,895,324)	4,420,261	468,020	77,136	8,238	3,078,331
Total Administrative Expenses				82,372,278	11,911,588	1,479,051	1,264,460	125,595	97,152,972
Admin Loss Ratio				3.1%	5.4%	6.5%	4.7%	30.5%	3.3%
INCOME (LOSS) FROM OPERATIONS				121,433,045	9,371,599	(777,630)	2,900,591	(211)	132,927,395
INVESTMENT INCOME									(9,568,231)
TOTAL MCO TAX				335,975					335,975
OTHER INCOME				8,808					8,808
CHANGE IN NET ASSETS				**$ 121,777,828**	**$ 9,371,599**	**$ (777,630)**	**$ 2,900,591**	**$ (211)**	**$ 123,703,947**
BUDGETED CHANGE IN NET ASSETS				(47,187,195)	(2,962,837)	(765,783)	1,183,795	(25,697)	(43,091,051)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 168,965,023	$ 12,334,436	$ (11,847)	$ 1,716,796	$ 25,486	$ 166,794,998

Note:* Total membership does not include MSSP

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February 28, 2022 Unaudited Financial Statements

SUMMARY MONTHLY RESULTS:

- Change in Net Assets is $37.3 million, $30.7 million favorable to budget
- Operating surplus is $43.3 million, with a deficit in non-operating income of $6.0 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $123.7 million, $166.8 million favorable to budget
- Operating surplus is $132.9 million, with a deficit in non-operating income of $9.2 million

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

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
39.8	4.9	34.9	Medi-Cal	121.4	(47.2)	168.6
3.2	0.6	2.6	OCC	9.4	(3.0)	12.3
(0.0)	0.0	(0.1)	OneCare	(0.8)	(0.8)	(0.0)
0.3	0.3	0.0	PACE	2.9	1.2	1.7
(0.0)	(0.0)	0.0	MSSP	(0.0)	(0.0)	0.0
43.3	**5.8**	**37.5**	**Operating**	**132.9**	**(49.8)**	**182.7**
(6.0)	0.8	(6.8)	Inv./Rental Inc, MCO tax	(9.2)	6.7	(15.9)
(6.0)	**0.8**	**(6.8)**	**Non-Operating**	**(9.2)**	**6.7**	**(15.9)**
37.3	**6.6**	**30.7**	**TOTAL**	**123.7**	**(43.1)**	**166.8**

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CalOptima - Consolidated
Enrollment Summary
For the Eight Months Ended February 28, 2022

February					July-February			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
119,764	117,616	2,148	1.8%	SPD	950,951	938,042	12,909	1.4%
302,823	295,348	7,475	2.5%	TANF Child	2,403,044	2,372,892	30,152	1.3%
116,984	106,682	10,302	9.7%	TANF Adult	901,733	854,491	47,242	5.5%
2,957	3,191	(234)	(7.3%)	LTC	25,028	25,528	(500)	(2.0%)
310,781	290,122	20,659	7.1%	MCE	2,402,382	2,318,881	83,501	3.6%
11,300	11,159	141	1.3%	WCM	94,096	89,272	4,824	5.4%
864,609	**824,118**	**40,491**	**4.9%**	**Medi-Cal Total**	**6,777,234**	**6,599,106**	**178,128**	**2.7%**
14,579	**15,186**	**(607)**	**(4.0%)**	**OneCare Connect**	**118,232**	**120,816**	**(2,584)**	**(2.1%)**
2,395	**1,789**	**606**	**33.9%**	**OneCare**	**17,831**	**14,200**	**3,631**	**25.6%**
418	**417**	**1**	**0.2%**	**PACE**	**3,316**	**3,229**	**87**	**2.7%**
457	**455**	**2**	**0.4%**	**MSSP**	**909**	**910**	**(1)**	**(0.1%)**
882,001	**841,510**	**40,491**	**4.8%**	**CalOptima Total***	**6,916,613**	**6,737,351**	**179,262**	**2.7%**
				Enrollment (by Network)				
201,561	191,526	10,035	5.2%	HMO	1,576,989	1,529,367	47,622	3.1%
231,824	226,651	5,173	2.3%	PHC	1,836,546	1,820,453	16,093	0.9%
211,137	201,926	9,211	4.6%	Shared Risk Group	1,657,136	1,621,854	35,282	2.2%
220,087	204,015	16,072	7.9%	Fee for Service	1,706,563	1,627,432	79,131	4.9%
864,609	**824,118**	**40,491**	**4.9%**	**Medi-Cal Total**	**6,777,234**	**6,599,106**	**178,128**	**2.7%**
14,579	**15,186**	**(607)**	**(4.0%)**	**OneCare Connect**	**118,232**	**120,816**	**(2,584)**	**(2.1%)**
2,395	**1,789**	**606**	**33.9%**	**OneCare**	**17,831**	**14,200**	**3,631**	**25.6%**
418	**417**	**1**	**0.2%**	**PACE**	**3,316**	**3,229**	**87**	**2.7%**
457	**455**	**2**	**0.4%**	**MSSP**	**909**	**910**	**(1)**	**(0.1%)**
882,001	**841,510**	**40,491**	**4.8%**	**CalOptima Total***	**6,916,613**	**6,737,351**	**179,262**	**2.7%**

*Note: CalOptima Total does not include MSSP

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CalOptima
Enrollment Trend by Network
Fiscal Year 2022

	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	YTD Actual	YTD Budget	Variance
HMOs															
SPD	10,759	10,772	10,796	10,750	10,821	10,837	10,841	10,887					86,463	86,426	37
TANF Child	57,684	57,453	57,592	57,944	58,108	58,236	58,526	58,795					464,338	455,862	8,476
TANF Adult	33,827	34,099	34,339	34,622	35,046	35,411	35,758	36,052					279,154	265,191	13,963
LTC		1	3	1		1	1						7		7
MCE	88,797	89,334	90,159	91,017	91,516	92,159	93,225	93,841					730,048	705,808	24,240
WCM	2,114	2,193	2,177	2,133	2,130	2,143	2,103	1,986					16,979	16,080	899
Total	**193,181**	**193,852**	**195,066**	**196,467**	**197,621**	**198,787**	**200,454**	**201,561**					**1,576,989**	**1,529,367**	**47,622**
PHCs															
SPD	6,896	6,819	6,942	6,915	6,953	6,926	6,861	6,880					55,192	56,944	(1,752)
TANF Child	155,214	154,985	155,440	155,771	156,156	156,251	156,692	157,039					1,247,548	1,236,641	10,907
TANF Adult	14,006	14,054	14,197	14,390	14,667	14,851	14,985	15,115					116,265	110,399	5,866
LTC		2	1			1							4		4
MCE	44,256	44,359	44,580	44,754	44,973	45,241	45,668	45,753					359,584	361,493	(1,909)
WCM	7,304	7,368	7,236	7,322	7,178	7,262	7,246	7,037					57,953	54,976	2,977
Total	**227,676**	**227,587**	**228,396**	**229,152**	**229,927**	**230,532**	**231,452**	**231,824**					**1,836,546**	**1,820,453**	**16,093**
Shared Risk Groups															
SPD	10,063	10,104	10,074	10,003	10,122	10,095	10,096	10,086					80,643	82,627	(1,984)
TANF Child	59,085	58,837	58,641	58,541	58,523	58,347	58,363	58,200					468,537	476,139	(7,602)
TANF Adult	33,013	33,123	33,374	33,745	34,109	34,482	34,824	35,120					271,790	265,010	6,780
LTC	1	1	1		1			1					5		5
MCE	99,994	100,643	101,666	102,780	103,620	104,418	105,563	106,367					825,051	786,750	38,301
WCM	1,373	1,368	1,394	1,400	1,395	1,394	1,423	1,363					11,110	11,328	(218)
Total	**203,529**	**204,076**	**205,150**	**206,469**	**207,770**	**208,736**	**210,269**	**211,137**					**1,657,136**	**1,621,854**	**35,282**
Fee for Service (Dual)															
SPD	79,829	80,117	80,139	80,438	80,738	80,494	81,326	81,148					644,229	629,029	15,200
TANF Child	1	1	1	1	1	1	1	1					8		8
TANF Adult	1,318	1,351	1,392	1,408	1,435	1,465	1,529	1,568					11,466	9,288	2,178
LTC	2,788	2,778	2,806	2,847	2,864	2,870	2,914	2,624					22,491	23,096	(605)
MCE	3,612	3,813	4,013	4,268	4,489	4,889	4,982	5,145					35,211	20,809	14,402
WCM	16	16	18	20	15	18	16	16					135	120	15
Total	**87,564**	**88,076**	**88,369**	**88,982**	**89,542**	**89,737**	**90,768**	**90,502**					**713,540**	**682,342**	**31,198**
Fee for Service (Non-Dual - Total)															
SPD	10,163	10,047	10,616	10,358	10,832	10,708	10,937	10,763					84,424	83,016	1,408
TANF Child	26,720	26,952	27,715	28,188	27,730	27,774	28,746	28,788					222,613	204,250	18,363
TANF Adult	26,224	26,653	27,382	27,916	28,150	28,339	29,265	29,129					223,058	204,603	18,455
LTC	309	314	305	316	321	332	292	332					2,521	2,432	89
MCE	53,947	54,384	55,449	56,467	56,714	56,885	58,967	59,675					452,488	444,021	8,467
WCM	993	962	999	1,030	1,009	975	1,053	898					7,919	6,768	1,151
Total	**118,356**	**119,312**	**122,466**	**124,275**	**124,756**	**125,013**	**129,260**	**129,585**					**993,023**	**945,090**	**47,933**
SPD	117,710	117,859	118,567	118,464	119,466	119,060	120,061	119,764					950,951	938,042	12,909
TANF Child	298,704	298,228	299,389	300,445	300,518	300,609	302,328	302,823					2,403,044	2,372,892	30,152
TANF Adult	108,388	109,280	110,684	112,081	113,407	114,548	116,361	116,984					901,733	854,491	47,242
LTC	3,098	3,096	3,116	3,164	3,186	3,204	3,207	2,957					25,028	25,528	(500)
MCE	290,606	292,533	295,867	299,286	301,312	303,592	308,405	310,781					2,402,382	2,318,881	83,501
WCM	11,800	11,907	11,824	11,905	11,727	11,792	11,841	11,300					94,096	89,272	4,824
Total Medi-Cal MM	**830,306**	**832,903**	**839,447**	**845,345**	**849,616**	**852,805**	**862,203**	**864,609**					**6,777,234**	**6,599,106**	**178,128**
OneCare Connect	**14,688**	**14,819**	**14,817**	**14,833**	**14,877**	**14,933**	**14,686**	**14,579**					**118,232**	**120,816**	**(2,584)**
OneCare	**2,019**	**2,110**	**2,152**	**2,232**	**2,274**	**2,330**	**2,319**	**2,395**					**17,831**	**14,200**	**3,631**
PACE	**401**	**407**	**409**	**418**	**415**	**421**	**427**	**418**					**3,316**	**3,229**	**87**
MSSP							**452**	**457**					**909**	**910**	**(1)**
Grand Total*	**847,414**	**850,239**	**856,825**	**862,828**	**867,182**	**870,489**	**879,635**	**882,001**					**6,916,613**	**6,737,351**	**179,262**

*Note: Grand Total does not include MSSP

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ENROLLMENT:

Overall, February enrollment was 882,001

- Favorable to budget 40,491 or 4.8%
- Increased 2,366 or 0.3% from Prior Month (PM) (January 2022)
- Increased 71,896 or 8.9% from Prior Year (PY) (February 2021)

Medi-Cal enrollment was 864,609

- Favorable to budget 40,491 or 4.9%
  - Medi-Cal Expansion (MCE) favorable 20,659
  - Temporary Assistance for Needy Families (TANF) favorable 17,777
  - Seniors and Persons with Disabilities (SPD) favorable 2,148
  - Whole Child Model (WCM) favorable 141
  - Long-Term Care (LTC) unfavorable 234
- Increased 2,406 from PM

OneCare Connect enrollment was 14,579

- Unfavorable to budget 607 or 4.0%
- Decreased 107 from PM

OneCare enrollment was 2,395

- Favorable to budget 606 or 33.9%
- Increased 76 from PM

PACE enrollment was 418

- Favorable to budget 1 or 0.2%
- Decreased 9 from PM

MSSP enrollment was 457

- Favorable to budget 2 or 0.4%
- Increased 5 from PM

CalOptima
Medi-Cal Total
Statement of Revenues and Expenses
For the Eight Months Ending February 28, 2022

February					July-February			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
864,609	**824,118**	**40,491**	**4.9%**	**Member Months**	**6,777,234**	**6,599,106**	**178,128**	**2.7%**
				Revenues				
282,869,544	244,100,526	38,769,018	15.9%	Capitation Revenue	2,637,793,481	2,279,514,501	358,278,980	15.7%
-	-	-	0.0%	Other Income	-	-	-	0.0%
282,869,544	**244,100,526**	**38,769,018**	**15.9%**	**Total Operating Revenue**	**2,637,793,481**	**2,279,514,501**	**358,278,980**	**15.7%**
				Medical Expenses				
105,265,648	89,530,958	(15,734,690)	(17.6%)	Provider Capitation	854,806,068	734,289,899	(120,516,169)	(16.4%)
52,464,464	60,457,651	7,993,187	13.2%	Facilities Claims	444,596,044	509,534,968	64,938,924	12.7%
35,959,596	29,086,908	(6,872,688)	(23.6%)	Professional Claims	270,923,972	248,894,500	(22,029,472)	(8.9%)
(910,080)	-	910,080	0.0%	Prescription Drugs	345,090,945	345,521,586	430,641	0.1%
35,959,234	39,153,988	3,194,754	8.2%	MLTSS	334,314,909	336,041,152	1,726,243	0.5%
4,068,443	5,263,995	1,195,552	22.7%	Medical Management	34,705,954	42,523,374	7,817,420	18.4%
524,554	3,295,105	2,770,551	84.1%	Reinsurance & Other	149,550,266	10,787,737	(138,762,529)	(1286.3%)
233,331,860	**226,788,605**	**(6,543,255)**	**(2.9%)**	**Total Medical Expenses**	**2,433,988,158**	**2,227,593,216**	**(206,394,942)**	**(9.3%)**
49,537,684	**17,311,921**	**32,225,763**	**186.1%**	**Gross Margin**	**203,805,323**	**51,921,285**	**151,884,038**	**292.5%**
				Administrative Expenses				
6,711,549	8,142,938	1,431,389	17.6%	Salaries, Wages & Employee Benefits	56,397,586	65,664,016	9,266,430	14.1%
517,204	725,618	208,414	28.7%	Professional Fees	2,325,318	5,016,056	2,690,738	53.6%
580,373	977,195	396,822	40.6%	Purchased Services	7,517,828	8,911,810	1,393,982	15.6%
380,932	383,828	2,896	0.8%	Printing and Postage	2,655,328	3,070,624	415,296	13.5%
344,248	492,500	148,252	30.1%	Depreciation & Amortization	3,009,472	3,940,000	930,528	23.6%
1,435,512	2,018,903	583,391	28.9%	Other Operating Expenses	12,362,071	14,891,638	2,529,567	17.0%
(246,004)	(301,871)	(55,867)	(18.5%)	Indirect Cost Allocation, Occupancy Expense	(1,895,324)	(2,385,664)	(490,340)	(20.6%)
9,723,814	**12,439,111**	**2,715,297**	**21.8%**	**Total Administrative Expenses**	**82,372,278**	**99,108,480**	**16,736,202**	**16.9%**
				Operating Tax				
15,441,930	13,878,151	1,563,779	11.3%	Tax Revenue	115,892,266	111,128,942	4,763,324	4.3%
18,577,124	13,878,151	(4,698,973)	(33.9%)	Premium Tax Expense	115,556,291	111,128,942	(4,427,349)	(4.0%)
(3,135,194)	-	(3,135,194)	**0.0%**	**Total Net Operating Tax**	335,975	-	335,975	**0.0%**
7	**-**	**7**	**0.0%**	**Other income**	**8,808**	**-**	**8,808**	**0.0%**
36,678,684	**4,872,810**	**31,805,874**	**652.7%**	**Change in Net Assets**	**121,777,828**	**(47,187,195)**	**168,965,023**	**358.1%**
82.5%	***92.9%***	***10.4%***	***11.2%***	***Medical Loss Ratio***	***92.3%***	***97.7%***	***5.4%***	***5.6%***
3.4%	***5.1%***	***1.7%***	***32.5%***	***Admin Loss Ratio***	***3.1%***	***4.3%***	***1.2%***	***28.2%***

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MEDI-CAL INCOME STATEMENT– FEBRUARY MONTH:

REVENUES of $282.9 million are favorable to budget $38.8 million driven by:

- Favorable volume related variance of $12.0 million
- Favorable price related variance of $26.8 million
  - $29.1 million due to favorable revenue rates and Proposition 56 risk corridor estimates
  - Offset by:
    - $2.1 million due to COVID-19 and Proposition 56 risk corridor estimates

MEDICAL EXPENSES of $233.3 million are unfavorable to budget $6.5 million driven by:

- Unfavorable volume related variance of $11.1 million
- Favorable price related variance of $4.6 million
  - Facilities Claims expense favorable variance of $11.0 million due to deferred and delayed services
  - Managed Long Term Services and Supports (MLTSS) expense favorable variance of $5.1 million due to Incurred But Not Reported (IBNR) claims
  - Reinsurance & Other expense favorable variance of $2.9 million
  - Medical Management expense favorable variance of $1.5 million
  - Offset by:
    - Provider Capitation expense unfavorable variance of $11.3 million due primarily to the extension of Proposition 56 and short-term supplemental rate increase due to COVID-19
    - Professional Claims expense unfavorable variance of $5.4 million

ADMINISTRATIVE EXPENSES of $9.7 million are favorable to budget $2.7 million driven by:

- Salaries & Benefit expense favorable to budget $1.4 million
- Other Non-Salary expense favorable to budget $1.3 million

CHANGE IN NET ASSETS is $36.7 million, favorable to budget $31.8 million

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CalOptima
OneCare Connect Total
Statement of Revenue and Expenses
For the Eight Months Ending February 28, 2022

February					July-February			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
14,579	**15,186**	**(607)**	**(4.0%)**	**Member Months**	**118,232**	**120,816**	**(2,584)**	**(2.1%)**
14,579	15,186	(607)	(4.0%)	OCC 20 Member Months	118,232	120,816	(2,584)	(2.1%)
-	-	-	0.0%	OCC 25 Member Months	-	-	-	0.0%
				Revenues				
2,604,845	2,801,055	(196,210)	(7.0%)	Medi-Cal Capitation Revenue	21,870,479	22,456,057	(585,578)	(2.6%)
23,018,273	20,555,875	2,462,398	12.0%	Medicare Capitation Revenue Part C	152,686,165	155,447,853	(2,761,688)	(1.8%)
5,671,466	5,819,711	(148,245)	(2.5%)	Medicare Capitation Revenue Part D	47,458,095	45,910,540	1,547,555	3.4%
-	-	-	0.0%	Other Income	-	-	-	0.0%
31,294,584	**29,176,641**	**2,117,943**	**7.3%**	**Total Operating Revenue**	**222,014,739**	**223,814,450**	**(1,799,711)**	**(0.8%)**
				Medical Expenses				
13,310,063	12,571,055	(739,008)	(5.9%)	Provider Capitation	90,151,441	93,939,211	3,787,770	4.0%
4,108,426	4,275,865	167,439	3.9%	Facilities Claims	32,022,581	34,737,516	2,714,935	7.8%
1,003,995	985,370	(18,625)	(1.9%)	Ancillary	8,743,531	8,304,922	(438,609)	(5.3%)
1,482,160	1,301,853	(180,307)	(13.9%)	MLTSS	11,508,660	11,409,218	(99,442)	(0.9%)
5,713,796	6,147,096	433,300	7.0%	Prescription Drugs	48,656,271	52,160,855	3,504,584	6.7%
1,006,774	1,235,094	228,320	18.5%	Medical Management	8,199,485	9,834,092	1,634,607	16.6%
117,726	165,526	47,800	28.9%	Other Medical Expenses	1,449,583	1,411,119	(38,464)	(2.7%)
26,742,940	**26,681,859**	**(61,081)**	**(0.2%)**	**Total Medical Expenses**	**200,731,552**	**211,796,933**	**11,065,381**	**5.2%**
4,551,644	**2,494,782**	**2,056,862**	**82.4%**	**Gross Margin**	**21,283,187**	**12,017,517**	**9,265,670**	**77.1%**
				Administrative Expenses				
585,389	863,005	277,616	32.2%	Salaries, Wages & Employee Benefits	5,686,191	6,992,447	1,306,256	18.7%
313	29,320	29,008	98.9%	Professional Fees	174,469	371,710	197,241	53.1%
107,147	119,752	12,605	10.5%	Purchased Services	863,287	902,301	39,014	4.3%
110,243	138,109	27,866	20.2%	Printing and Postage	759,634	1,104,872	345,238	31.2%
556	21,075	20,519	97.4%	Other Operating Expenses	7,746	168,600	160,854	95.4%
552,533	680,053	127,520	18.8%	Indirect Cost Allocation	4,420,261	5,440,424	1,020,163	18.8%
1,356,178	**1,851,314**	**495,136**	**26.7%**	**Total Administrative Expenses**	**11,911,588**	**14,980,354**	**3,068,766**	**20.5%**
3,195,466	**643,468**	**2,551,998**	**396.6%**	**Change in Net Assets**	**9,371,599**	**(2,962,837)**	**12,334,436**	**416.3%**
85.5%	***91.4%***	***6.0%***	***6.6%***	***Medical Loss Ratio***	***90.4%***	***94.6%***	***4.2%***	***4.5%***
4.3%	***6.3%***	***2.0%***	***31.7%***	***Admin Loss Ratio***	***5.4%***	***6.7%***	***1.3%***	***19.8%***

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ONECARE CONNECT INCOME STATEMENT– FEBRUARY MONTH:

REVENUES of $31.3 million are favorable to budget $2.1 million driven by:

- Unfavorable volume related variance of $1.2 million
- Favorable price related variance of $3.3 million due primarily to 100% receipt of CY 2020 Quality Withhold from the Centers of Medicare & Medicaid Services (CMS)

MEDICAL EXPENSES of $26.7 million are unfavorable to budget $0.1 million driven by:

- Favorable volume related variance of $1.1 million
- Unfavorable price related variance of $1.1 million
  - Provider Capitation expense unfavorable variance of $1.2 million
  - MLTSS expense unfavorable variance of $0.2 million
  - Offset by:
    - Prescription Drugs expense favorable variance of $0.2 million
    - Medical Management expense favorable variance of $0.2 million

ADMINISTRATIVE EXPENSES of $1.4 million are favorable to budget $0.5 million

CHANGE IN NET ASSETS is $3.2 million, favorable to budget $2.6 million

CalOptima
OneCare
Statement of Revenues and Expenses
For the Eight Months Ending February 28, 2022

February					July-February			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
2,395	**1,789**	**606**	**33.9%**	**Member Months**	**17,831**	**14,200**	**3,631**	**25.6%**
				Revenues				
2,078,918	1,478,296	600,622	40.6%	Medicare Part C revenue	15,391,980	11,343,816	4,048,164	35.7%
819,991	719,590	100,401	14.0%	Medicare Part D revenue	7,367,077	5,254,450	2,112,627	40.2%
2,898,909	**2,197,886**	**701,023**	**31.9%**	**Total Operating Revenue**	**22,759,057**	**16,598,266**	**6,160,791**	**37.1%**
				Medical Expenses				
819,583	585,707	(233,876)	(39.9%)	Provider Capitation	6,245,672	4,428,724	(1,816,948)	(41.0%)
865,620	614,669	(250,951)	(40.8%)	Inpatient	6,991,147	4,866,671	(2,124,476)	(43.7%)
88,165	69,203	(18,962)	(27.4%)	Ancillary	815,440	577,240	(238,200)	(41.3%)
4,297	26,895	22,598	84.0%	Skilled Nursing Facilities	388,442	233,669	(154,773)	(66.2%)
938,516	636,851	(301,665)	(47.4%)	Prescription Drugs	7,296,628	5,406,335	(1,890,293)	(35.0%)
35,560	50,977	15,417	30.2%	Medical Management	295,488	406,556	111,068	27.3%
100	1,324	1,224	92.4%	Other Medical Expenses	24,819	10,507	(14,312)	(136.2%)
2,751,841	**1,985,626**	**(766,215)**	**(38.6%)**	**Total Medical Expenses**	**22,057,636**	**15,929,702**	**(6,127,934)**	**(38.5%)**
147,068	**212,260**	**(65,192)**	**(30.7%)**	**Gross Margin**	**701,421**	**668,564**	**32,857**	**4.9%**
				Administrative Expenses				
74,935	72,268	(2,667)	(3.7%)	Salaries, wages & employee benefits	609,965	585,475	(24,490)	(4.2%)
29,167	29,166	(1)	(0.0%)	Professional fees	240,099	233,328	(6,771)	(2.9%)
11,449	9,167	(2,282)	(24.9%)	Purchased services	89,256	73,336	(15,920)	(21.7%)
3,131	15,823	12,692	80.2%	Printing and postage	70,635	126,584	55,949	44.2%
-	1,029	1,029	100.0%	Other operating expenses	1,076	8,232	7,156	86.9%
58,503	50,924	(7,579)	(14.9%)	Indirect cost allocation, occupancy expense	468,020	407,392	(60,628)	(14.9%)
177,184	**178,377**	**1,193**	**0.7%**	**Total Administrative Expenses**	**1,479,051**	**1,434,347**	**(44,704)**	**(3.1%)**
(30,116)	**33,883**	**(63,999)**	**(188.9%)**	**Change in Net Assets**	**(777,630)**	**(765,783)**	**(11,847)**	**(1.5%)**
94.9%	***90.3%***	***(4.6%)***	***(5.1%)***	***Medical Loss Ratio***	***96.9%***	***96.0%***	***(0.9%)***	***(1.0%)***
6.1%	***8.1%***	***2.0%***	***24.7%***	***Admin Loss Ratio***	***6.5%***	***8.6%***	***2.1%***	***24.8%***

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CalOptima
PACE
Statement of Revenues and Expenses
For the Eight Months Ending February 28, 2022

February					July-February			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
418	**417**	**1**	**0.2%**	**Member Months**	**3,316**	**3,229**	**87**	**2.7%**
				Revenues				
2,639,630	2,575,256	64,374	2.5%	Medi-Cal Capitation Revenue	20,485,737	20,033,729	452,008	2.3%
623,593	674,543	(50,950)	(7.6%)	Medicare Part C Revenue	4,853,725	5,006,272	(152,547)	(3.0%)
178,668	150,093	28,575	19.0%	Medicare Part D Revenue	1,546,215	1,173,555	372,660	31.8%
3,441,891	**3,399,892**	**41,999**	**1.2%**	**Total Operating Revenue**	**26,885,676**	**26,213,556**	**672,120**	**2.6%**
				Medical Expenses				
848,526	1,033,317	184,791	17.9%	Medical Management	6,616,444	8,001,396	1,384,952	17.3%
935,678	694,964	(240,714)	(34.6%)	Facilities Claims	5,784,628	5,804,227	19,599	0.3%
742,467	636,338	(106,129)	(16.7%)	Professional Claims	6,378,918	5,278,382	(1,100,536)	(20.8%)
136,809	172,022	35,213	20.5%	Patient Transportation	975,024	1,188,603	213,579	18.0%
340,387	312,699	(27,688)	(8.9%)	Prescription Drugs	2,565,193	2,563,538	(1,655)	(0.1%)
2,711	48,674	45,963	94.4%	MLTSS	358,968	337,260	(21,708)	(6.4%)
5,225	4,747	(478)	(10.1%)	Other Expenses	41,450	39,853	(1,597)	(4.0%)
3,011,802	**2,902,761**	**(109,041)**	**(3.8%)**	**Total Medical Expenses**	**22,720,626**	**23,213,259**	**492,633**	**2.1%**
430,089	**497,131**	**(67,042)**	**-13.5%**	**Gross Margin**	**4,165,050**	**3,000,297**	**1,164,753**	**38.8%**
				Administrative Expenses				
74,957	154,424	79,467	51.5%	Salaries, wages & employee benefits	866,079	1,218,067	351,988	28.9%
-	167	167	100.0%	Professional fees	7,251	1,336	(5,915)	(442.8%)
54,662	40,925	(13,737)	(33.6%)	Purchased services	152,821	327,400	174,579	53.3%
5,794	19,238	13,444	69.9%	Printing and postage	101,409	153,904	52,495	34.1%
370	400	30	7.5%	Depreciation & amortization	6,773	3,200	(3,573)	(111.7%)
10,421	17,166	6,745	39.3%	Other operating expenses	52,991	73,043	20,052	27.5%
11,506	4,944	(6,562)	(132.7%)	Indirect Cost Allocation, Occupancy Expense	77,136	39,552	(37,584)	(95.0%)
157,711	**237,264**	**79,553**	**33.5%**	**Total Administrative Expenses**	**1,264,460**	**1,816,502**	**552,042**	**30.4%**
				Operating Tax				
6,203	-	6,203	0.0%	Tax Revenue	49,209	-	49,209	0.0%
6,203	-	(6,203)	0.0%	Premium Tax Expense	49,209	-	(49,209)	0.0%
-	**-**	**-**	**0.0%**	**Total Net Operating Tax**	**-**	**-**	**-**	**0.0%**
272,378	**259,867**	**12,511**	**4.8%**	**Change in Net Assets**	**2,900,591**	**1,183,795**	**1,716,796**	**145.0%**
87.5%	***85.4%***	***(2.1%)***	***(2.5%)***	***Medical Loss Ratio***	***84.5%***	***88.6%***	***4.0%***	***4.6%***
4.6%	***7.0%***	***2.4%***	***34.3%***	***Admin Loss Ratio***	***4.7%***	***6.9%***	***2.2%***	***32.1%***

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CalOptima
Multipurpose Senior Select Program
Statement of Revenues and Expenses
For the Eight Months Ending February 28, 2022

February					July-February			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
457	**455**	**2**	**0.4%**	**Member Months**	**909**	**910**	**(1)**	**(0.1%)**
				Revenues				
192,032	203,089	(11,057)	(5.4%)	Capitation Revenue	411,166	406,179	4,987	1.2%
192,032	**203,089**	**(11,057)**	**(5.4%)**	**Total Operating Revenue**	**411,166**	**406,179**	**4,987**	**1.2%**
				Medical Expenses				
107,386	117,824	10,438	8.9%	Medical Management	231,008	236,295	5,287	2.2%
				Waived Services				
224	120	(104)	(86.7%)	Minor home repairs	457	240	(217)	(90.4%)
6,487	7,505	1,018	13.6%	Non-medical home equipment	13,747	15,010	1,263	8.4%
4,253	3,052	(1,201)	(39.3%)	Chores	8,214	6,104	(2,110)	(34.6%)
2,412	2,615	203	7.7%	Personal care	8,768	5,230	(3,538)	(67.7%)
(241)	400	641	160.1%	In-home respite	273	800	527	65.9%
240	644	404	62.8%	Transportation	651	1,288	637	49.4%
599	961	362	37.7%	Home delivered meals	1,113	1,922	809	42.1%
70	152	82	54.1%	Food	1	304	303	99.6%
9,604	10,118	514	5.1%	Communications	18,835	20,236	1,401	6.9%
47	835	788	94.3%	Non-Covered Services	72	1,670	1,598	95.7%
2,641	-	(2,641)	0.0%	Protective Services	2,641	-	(2,641)	0.0%
107,386	117,824	10,438	8.9%	Total Medical Management	231,008	236,295	5,287	2.2%
26,337	26,402	65	0.2%	Other Medical Expenses	54,773	52,804	(1,969)	(3.7%)
133,723	**144,226**	**10,503**	**7.3%**	**Total Program Expenses**	**285,781**	**289,099**	**3,318**	**1.1%**
58,310	**58,863**	**(553)**	**(0.9%)**	**Gross Margin**	**125,385**	**117,080**	**8,305**	**7.1%**
				Administrative Expenses				
46,348	57,990	11,642	20.1%	Salaries, wages & employee benefits	102,271	116,141	13,870	11.9%
2,207	1,125	(1,082)	(96.2%)	Professional fees	2,916	2,250	(666)	(29.6%)
6,016	7,309	1,293	17.7%	Other operating expenses	12,170	14,618	2,448	16.7%
4,119	4,884	765	15.7%	Indirect Cost Allocation	8,238	9,768	1,530	15.7%
58,690	**71,308**	**12,618**	**17.7%**	**Total Administrative Expenses**	**125,595**	**142,777**	**17,182**	**12.0%**
(380)	**(12,445)**	**12,065**	**96.9%**	**Change in Net Assets**	**(211)**	**(25,697)**	**25,486**	**99.2%**
69.6%	***71.0%***	***1.4%***	***1.9%***	***Medical Loss Ratio***	***69.5%***	***71.2%***	***1.7%***	***2.3%***
30.6%	***35.1%***	***4.5%***	***13.0%***	***Admin Loss Ratio***	***30.5%***	***35.2%***	***4.6%***	***13.1%***

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CalOptima
Building 505 - City Parkway
Statement of Revenues and Expenses
For the Eight Months Ending February 28, 2022

February					July-February			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
-	-	-	0.0%	Rental Income	-	-	-	0.0%
-	-	-	**0.0%**	**Total Operating Revenue**	-	-	-	**0.0%**
				Administrative Expenses				
37,557	54,250	16,693	30.8%	Purchase services	300,410	434,000	133,590	30.8%
174,242	206,000	31,758	15.4%	Depreciation & amortization	1,383,094	1,648,000	264,906	16.1%
19,565	19,750	185	0.9%	Insurance expense	156,518	158,000	1,482	0.9%
141,490	131,583	(9,907)	(7.5%)	Repair and maintenance	903,975	1,052,664	148,689	14.1%
46,938	43,000	(3,938)	(9.2%)	Other Operating Expense	404,319	344,000	(60,319)	(17.5%)
(419,791)	(454,583)	(34,792)	(7.7%)	Indirect allocation, Occupancy	(3,148,316)	(3,636,664)	(488,348)	(13.4%)
-	-	-	**0.0%**	**Total Administrative Expenses**	-	-	-	**0.0%**
-	-	-	**0.0%**	**Change in Net Assets**	-	-	-	**0.0%**

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OTHER INCOME STATEMENTS – FEBRUARY MONTH:

ONECARE INCOME STATEMENT

CHANGE IN NET ASSETS is ($30,116), unfavorable to budget $63,999

PACE INCOME STATEMENT

CHANGE IN NET ASSETS is $0.3 million, favorable to budget $12,511

MSSP INCOME STATEMENT

CHANGE IN NET ASSETS is ($380), favorable to budget $12,065

- Carved out of Medi-Cal effective January 1, 2022

NET INVESTMENT INCOME

- Unfavorable variance of $3.7 million is primarily driven by unrealized losses in bond value due to an earlier than expected interest rate increase by the Federal Reserve

CalOptima
Balance Sheet
February 28, 2022

ASSETS		LIABILITIES & NET POSITION	
Current Assets		**Current Liabilities**	
Operating Cash	$737,165,482	Accounts Payable	$40,865,830
Short-term Investments	909,524,503	Medical Claims liability	830,507,863
Capitation receivable	165,221,848	Accrued Payroll Liabilities	13,884,845
Receivables - Other	44,320,597	Deferred Revenue	10,167,080
Prepaid expenses	13,292,098	Deferred Lease Obligations	107,023
		Capitation and Withholds	171,987,145
Total Current Assets	**1,869,524,529**	**Total Current Liabilities**	**1,067,519,786**
Capital Assets			
Furniture & Equipment	46,251,085		
Building/Leasehold Improvements	8,298,842		
505 City Parkway West	52,168,012		
	106,717,939		
Less: accumulated depreciation	(62,096,115)		
Capital assets, net	44,621,824	Other (than pensions) post employment benefits liability	31,971,165
Other Assets		Net Pension Liabilities	30,757,228
Restricted Deposit & Other	300,000	Bldg 505 Development Rights	-
Homeless Health Reserve	56,798,913		
Board-designated assets:		**TOTAL LIABILITIES**	**1,130,248,179**
Cash and Cash Equivalents	8,762,902		
Investments	572,095,597	**Deferred Inflows**	
Total Board-designated Assets	580,858,499	Excess Earnings	344,198
		OPEB 75 Difference in Experience	536,000
Total Other Assets	637,957,412	Change in Assumptions	2,709,945
		OPEB Changes in Assumptions	773,000
		Net Position	
TOTAL ASSETS	**2,552,103,765**	TNE	105,416,625
		Funds in Excess of TNE	1,327,068,115
Deferred Outflows		**TOTAL NET POSITION**	1,432,484,740
Contributions	1,508,025		
Difference in Experience	3,236,721		
Excess Earning	2,104,780		
Changes in Assumptions	3,692,771		
OPEB 75 Changes in Assumptions	3,906,000		
Pension Contributions	544,000		
TOTAL ASSETS & DEFERRED OUTFLOWS	**2,567,096,062**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**2,567,096,062**

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CalOptima
Board Designated Reserve and TNE Analysis
as of February, 2022

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	235,688,440				
	Tier 1 - MetLife	234,535,255				
Board-designated Reserve		470,223,696	377,815,995	584,915,690	92,407,700	(114,691,994)
	Tier 2 - Payden & Rygel	55,334,415				
	Tier 2 - MetLife	55,300,389				
TNE Requirement		110,634,804	105,416,625	105,416,625	5,218,179	5,218,179
	Consolidated:	**580,858,499**	**483,232,620**	**690,332,314**	**97,625,879**	**(109,473,815)**
	Current reserve level	*1.68*	*1.40*	*2.00*		

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CalOptima
Statement of Cash Flows
February 28, 2022

	February	July-February
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	37,297,676	123,703,947
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Depreciation and amortization	518,860	4,399,339
Changes in assets and liabilities:		
Prepaid expenses and other	1,861,972	(1,313,487)
Catastrophic reserves		
Capitation receivable	(5,343,823)	265,353,573
Medical claims liability	(132,270,234)	(113,811,084)
Deferred revenue	416,259	(3,419,745)
Payable to health networks	3,259,475	27,207,356
Accounts payable	18,734,317	(5,548,591)
Accrued payroll	1,983,742	(1,833,687)
Other accrued liabilities	(2,935)	(20,305)
Net cash provided by/(used in) operating activities	(73,544,690)	294,717,315
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	45,108,265	155,885,303
Change in Property and Equipment	(580,458)	(3,293,287)
Change in Board designated reserves	2,312,450	8,021,653
Change in Homeless Health Reserve	-	-
Net cash provided by/(used in) investing activities	46,840,258	160,613,669
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	(26,704,432)	455,330,984
CASH AND CASH EQUIVALENTS, beginning of period	$763,869,915	281,834,499
CASH AND CASH EQUIVALENTS, end of period	**737,165,482**	**737,165,482**

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BALANCE SHEET – FEBRUARY MONTH:

ASSETS of $2.6 billion decreased $70.6 million from January or 2.7%

- Operating Cash and Short-term Investments net decrease of $71.8 million due to the payment of the Hospital Quality Assurance Fee (HQAF) of $146.4 million received in prior month, offset by the timing of capitation receipts
  - Operating cash decreased $26.7 million
  - Short-term Investments decreased $45.1 million
- Prepaid Expenses decreased $1.9 million
- Capitation Receivables increased $2.9 million due to the timing of cash receipts

LIABILITIES of $1.1 billion decreased $107.9 million from January or 8.7%

- Claims Liabilities decreased $132.3 million due to timing of claim payments, changes in IBNR and HQAF paid out in February
- Accounts Payable increased $18.7 million due to the timing of accruals for the quarterly premium tax payment
- Capitation and Withhold increased $3.2 million

NET ASSETS of $1.4 billion, increased $37.3 million from January or 2.7%

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Summary of Homeless Health Initiatives and Allocated Funds
As of February 22, 2022

			Amount
Program Commitment		**$**	**100,000,000**
Funds Allocation, approved initiatives:			
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000		
Recuperative Care	8,250,000		
Medical Respite	250,000		
Day Habilitation (County for HomeKey)	2,500,000		
Clinical Field Team Start-up & Federal Qualified Health Center (FQHC)	1,600,000		
CalOptima Homeless Response Team	6,000,000		
Homeless Coordination at Hospitals	10,000,000		
CalOptima Days & QI Program - Homeless Clinic Access Program or HCAP	1,231,087		
FQHC (Community Health Center) Expansion and HHI Support	570,000		
HCAP Expansion for Telehealth and CFT On Call Days	1,000,000		
Vaccination Intervention and Member Incentive Strategy	400,000		
Funds Allocation Total		**$**	**43,201,087**
Program Commitment Balance, available for new initiatives*		**$**	**56,798,913**

On June 27, 2019 at a Special Board meeting, the Board approved four funding categories.

This report only lists Board approved projects.

* Funding sources of the remaining balance are IGT8 and CalOptima's operating income, which must be used for Medi-Cal covered services for the Medi-Cal population

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Budget Allocation Changes
Reporting Changes for February 2022

Transfer Month	Line of Business	From	To	Amount	Expense Description	Fiscal Year
August	Medi-Cal	Ground Floor Corridor Heating and Cooling Boxes Replacement	Multiple Bathroom Upgrades (Original Bathrooms on 2nd and 4th Floors)	$25,800	To transfer funds from capital project Ground Floor Corridor Heating and Cooling Boxes Replacement to capital project Multiple Bathroom Upgrades (Original Bathrooms on the 2nd and 4th Floors) to fund the final bathroom change order.	2020-21
November	Medi-Cal	Upgrade the System Backup Application Disk Storage - Hardware	Upgrade the Citrix Virtual Servers to Support Version - Hardware	$24,000	To transfer funds from capital project Upgrade the System Backup Application Disk Storage to capital project Upgrade the Citrix Virtual Servers to Support Version to provide additional funds for hardware purchases.	2021-22
November	Medi-Cal	Upgrade the System Backup Application Disk Storage - Hardware	Upgrade the Database Disk Storage Equipment - Hardware	$51,000	To transfer funds from capital project Upgrade the System Backup Application Disk Storage to capital project Upgrade the Database Disk Storage Equipment to provide additional funds for hardware purchases.	2021-22
December	Medi-Cal	Maintenance HW/SW - BMC	Maintenance HW/SW – SolarWinds	$10,500	To repurpose funds from BMC to SolarWinds to provide additional funds for maintenance contract renewal.	2021-22
December	Medi-Cal	Upgrade the Citrix Virtual Servers to Support Version - Hardware	Upgrade the Database Disk Storage Equipment - Hardware	$13,500	To transfer funds from capital project Upgrade the Citrix Virtual Servers to Support Version to capital project Upgrade the Database Disk Storage Equipment to provide additional funds for hardware purchases.	2021-22
December	Medi-Cal	Maintenance HW/SW – Optum/Ingenix ICD 10	Maintenance HW/SW – Smart Communications	$14,000	To repurpose funds from Optum/Ingenix ICD10 to Smart Communications to provide additional funds for maintenance contract renewal.	2021-22
December	Medi-Cal	Maintenance HW/SW – Microsoft True-Up	Maintenance HW/SW – Extreme Networks	$24,000	To repurpose funds from Microsoft True-UP to Extreme Networks to provide additional funds for maintenance contract renewal.	2021-22
January	Medi-Cal	Professional Fees – Citrix Pro Fees	Professional Fees – HIPPA Compliance (Risk Assessment & Network Penetration)	$10,500	To repurpose funds from Citrix professional fees to HIPPAA Compliance professional fees to provide additional funds.	2021-22
January	Medi-Cal	Maintenance HW/SW – Microsoft True-Up	Maintenance HW/SW – SSL Certs for Production Applications	$12,000	To repurpose funds from Microsoft True-UP to SSL Certs for Production Applications to provide additional funds for maintenance contract renewal.	2021-22
January	Medi-Cal	Purchased Services – Executive Coaching	Purchased Services – Concentra	$18,000	To reallocate funding from Executive Coaching to Concentra for additional funds needed.	2021-22
February	Medi-Cal	Purchased Services – Disaster Recovery Technology Services	Purchased Services – Offsite Backup Tape Storage and Services	$25,000	To repurpose funds from Purchased Services - Disaster Recovery Technology Services to Purchased Services - Offsite Backup Tape Storage and Services to provide additional funds.	2021-22

This report summarizes budget transfers between general ledger classes that are greater than $10,000 and less than $100,000.
This is the result of Board Resolution No. 12-0301-01 which permits the CEO to make budget allocation changes within certain parameters.

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Board of Directors Meeting
April 7, 2022

Monthly Compliance Report

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

A. Updates on Regulatory Audits

1. OneCare

- 2022 Medicare Parts C and D Data Validation Audit (*applicable to OneCare and OneCare Connect*):

  On an annual basis, CMS requires all plans to engage an independent auditor to validate all Medicare Parts C and D data reported for the prior calendar year. CalOptima has requested the required Parts C and D reporting data from all impacted business areas to ensure the accuracy of the data prior to submission in February 2022. The validation audit is expected to take place starting in March and conclude in June 2022. The audit includes a webinar validation and source documentation review for various Medicare Parts C and D measures/

  CalOptima has completed submission of reports to CMS ahead of February 7, 2022, and February 28, 2022 deadlines. In terms of next steps, RAC will work with the business owners to complete the Organization Assessment Instrument, Measure Overviews and compile requested supporting documents.

- 2021 CMS Program Audit (applicable to OneCare and OneCare Connect):

  CMS conducted a program audit on both OneCare and OneCare Connect. CMS released the preliminary draft audit report on 8/6/21 and completed the exit conference. On October 21, 2021, CMS issued the Draft Audit Report, which noted a total of 11 observations, 8 Corrective Action Required (CARs), and one ICAR. (The ICAR issued on August 27th and the CAP was accepted by CMS on 9/13/21.) As there were no comments/rebuttals to the Draft Audit Report, CMS released the Final Audit Report, with no changes to the findings, on 11/5/21.

  CalOptima submitted the corrective action plans (CAPs) for the non-ICAR condition on 12/9/21. On 1/5/22, CMS informed CalOptima that the CAPs submitted for the SNP, CCQIPE and FA program areas have been accepted. In terms of next steps, CMS has

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provided a deadline of 7/5/2022 for CalOptima to complete the independent validation audit (IVA).

CalOptima has chosen Integritas Medicare to conduct the IVA and will be working with BluePeak to conduct a mock validation audit ahead of the IVA. CalOptima submitted the IVA workplan to CMS for review and approval on 2/9/22 and is pending feedback.

On 3/1/22, CalOptima in collaboration with BluePeak, held a mock IVA webinar for the FA program area. Mock IVA webinars for ODAG, SNP-MOC and CCQIPE will be held in April and May, respectively.

2. OneCare Connect

- CY 2020 Medicare Part C Improper Payment Measure (Part C IPM)

On 12/17/21, CMS informed CalOptima that its OneCare Connect program was selected to participate in the CY 2020 Medicare Part C IPM (formerly known as NAT20 RADV). CMS conducts Medicare Part C IPM activity to calculate a program wide improper payment rate for Medicare Part C.

On 1/20/22, CMS released the enrollee list which contained nineteen (19) CMS-HCC's for which medical records will need to be collected for submission to CMS. The internal deadline for this activity is 5/5/22.

On 1/20/22, CMS encouraged plans to submit records early in the submission window to take advantage of the Interim Findings Reports (IFRs). IFRs provide preliminary feedback on medical record review results for all medical record submissions received as of the cutoff date.

On 2/16/22, CalOptima submitted records early in the submission window to take advantage of the IFRs. Records have been submitted for all 19 HCCs. On 3/10/22, CalOptima received the Interim Findings Report which indicated no discrepancies with the submitted medical records. Since the sampled CMS-HCCs were found, no further action is needed from the plan.

3. Medi-Cal

- 2021 DHCS Medical Audit:

DHCS hosted its audit via webinar from January 24, 2022 through February 4, 2022. The Entrance Conference was held on January 24, 2022.

DHCS intends to host an Exit Conference in April 2022 to review CalOptima's draft audit findings. At that time, the draft findings report will be provided for CalOptima's review. CalOptima will have fifteen (15) calendar days to confirm or rebut the draft findings.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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DHCS will provide CalOptima with a final audit report and formal request for corrective action, thirty (30) calendar days from the Exit Conference (slated for May 2022).

- 2022 Department of Managed Care (DMHC) Routine Examination:

  On February 9, 2022, the DMHC engaged CalOptima for the 2022 DMHC Routine Examination. This examination is routine and occurs every three (3) years. The examination will review CalOptima's fiscal and administrative affairs and includes an examination of CalOptima's financial reports.

  The examination will begin on May 16, 2022 and will be conducted remotely. DMHC has requested the submission of pre-audit deliverables by April 7, 2022. CalOptima delegates are not expected to participate.

  On February 16, 2022, RAC hosted a kick-off to review all audit deliverables and resources. RAC will continue to work with the impacted teams to ensure audit readiness.

B. Regulatory Notices of Non-Compliance

- CalOptima did not receive any notices of non-compliance from its regulators for the month of February 2022.

C. Updates on Internal and Health Network Monitoring and Audits

1. Internal Monitoring Dashboard:

- As part of its monitoring process, CalOptima's Audit & Oversight department, in collaboration with business areas, maintains a dashboard to monitor key performance metrics for internal and external operations on a monthly basis. Dashboard results are presented to CalOptima's Audit & Oversight Committee and Compliance Committee for oversight. Below are the dashboard results.

- **Requirement: Medi-Cal Routine authorizations processed ≤ 5 business days after receipt of information reasonably necessary to make a decision but no later than ≤ 14 Calendar Days from receipt of request.**

Internal Goal	Nov.	Dec.	Jan.
98%	58.92%	78.50%	80.35%

  - CalOptima's Audit & Oversight (A&O) department has issued a request for a corrective action plan (CAP) for deficiencies identified. The A&O department continues to work with the impacted department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure sustained compliance.

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- **Requirement: Standard Pre-Service Organization Determinations (SOD) processed ≤ 14 calendar days from receipt of request.**

Internal Goal	Nov.	Dec.	Jan.
98%	73.33%	50%	63%

  - ➢ CalOptima's Audit & Oversight (A&O) department has issued a request for a corrective action plan (CAP) for deficiencies identified. The A&O department continues to work with the impacted department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure sustained compliance.

2. Internal Monitoring: Medi-Cal[a\]

- Medi-Cal GARS: Standard Appeals - Reporting of monitoring includes the most results available at the time of reporting.

Month(s)	Classification Score	Standard Appeals Acknowledged within ≤ 5 Calendar Days of Receipt	Language Preference	Clinical Decision Making	Member Notice Content	Timely Effectuation	Resolution of Appeals within ≤ 30 Calendar Days of Receipt
October 2021	100%	94%	100%	100%	82%	88%	100%
November 2021	100%	100%	100%	100%	100%	89%	100%
December 2021	100%	100%	100%	100%	100%	100%	100%

  - ➢ No trends to report for December data.

- Medi-Cal GARS: Expedited Appeals - Reporting of monitoring includes the most results available at the time of reporting.

Month(s)	Classification Score	Language Preference	Clinical Decision Making	Timely Effectuation	Member Notice Content	Resolution of Expedited Appeals within 72 Hours of Receipt
October 2021	100%	100%	100%	66%	100%	100%
November 2021	100%	100%	100%	67%	100%	100%
December 2021	100%	100%	100%	100%	100%	100%

  - ➢ No trends to report for December data.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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- Medi-Cal GARS: Standard Grievances - Reporting of monitoring includes the most results available at the time of reporting.

Month(s)	Classification Score	Standard Grievances Acknowledged within ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Standard Resolution of Grievances within ≤ 30 Calendar Days of Receipt
October 2021	100%	100%	100%	76%	100%
November 2021	100%	100%	100%	81%	100%
December 2021	100%	100%	100%	93%	100%

  - Based on a focused review of sixteen (15) Medi-Cal standard grievances for December 2021, the lower compliance score of 93 % for member notice content was due to one (1) file exceeding the sixth (6^{th}) grade reading level.

- Medi-Cal GARS: Expedited Grievances - Reporting of monitoring includes the most results available at the time of reporting.

Month(s)	Classification Score	Expedited Grievances Verbally Acknowledged within ≤ 24 Hours of Receipt	Language Preference	Member Notice Content	Expedited Grievances Resolved within ≤ 72 Hours of Receipt
October 2021	100%	100%	100%	67%	100%
November 2021	100%	100%	100%	50%	100%
December 2021	100%	100%	100%	100%	100%

  - No trends to report for December data.

5 a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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- Medi-Cal Utilization Management: Standard Prior Authorizations - Reporting of monitoring includes the most results available at the time of reporting.

Month(s)	File Classification	Resolution Timeliness	Provider and Member Notification Timeliness	Clinical Decision Making Review	Written Response in Member's Preferred Language	Accuracy of Member Notice Content
October 2021	100%	10%	100%	100%	100%	83%
November 2021	100%	67%	100%	100%	100%	100%
December 2021	N/A	N/A	N/A	N/A	N/A	N/A

  - CalOptima Monthly Utilization Management (UM) Monitoring of Files.
    - CalOptima has suspended the monitoring of monthly UM files for the months of December 2021 and January 2022.

- Medi-Cal Utilization Management: Urgent Prior Authorizations - Reporting of monitoring includes the most results available at the time of reporting.

Month(s)	File Classification	Resolution Timeliness	Provider and Member Notification Timeliness	Clinical Decision Making Review	Written Response in Member's Preferred Language	Accuracy of Member Notice Content
October 2021	100%	60%	100%	100%	100%	100%
November 2021	100%	50%	100%	100%	100%	86%
December 2021	N/A	N/A	N/A	N/A	N/A	N/A

  - CalOptima Monthly Utilization Management (UM) Monitoring of Files.
    - CalOptima has suspended the monitoring of monthly UM files for the months of December 2021 and January 2022.

[6] a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

3. Internal Monitoring: OneCare [a\]

- OneCare GARS: Standard Appeals - Reporting of monitoring includes the most results available at the time of reporting.

Month(s)	Classification Score	Standard Appeals Acknowledged within ≤ 5 Calendar Days of Receipt	Language Preference	Clinical Decision Making	Member Notice Content	Resolution of Appeals within ≤ 30 Calendar Days of Receipt
October 2021	100%	100%	100%	50%	100%	100%
November 2021	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report
December 2021	100%	100%	100%	100%	100%	100%

  - ➢ No trends to report for December data.

- OneCare GARS: Payment Reconsiderations (PREC) - Reporting of monitoring includes the most results available at the time of reporting.

Month(s)	Classification Score	Standard Appeals Acknowledged within ≤ 5 Calendar Days of Receipt	Language Preference	Clinical Decision Making	Member Notice Content	Resolution of Appeals within ≤ 30 Calendar Days of Receipt
October 2021	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report
November 2021	100%	100%	N/A	100%	N/A	100%
December 2021	Nothing to Report	Nothing to Report	Nothing to Report	othing to Report	Nothing to Report	Nothing to Report

  - ➢ No significant trends for December data.

- OneCare GARS: Standard Grievances - Reporting of monitoring includes the most results available at the time of reporting.

Month(s)	Classification Score	Standard Appeals Acknowledged within ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Resolution of Appeals within ≤ 30 Calendar Days of Receipt
October 2021	100%	100%	100%	92%	100%

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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November 2021	100%	100%	100%	92%	100%
December 2021	100%	100%	100%	92%	100%

- Based on a focused review of twelve (12) OneCare standard grievances for December 2021, the lower compliance score of 92% for member notice content was due to one (1) file exceeding the sixth (6^{th}) grade reading level.

4. Internal Monitoring: OneCare Connect [a\]

- OneCare Connect GARS: Standard Appeals - Reporting of monitoring includes the most recent results available at the time of reporting.

Month(s)	Classification Score	Standard Appeals Acknowledged within ≤ 5 Calendar Days of Receipt	Language Preference	Clinical Decision Making	Member Notice Content	Resolution of Appeals within ≤ 30 Calendar Days of Receipt
October 2021	100%	100%	100%	100%	100%	100%
November 2021	100%	100%	100%	100%	100%	100%
December 2021	100%	100%	100%	100%	100%	100%

- No trends to report for December data.

- OneCare Connect GARS: Expedited Appeals - Reporting of monitoring includes the most recent results available at the time of reporting.

Month(s)	Classification Score	Language Preference	Clinical Decision Making	Member Notice Content	Resolution of Appeals within ≤ 30 Calendar Days of Receipt
October 2021	100%	100%	100%	100%	100%
November 2021	100%	100%	100%	100%	100%
December 2021	100%	100%	100%	100%	100%

- No trends to report for December data.

- OneCare Connect GARS: Standard Grievances - Reporting of monitoring includes the most recent results available at the time of reporting.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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Month(s)	Classification Score	Standard Grievance Acknowledged within ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Resolution of Grievance within ≤ 30 Calendar Days of Receipt
October 2021	100%	100%	100%	100%	100%
November 2021	100%	100%	100%	87%	100%
December 2021	100%	100%	100%	93%	100%

- Based on a focused review of fifteen (15) OneCare Connect standard grievances for December 2021, the lower compliance score of 93% for member notice content was due to one (1) file exceeding the sixth (6^{th}) grade reading level.

- OneCare Connect GARS: Expedited Grievances - Reporting of monitoring includes the most recent results available at the time of reporting.

Month(s)	Classification Score	Expedited Grievances Verbally Acknowledged within ≤ 24 Hours of Receipt	Language Preference	Member Notice Content	Expedited Grievances Resolved within ≤ 72 Hours of Receipt
October 2021	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report
November 2021	100%	100%	100%	100%	100%
December 2021	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report

- No trends for December 2021.

- OneCare Connect Utilization Management: Standard Prior Authorizations - Reporting of monitoring includes the most recent results available at the time of reporting.

Month(s)	File Classification	Resolution Timeliness	Provider and Member Notification Timeliness	Clinical Decision Making Review	Written Response in Member's Preferred Language	Accuracy of Member Notice Content
October 2021	100%	100%	100%	100%	100%	90%
November 2021	100%	100%	100%	100%	100%	100%
December 2021	N/A	N/A	N/A	N/A	N/A	N/A

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- CalOptima Monthly Utilization Management (UM) Monitoring of Files.
  - CalOptima has suspended the monitoring of monthly UM files for the months of December 2021 and January 2022.

- OneCare Connect Utilization Management: Expedited Prior Authorizations - Reporting of monitoring includes the most recent results available at the time of reporting.

Month(s)	File Classification	Resolution Timeliness	Provider and Member Notification Timeliness	Clinical Decision Making Review	Written Response in Member's Preferred Language	Accuracy of Member Notice Content
October 2021	100%	100%	100%	100%	N/A	100%
November 2021	100%	89%	78%	100%	100%	100%
December 2021	N/A	N/A	N/A	N/A	N/A	N/A

- CalOptima Monthly Utilization Management (UM) Monitoring of Files.
  - CalOptima has suspended the monitoring of monthly UM files for the months of December 2021 and January 2022.

5. Health Network Monitoring: Medi-Cal [a\]

- Medi-Cal Utilization Management (UM): Prior Authorization (PA) Requests

Month	Timely Urgent Requests	Clinical Decision Making (CDM) for Urgent Requests	Letter Score for Urgent Requests	Timely Routine Requests	Timely Denials	CDM for Denials	Letter Score for Denials	Timely Modified Requests	CDM for Modified Requests	Letter Score for Modified Requests	Timely Deferrals	CDM for Deferrals	Letter Score for Deferrals
November 2021	93%	92%	96%	92%	85%	93%	93%	76%	89%	97%	80%	70%	100%
December 2021	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
January 2022	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

- CalOptima Monthly Utilization Management (UM) Monitoring of Files.
  - CalOptima has suspended the monitoring of monthly UM files for the months of December 2021 and January 2022.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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- Medi-Cal Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
November 2021	89%	92%	87%	96%
December 2021	80%	93%	81%	97%
January 2022	87%	95%	93%	98%

  - Overall scores for Medi-Cal claims increased in the aggregate for the January 2022 file review month.
  - Based on the focus review of the select files, four (4) health networks attributed to the compliance score for paid claims timeliness during the month of January 2022 leading to an aggregate of 87%.
  - Based on the focus review of the select files, three (3) health networks attributed to the compliance score for denied claims timeliness during the month of January 2022 leading to an aggregate of 93%.
  - Based on the focus review of the select files, two (2) health networks attributed to the compliance score for paid claims accuracy during the month of January 2022 leading to an aggregate of 95%.
  - Based on the focus review of the select files, one (1) health networks attributed to the compliance score for denied claims accuracy during the month of January 2022 leading to an aggregate of 98%.
  - CalOptima's claims department issued requests for corrective action plans (CAPs) or Pre-CAP to all health networks with deficiencies identified during the review of claims processing for timeliness and accuracy. The claims department continues to work with each health network to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of claims within regulatory requirements.

6. Health Network Monitoring: OneCare [a\]

- OneCare Utilization Management (UM): Prior Authorization Requests

Month	Timeliness for Expedited Initial Organization Determinations (EIOD)	Clinical Decision Making for EIOD	Letter Score for EIOD	Timeliness for Standard Organization Determinations (SOD)	Letter Score for SOD	Timeliness for Denials	Clinical Decision Making for Denials	Letter Score for Denials
November 2021	100%	99%	95%	100%	98%	100%	92%	100%

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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December 2021	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
January 2022	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

- CalOptima Monthly Utilization Management (UM) Monitoring of Files.
  - CalOptima has suspended the monitoring of monthly UM files for the months of December 2021 and January 2022.

- OneCare Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
November 2021	90%	88%	93%	56%
December 2021	100%	98%	100%	96%
January 2022	97%	97%	98%	74%

- Overall scores for OneCare claims decreased in the aggregate for the January 2022 file review month.
- Based on the focus review of the select files, one (1) health networks attributed to the compliance score for paid claims timeliness during the month of January 2022 leading to an aggregate of 97%.
- Based on the focus review of the select files, one (1) health networks attributed to the compliance score for denied claims timeliness during the month of January 2022 leading to an aggregate of 98%.
- Based on the focus review of select files, one (1) health network attributed to the compliance score for paid claims accuracy during the month of January 2022 leading to an aggregate of 97%.
- Based on the focus review of the select files, two (2) health networks attributed to the compliance score for denied claims accuracy during the month of January 2022 leading to an aggregate of 74%.
- CalOptima's claims department issued requests for corrective action plans (CAPs) or Pre-CAP to all health networks with deficiencies identified during the review of claims processing for timeliness and accuracy. The claims department continues to work with each health network to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of claims within regulatory requirements.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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7. Health Network Monitoring: OneCare Connect [a\]

- OneCare Connect Utilization Management (UM): Prior Authorization Requests

Month	Timeliness for Urgent Requests	Clinical Decision Making (CDM) for Urgent Requests	Letter Score for Urgent Requests	Timeliness for Routine Requests	Letter Score for Routine Requests	Timeliness for Denials	CDM for Denials	Letter Score for Denials	Timeliness for Modified Requests	CDM for Modified Requests	Letter Score for Modified Requests
November 2021	100%	92%	97%	98%	96%	86%	87%	98%	90%	85%	97%
December 2021	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
January 2022	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

  - CalOptima Monthly Utilization Management (UM) Monitoring of Files.
    - CalOptima has suspended the monitoring of monthly UM files for the months of December 2021 and January 2022.

- OneCare Connect Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
November 2021	80%	96%	98%	81%
December 2021	87%	90%	96%	97%
January 2022	92%	94%	96%	70%

  - Overall scores for OneCare Connect Claims increased in the aggregate for the January 2022 file review month.
  - Based on the focus review of select files, four (4) health network attributed to the compliance score for paid claims timeliness during the month of January 2022 leading to an aggregate of 92%.
  - Based on the focus review of select files, two (2) health network attributed to the compliance score for denied claims timeliness during the month of January 2022 leading to an aggregate of 96%.
  - Based on the focus review of the select files, two (2) health networks attributed to the compliance score for paid claims accuracy during the month of January 2022 leading to an aggregate of 94%.
  - Based on the focus review of the select files, three (3) health networks attributed to the compliance score for denied claims accuracy during the month of January 2022 leading to an aggregate of 70%.
  - CalOptima's claims management department issued requests for corrective action plans (CAPs) or Pre – CAP to all health networks with deficiencies identified during the

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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review of claims processing for timeliness and accuracy. The claims department continues to work with each health network to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of claims within regulatory requirements.

a\ “N/A” indicates that the category is not applicable to that file type. “Nothing to Report” indicates that there were no files submitted for review for that file type.

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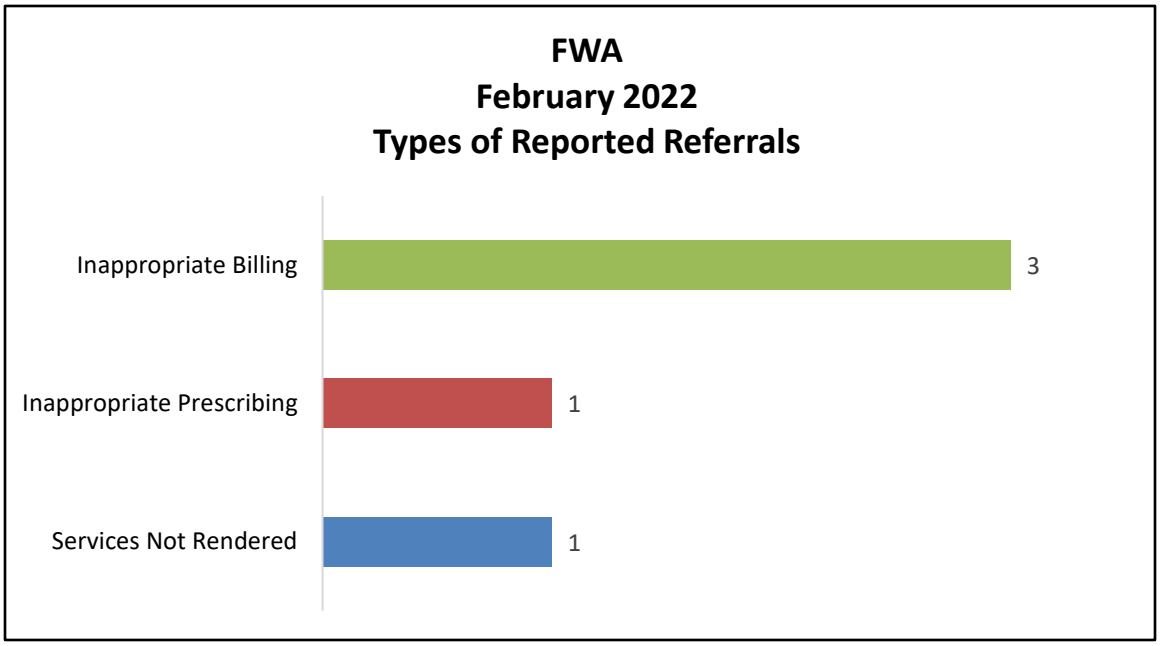
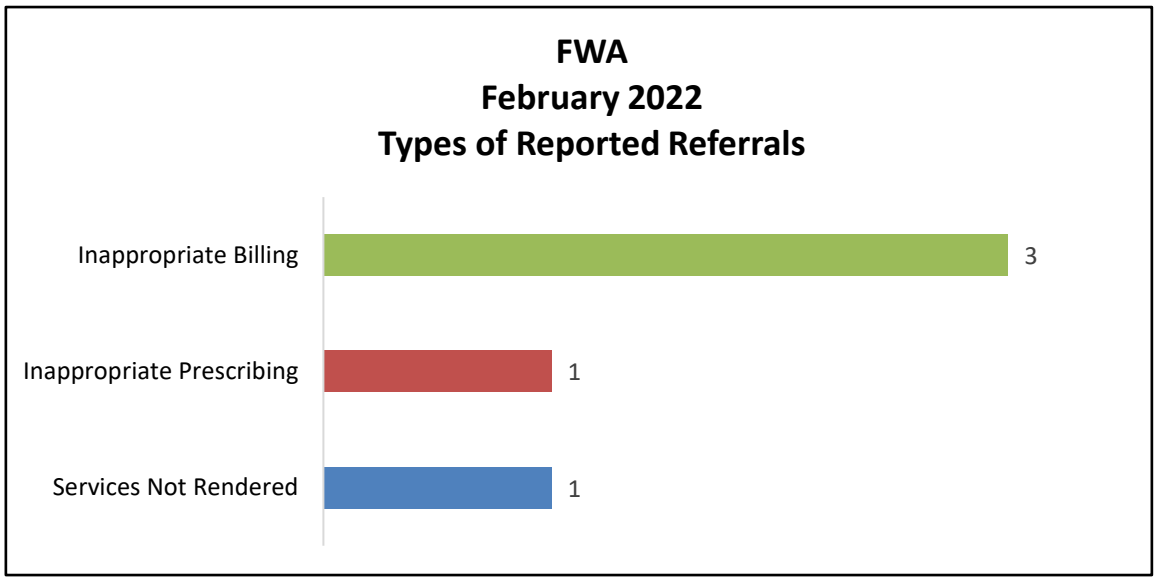
D. Fraud, Waste & Abuse (FWA) Investigations

Types of FWA Cases: (February 2022)





Total Number of New Cases Referred to DHCS (State)	5
Total Number of New Cases Referred to DHCS and CMS*	1

*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.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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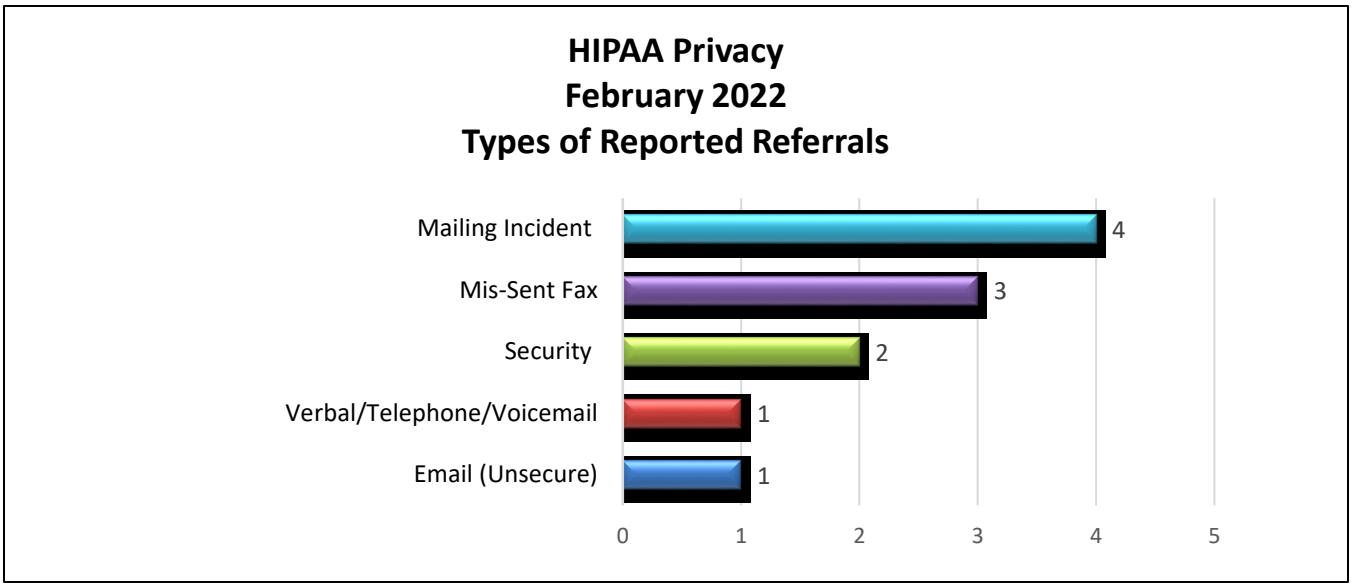
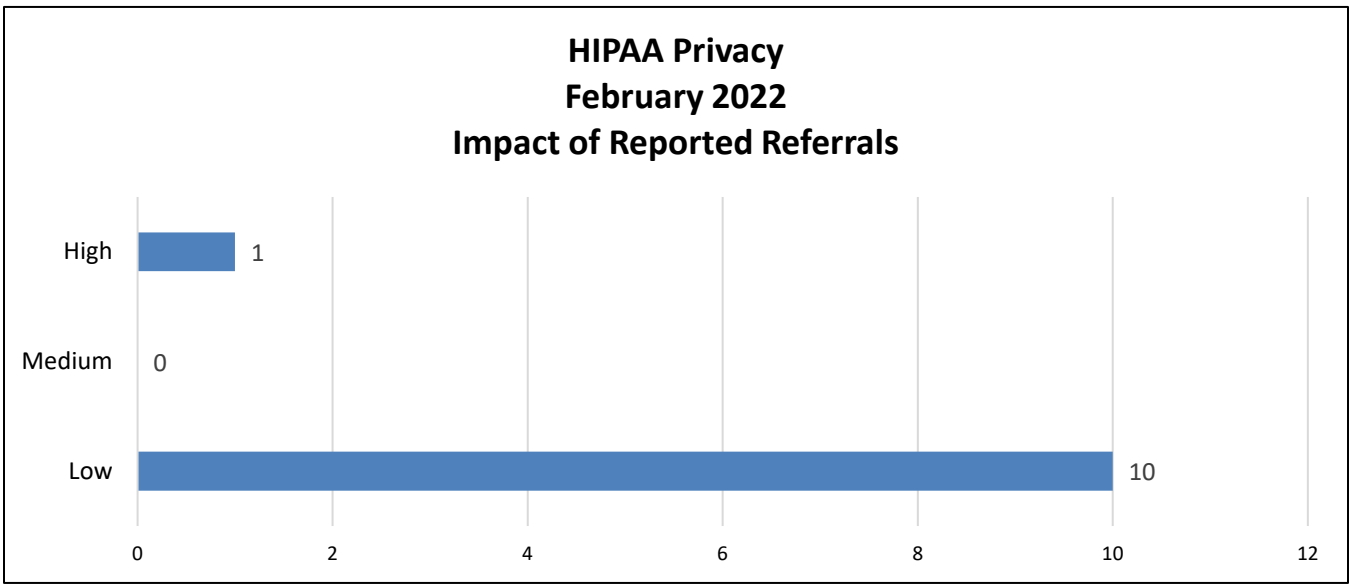
E. Privacy Update: (February 2022)





Total Number of Referrals Reported to DHCS (State)	10
Total Number of Referrals / Breaches Reported to DHCS and Office for Civil Rights (OCR)	1

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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POTOMAC PARTNERS DC

STRATEGIC HEALTH CARE

M E M O R A N D U M

March 18, 2022

To: CalOptima

From: Potomac Partners DC & Strategic Health Care

Re: March Board of Directors Report

FISCAL YEAR 2022 APPROPRIATIONS OMNIBUS PASSES CONGRESS

On March 15th, the President signed a $1.5 trillion omnibus spending package that was recently passed by Congress with bipartisan support. The $1.5 trillion omnibus will provide $730 billion in nondefense funding (a $46 billion increase compared to FY21) and $782 billion for defense funding (a $42 billion increase). Prior to House floor passage, Chairwoman Rosa DeLauro (D-CT) removed a provision that would provide $15.6 billion in supplemental COVID-19 relief. The supplemental COVID-19 funding provision was struck from the bill due to a $7 billion claw-back that would have rescinded COVID-19 dollars given to states under the American Rescue Plan Act last year. The COVID-19 relief was reintroduced as a standalone package (H.R. 7007, found HERE) that is nearly identical to the original language, but without the $7 billion claw-back offset. The omnibus also included three Community Project Funding items (also known as earmarks) related to Orange County health services, included below:

HHS - Substance Abuse and Mental Health Services Administration (SAMHSA)
$325,000: Children's Hospital of Orange County

- For mental health treatment services and programs for children and families.
- Sponsored by Rep. Correa & Sen. Feinstein

HHS - Substance Abuse and Mental Health Services Administration (SAMHSA)
$500,000: City of Huntington Beach

- To establish a mobile crisis team.
- Sponsored by Sen. Feinstein

HHS - Health Resources and Services Administration (HRSA)
$2 million: County of Orange

- To develop a second Be Well campus.
- Sponsored by Rep. Kim

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Other items of interest in the Omnibus include:

- $7.5 million for Telehealth Centers of Excellence awarded sites.
- A provision directing CMS to work with states to identify and share best practices for leveraging telehealth and remote patient monitoring programs through Medicare and Medicaid for homeless populations.
- An extension of telehealth waivers 151 days beyond the end of the Public Health Emergency.
- Creates a new Mental Health Crisis Response Partnership Pilot Program, which will provide $10 million to help communities create mobile behavioral health crisis response teams.

The full text of the spending package, H.R. 2471, is available here.

- Explanatory statements, highlighting Community Project Funding, are available here.
- A full summary of the 12 regular appropriations bills is here.
- A summary of the Ukraine supplemental is here and a one-page fact sheet is here.

PROVIDER RELIEF FUND

HHS announced the distribution of more than $560 million in Provider Relief Fund (PRF) Phase 4 General Distribution payments to more than 4,100 providers across the country. This brings the total Phase 4 distribution to $11.5 billion to more than 78,000 providers in all 50 states, Washington D.C. and five territories. There is about $5.5 billion remaining in the Phase 4 fund, with approximately 86 percent of all Phase 4 applications processed. The remaining funds are expected to be distributed by the end of March. Click here for the HHS press release, and here for the list of distributions.

PUBLIC HEALTH EMERGENCY DESIGNATION

More than a third of House Republicans sent a letter to the President and HHS Secretary Becerra on February 10th urging a plan to end the Covid-19 public health emergency (PHE). The lawmakers say the administration is "long overdue" in laying out "concrete timelines" to end the PHE. The PHE preserves, among other things, telehealth, hospital at home and emergency use authorizations for Covid vaccines, tests and treatments. Acknowledging the emergency cannot "end overnight," the House Republicans call for extending certain policies, including telehealth for seniors. Click here for their letter. The Federation for American Hospitals is urging the Administration to extend the PHE well beyond the current mid-April end date. Click here for the letter. For the 44-page list of PHE waivers, click here.

TELEHEALTH

There is a groundswell of support in Congress to extend the telehealth waivers beyond the PHE. Yet another bipartisan bill has been introduced, this one by Senators Catherine Cortez Masto (D-NV) and Todd Young (R-IN), to extend Medicare enrollees' access to telehealth services no matter where they reside. For the press release, click here. Efforts to extend the waivers for Hospital at Home and many others are under consideration by Congress, but none have the near-universal support of telehealth. A new study shows that the number of Medicare beneficiaries utilizing telehealth service went from a high of 13 percent of outpatient visits in the first few months of lockdown to 8 percent between March and August of 2021. The study also shows that younger people used telehealth at higher percentages than older patients. To view the study results and analysis, click here. A study published in The American Journal of Managed Care found that Medicare Advantage patients who were discharged and received post-acute home health care had a 60 percent lower likelihood of readmission within 30 days of discharge. Click here for the study.

EDELSTEIN GILBERT ROBSON & SMITH LLC

Donald B. Gilbert Michael R. Robson Trent E. Smith Jason D. Ikerd Associate Bridget E. McGowan Associate

March 21, 2022

LEGISLATIVE UPDATE
Edelstein Gilbert Robson & Smith LLC

The Legislature passed a critical deadline on the legislative calendar on February 18 - the bill introduction deadline. Over 2,000 bills were introduced since the Legislature reconvened in January. Many of these bills were introduced as “spot” or “intent” bills that do not have any substantive language and are now starting to be amended further before being heard in committee.

Legislative rules require that all bills be in print for 30 days before being heard in policy committee. However, the Senate waived this rule for all Senate bills introduced this year. Policy committee hearings are beginning to ramp up and will continue through April.

In the meantime, Budget Subcommittees are beginning to meet and review the Governor’s proposed 2022-23 January Budget as well as legislative budget proposals. The Governor will present his May Revision of the budget in mid-May, roughly one month before the Legislature must adopt the final budget on June 15.

Since the Legislature has reconvened this year, CalOptima has been meeting with its legislative delegation to introduce delegation members to CalOptima’s new CEO and leadership staff as well as discuss legislative priorities, its strategic plan and other topics of interest.

One of these topics is the Governor’s proposal to allow Kaiser to directly contract for MediCal enrollees without negotiating with COHS. The Governor’s proposal was placed in draft Trailer Bill Language (TBL). However, it has not been heard in any budget committees. Last week, we learned the language may be amended into a policy bill authored by Assemblymember Arambula (D-Fresno), who chairs the Assembly Budget Sub-Committee on Health and Human Services. A policy bill must be heard in the Assembly Health Committee in April.

We are working closely with the Local Health Plans of California (LHPC) on a coordinated lobbying strategy. Most of our meetings with COHS legislators have been incredibly positive, but there is a long way to go in the Legislative process and the Governor and the Department of Health Care Services (DHCS) are adamant that this proposal benefits MediCal enrollees and therefore, should become law.

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2021–22 Legislative Tracking Matrix

COVID-19 (CORONAVIRUS)

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 4735 Axne (IA) **S. 2493 Bennet (CO)**	**Provider Relief Fund Deadline Extension Act:** Would delay the deadline by which providers must spend any funds received from the Provider Relief Fund (PRF) — created in response to the COVID-19 pandemic — until the end of 2021 or the end of the COVID-19 public health emergency (PHE), whichever occurs later. Funds that are unspent by any deadline must be repaid to the U.S. Department of Health and Human Services (HHS). ***Potential CalOptima Impact:*** *Increased financial stability for CalOptima's contracted providers.*	**07/28/2021** Introduced; referred to committees	CalOptima: Watch
H.R. 5963 Spanberger (VA) **S. 3611 Shaheen (NH)**	**Provider Relief Fund Improvement Act:** Would delay the deadline by which providers must spend any funds received from the PRF until the end of the COVID-19 PHE. Would also direct HHS to distribute any funds remaining in the PRF by March 31, 2022. Finally, would allow workplace safety improvements as an allowable use of PRF dollars. ***Potential CalOptima Impact:*** *Increased financial stability for CalOptima's contracted providers.*	**11/12/2021** Introduced; referred to committees	CalOptima: Watch

BEHAVIORAL HEALTH

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 1914 DeFazio (OR) **S. 764 Wyden (OR)**	**Crisis Assistance Helping Out On The Streets (CAHOOTS) Act:** Would allow State Medicaid programs to provide 24/7 community-based mobile crisis intervention services — under a State Plan Amendment or waiver — for those experiencing a mental health or substance use disorder (SUD) crisis. Would provide states a 95% Federal Medical Assistance Percentage (FMAP) to cover such services for three years as well as a total of $25 million in planning grants. ***Potential CalOptima Impact:*** *Subject to further action by the California Department of Health Care Services (DHCS), increased behavioral health and SUD services to CalOptima Medi-Cal members.*	**03/16/2021** Introduced; referred to committees	**08/05/2021** CalOptima: Support

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 552 **Quirk-Silva**	**Integrated School-Based Behavioral Health Partnership Program:** Would establish the Integrated School-Based Behavioral Health Partnership Program to expand prevention and early intervention behavioral health services for students. This would allow a county mental health agency and local education agency to develop a formal partnership whereby county mental health professionals would deliver brief school-based services to any student who has, or is at risk of developing, a behavioral health condition or SUD. ***Potential CalOptima Impact:*** *Additional member and provider outreach activities by CalOptima staff.*	**01/31/2022** Passed Assembly floor; referred to Senate	CalOptima: Watch
SB 1019 **Gonzalez**	**Mental Health Benefit Outreach and Education:** Would require a Medi-Cal managed care plan (MCP) to conduct annual outreach and education to beneficiaries and primary care physicians regarding covered mental health benefits while incorporating best practices in stigma reduction. ***Potential CalOptima Impact:*** *Additional member and provider outreach activities by CalOptima staff.*	**02/14/2022** Introduced	CalOptima: Watch
RN 22 06818 **Trailer Bill**	**Qualifying Community-Based Mobile Crisis Intervention Services:** No sooner than January 1, 2023, and through March 31, 2027, would add 24/7 community-based mobile crisis intervention services as a covered Medi-Cal benefit for beneficiaries experiencing a mental health or SUD crisis. Services would be provided through county behavioral health systems ***Potential CalOptima Impact:*** *Increased coordination with the Orange County Health Care Agency for behavioral health services; increased follow-up care by CalOptima and its contracted behavioral health providers.*	**03/03/2022** Published by the Department of Finance	CalOptima: Watch

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BUDGET

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 2471 **DeLauro (CT)**	**Consolidated Appropriations Act, 2022:** Appropriates $1.5 trillion to fund the federal government through September 30, 2022, including earmarks for the following projects in Orange County: ■ Children's Hospital of Orange County: $325,000 to expand capacity for mental health treatment services and programs in response to the COVID-19 pandemic ■ City of Huntington Beach: $500,000 to establish a mobile crisis response program ■ County of Orange: $2 million to develop a second Be Well Orange County campus in the City of Irvine ■ County of Orange: $5 million to develop a Coordinated Reentry Center to help justice-involved individuals with mental health conditions or SUDs reintegrate into the community ■ North Orange County Public Safety Task Force: $5 million to expand homeless outreach and housing placement services In addition, extends all current telehealth flexibilities in the Medicare program until approximately five months following the termination of the COVID-19 PHE. ***Potential CalOptima Impact:*** *Increased coordination with the County of Orange and other community partners to support implementation of projects that benefit CalOptima members. Continuation of all current telehealth flexibilities for CalOptima OneCare, OneCare Connect and Program of All-Inclusive Care for the Elderly (PACE).*	**03/15/2022** Signed into law	CalOptima: Watch

COVERED BENEFITS

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 56 **Biggs (AZ)**	**Patient Access to Medical Foods Act:** Would expand the federal definition of medical foods to include food prescribed as a therapeutic option when traditional therapies have been exhausted or may cause adverse outcomes. Effective January 1, 2022, medical foods, as defined, would be covered by private health insurance providers and federal public health programs, including Medicare, TRICARE, Children's Health Insurance Program (CHIP) and Medicaid, as a mandatory benefit. ***Potential CalOptima Impact:*** *New covered benefit for CalOptima's lines of business.*	**01/04/2021** Introduced; referred to committees	CalOptima: Watch
H.R. 1118 **Dingell (MI)**	**Medicare Hearing Aid Coverage Act of 2021:** Effective January 1, 2022, would require Medicare Part B coverage of hearing aids and related examinations. ***Potential CalOptima Impact:*** *New covered benefit for CalOptima OneCare, OneCare Connect and PACE.*	**02/18/2021** Introduced; referred to committees	CalOptima: Watch

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Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 4187 **Schrier (WA)**	**Medicare Vision Act of 2021:** Effective January 1, 2024, would require Medicare Part B coverage of vision services, including eyeglasses, contact lenses, routine eye examinations and fittings. ***Potential CalOptima Impact:*** *New covered benefits for CalOptima OneCare and PACE.*	**06/25/2021** Introduced; referred to committees	CalOptima: Watch
H.R. 4311 **Doggett (TX)** **S. 2618** **Casey (PA)**	**Medicare Dental, Vision, and Hearing Benefit Act of 2021:** Effective no sooner than January 1, 2022, would require Medicare Part B coverage of the following benefits: ■ Dental: Routine dental cleanings and examinations, basic and major dental services, emergency dental care, and dentures ■ Vision: Routine eye examinations, eyeglasses, contact lenses and low vision devices ■ Hearing: Routine hearing examinations, hearing aids and related examinations The Senate version would also increase the Medicaid FMAP for hearing, vision and dental services to 90%. ***Potential CalOptima Impact:*** *New covered benefits for CalOptima OneCare, OneCare Connect and PACE; higher federal funding rate for current Medi-Cal benefits.*	**07/01/2021** Introduced; referred to committees	CalOptima: Watch
H.R. 4650 **Kelly (IL)**	**Medicare Dental Coverage Act of 2021:** Effective January 1, 2025, would require Medicare Part B coverage of dental and oral health services, including routine dental cleanings and examinations, basic and major dental treatments, and dentures. ***Potential CalOptima Impact:*** *New covered benefits for CalOptima OneCare and PACE.*	**07/22/2021** Introduced; referred to committees	CalOptima: Watch
AB 1930 **Arambula**	**Perinatal Services:** Would require Medi-Cal coverage of additional perinatal assessments and services as developed by the California Department of Public Health and additional stakeholders for beneficiaries up to one year postpartum. ***Potential CalOptima Impact:*** *New covered benefit for CalOptima Medi-Cal members up to one-year postpartum.*	**02/10/2022** Introduced	CalOptima: Watch
SB 245 **Gonzalez**	**Abortion Services:** Would prohibit a health plan from imposing Medi-Cal cost-sharing on all abortion services, including any pre-abortion or follow-up care, no sooner than January 1, 2023. In addition, a health plan and its delegated entities may not require a prior authorization or impose an annual or lifetime limit on such coverage. ***Potential CalOptima Impact:*** *Modified Utilization Management (UM) procedures for a covered Medi-Cal benefit.*	**03/17/2022** Passed Assembly floor; returned to Senate floor to concur in amendments **06/01/2021** Passed Senate floor	CalOptima: Watch CAHP: Oppose
SB 912 **Limón**	**Biomarker Testing:** No later than July 1, 2023, would add biomarker testing, including whole genome sequencing, as a Medi-Cal covered benefit to diagnose, treat or monitor a disease. ***Potential CalOptima Impact:*** *New Medi-Cal covered benefit.*	**02/02/2022** Introduced	CalOptima: Watch

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MEDI-CAL ELIGIBILITY AND ENROLLMENT

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 6636 **Trone (MD)** **S. 2697** **Cassidy (LA)**	**Due Process Continuity of Care Act:** Would allow states to extend Medicaid coverage to inmates who are awaiting trial and have not been convicted of a crime. ***Potential CalOptima Impact:*** *If DHCS exercises option and requires enrollment into managed care, increased number of CalOptima Medi-Cal members.*	**08/10/2021** Introduced; referred to committees	CalOptima: Watch
AB 2680 **Arambula**	**Community Health Navigator Program:** Would require DHCS to create the Community Health Navigator Program to issue direct grants to qualified community-based organizations to conduct targeted outreach, enrollment and access activities for Medi-Cal-eligible individuals and families. ***Potential CalOptima Impact:*** *Increased number of CalOptima Medi-Cal members.*	**02/18/2022** Introduced	CalOptima: Watch
RN 22 07748 **Trailer Bill**	**Extend the Duration of Suspension of Medi-Cal Benefits for Adult Incarcerated Individuals:** Would require that Medi-Cal benefits are paused for the entire duration of incarceration without any termination of Medi-Cal eligibility. Current law requires that Medi-Cal benefits are paused for adult inmates for only one year before termination. ***Potential CalOptima Impact:*** *Increased number of CalOptima Medi-Cal members who are recently released from incarceration; improved continuity of care and health outcomes for such members.*	**02/10/2022** Published by the Department of Finance	CalOptima: Watch
RN 22 08022 **Trailer Bill**	**Expansion of Full Scope Medi-Cal Coverage to Individuals 26 to 49 Years of Age, Regardless of Immigration Status:** No sooner than January 1, 2024, would expand eligibility for full-scope Medi-Cal benefits to include individuals ages 26 to 49 years, regardless of immigration status. With previous legislative action extending such eligibility to those under 26 years and over 50 years, this would provide Medi-Cal coverage for all ages regardless of immigration status. ***Potential CalOptima Impact:*** *Increased number of CalOptima Medi-Cal members.*	**02/01/2022** Published by the Department of Finance	CalOptima: Watch

MEDI-CAL OPERATIONS AND ADMINISTRATION

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 1738 **Dingell (MI)** **S. 646** **Brown (OH)**	**Stabilize Medicaid and CHIP Coverage Act of 2021:** Would provide 12 months of continuous eligibility and coverage for any Medicaid or CHIP beneficiary. ***Potential CalOptima Impact:*** *Increased number of CalOptima Medi-Cal members.*	**03/10/2021** Introduced; referred to committees	CalOptima: Watch ACAP: Support

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Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 5610 **Bera (CA)** **S. 3001** **Van Hollen (MD)**	**Easy Enrollment in Health Care Act:** To streamline and increase enrollment into public health insurance programs, would allow taxpayers to request their federal income tax returns include a determination of eligibility for Medicaid, CHIP or advance premium tax credits to purchase insurance through a health plan exchange. Taxpayers could also consent to be automatically enrolled into any such program or plan if they would be subject to a zero net premium. ***Potential CalOptima Impact:*** *Increased number of CalOptima Medi-Cal members.*	**10/19/2021** Introduced; referred to committees	CalOptima: Watch ACAP: Support
AB 1355 **Levine**	**Medi-Cal Independent Medical Review (IMR) System:** Would require DHCS to establish an IMR system, effective January 1, 2023, for Medi-Cal services provided through the following: ■ County Drug Medi-Cal Organized Delivery Systems ■ County Mental Health Plans ■ Medi-Cal fee-for-service ■ Medi-Cal MCPs without a Knox-Keene license from the California Department of Managed Health Care (DMHC) ■ PACE The proposed DHCS IMR would closely mirror the current DMHC IMR process for Knox-Keene licensed health plans. As a result, the bill would provide every Medi-Cal beneficiary with access to an IMR. ***Potential CalOptima Impact:*** *Implementation of an additional Grievance and Appeals process for CalOptima Medi-Cal and PACE members.*	**01/27/2022** Passed Assembly floor; referred to Senate	CalOptima: Watch
AB 1400 **Kalra, Lee, Santiago**	**California Guaranteed Health Care for All:** Would create the California Guaranteed Health Care for All program (CalCare) to provide a comprehensive universal single-payer health care benefit for all California residents. Would require CalCare cover a wide range of medical benefits and other services and would incorporate the health care benefits and standards of CHIP, Medi-Cal, Medicare, the Knox-Keene Act, and ancillary health care or social services covered by regional centers for people with developmental disabilities. ***Potential CalOptima Impact:*** *Unknown but potentially significant impacts to the Medi-Cal delivery system and MCPs, including changes to administration, covered benefits, eligibility, enrollment, financing and organization.*	**01/31/2022** Died on Assembly floor	CalOptima: Watch CAHP: Oppose
AB 1880 **Arambula**	**Medication Prior Authorizations:** Would require a Medi-Cal MCP to approve a prior authorization or a step therapy exception request for a prescription drug if the MCP does not issue a determination within 72 hours for nonurgent requests or 24 hours for urgent requests. ***Potential CalOptima Impact:*** *Modified UM requirements for prescribed drugs covered by CalOptima; increased CalOptima costs for drug coverage.*	**02/08/2022** Introduced	CalOptima: Watch

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Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 1937 **Patterson**	**Out-of-Pocket Pregnancy Costs:** No later than January 1, 2024, would require DHCS to reimburse pregnant Medi-Cal beneficiaries up to $1,000 for out-of-pocket pregnancy costs, including but not limited to birthing classes, midwife and doula care, car seats, cribs, and related items. ***Potential CalOptima Impact:*** *Increased financial stability for CalOptima Medi-Cal members who are currently or were recently pregnant.*	**02/10/2022** Introduced	CalOptima: Watch
AB 1995 **Arambula**	**Medi-Cal Premium 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 (MCAP). ***Potential CalOptima Impact:*** *Increased financial stability for CalOptima Medi-Cal members in certain aid code categories.*	**02/10/2022** Introduced	CalOptima: Watch
AB 2402 **Rubio, B.**	**Medi-Cal Continuous Eligibility for Children:** Would allow Medi-Cal beneficiaries under five years of age to remain continuously eligible for Medi-Cal regardless of income changes or other eligibility requirements. ***Potential CalOptima Impact:*** *Increased number of CalOptima Medi-Cal members.*	**02/17/2022** Introduced	CalOptima: 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 utilization review and any appeals if the drug was previously covered for the beneficiary by any health plan. Would prohibit a plan from seeking reimbursement from a beneficiary if a denial is sustained. ***Potential CalOptima Impact:*** *Modified UM and Grievance and Appeals requirements for prescribed drugs covered by CalOptima; increased CalOptima costs for drug coverage.*	**01/19/2022** Introduced	CalOptima: Watch
SB 858 **Wiener**	**Health Plan Civil Penalties:** Would increase the civil penalty amount that DMHC could levy on a health plan from no more than $2,500 per violation to no less than $25,000 per violation per impacted beneficiary per day. The penalty amount would be adjusted annually, beginning January 1, 2024. ***Potential CalOptima Impact:*** *Increased civil penalties for any violations of managed health care laws and regulations under the jurisdiction of DMHC.*	**01/19/2022** Introduced	CalOptima: Watch
SB 923 **Wiener**	**TGI Inclusive Care Act:** Would require health plan staff and contracted providers to complete cultural competency training to help provide inclusive health care services for individuals who identify as transgender, gender nonconforming or intersex (TGI). In addition, no later than July 31, 202, would require a health plan to include in its provider directory any in-network providers who offer gender-affirming services. ***Potential CalOptima Impact:*** *Additional training requirement for CalOptima employees and contracted providers; additional requirement for provider directory publication.*	**02/03/2022** Introduced	CalOptima: Watch

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Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 987 **Portantino**	**Medi-Cal Time and Distance Standards:** Would extend the current time and distance standards for Medi-Cal plans, which are set to expire on January 1, 2023, until January 1, 2028. ***Potential CalOptima Impact:*** *Continuation of current timely access standards for CalOptima Medi-Cal.*	**02/14/2022** Introduced	CalOptima: Watch
RN 22 08897 **Trailer Bill**	**Alternate Health Care Service Plan:** No sooner than January 1, 2024, would authorize DHCS to contract with an Alternate Health Care Service Plan (AHCSP) as a Medi-Cal MCP in any region. An AHCSP is a nonprofit health plan with at least four million enrollees statewide that owns or operates pharmacies and provides medical services through an exclusive contract with a single medical group in each region. Enrollment into an AHCSP would be limited to the following Medi-Cal beneficiaries: ■ Previous AHCSP enrollees and their immediate family members ■ Dually eligible for Medi-Cal and Medicare benefits ■ Foster youth ***Potential CalOptima Impact:*** *Additional Medi-Cal MCP in Orange County; decreased number of CalOptima Medi-Cal members; increased percentage of CalOptima members who are high-risk.*	**03/10/2022** Published by the Department of Finance	CalOptima: Watch
RN 22 10705 **Trailer Bill**	**Reducing Premiums for the Optional Targeted Low-Income Children's Program (OTLICP), 250 Percent Working Disabled Program (WDP), and Children's Health Insurance Program (CHIP):** Effective July 1, 2022, would allow DHCS to eliminate Medi-Cal premiums for low-income children whose family income exceeds 160% 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 (MCAP). ***Potential CalOptima Impact:*** *Increased financial stability for CalOptima Medi-Cal members in certain aid code categories.*	**03/03/2022** Published by the Department of Finance	CalOptima: Watch

OLDER ADULT SERVICES

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 4131 **Dingell (MI)** **S. 2210** **Casey (PA)**	**Better Jobs Better Care Act:** Would make permanent the enhanced 10% FMAP for Medicaid home- and community-based services (HCBS) enacted by the American Rescue Plan Act of 2021. Would also provide states with $100 million in planning grants to develop HCBS infrastructure and workforces. Additionally, would make permanent spousal impoverishment protections for those receiving HCBS. ***Potential CalOptima Impact:*** *Continuation of current federal funding rate for HCBS; expansion of HCBS opportunities.*	**06/24/2021** Introduced; referred to committees	CalOptima: Watch NPA: Support

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Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 4941 **Blumenauer (OR)**	**PACE Part D Choice Act of 2021:** Would allow a Medicare-only PACE participant to opt out of drug coverage provided by the PACE program and instead enroll in a standalone Medicare Part D prescription drug plan that results in equal or lesser out-of-pocket costs. PACE programs would be required to educate their participants about this option. ***Potential CalOptima Impact:*** *Increased enrollment into CalOptima PACE by Medicare-only beneficiaries due to decreased out-of-pocket costs.*	**08/06/2021** Introduced; referred to committees	CalOptima: Watch NPA: Support
H.R. 6770 **Dingell (MI)** **S. 1162** **Casey (PA)**	**PACE Plus Act:** Would increase the number of PACE programs nationally by making it easier for states to adopt PACE as a model of care and providing grants to organizations to start PACE centers or expand existing PACE centers. Would incentivize states to expand the number of seniors and people with disabilities eligible to receive PACE services beyond those deemed to require a nursing home level of care. Would provide states a 90% FMAP to cover the expanded eligibility. ***Potential CalOptima Impact:*** *Subject to further DHCS authorization, expanded eligibility for CalOptima PACE; additional federal funding to expand the size and/or service area of a current PACE center or to establish a new PACE center(s).*	**04/15/2021** Introduced; referred to committees	CalOptima: Watch CalPACE: Support NPA: Support
S. 3626 **Casey**	**PACE Expanded Act:** To increase access to and the affordability of PACE, would allow PACE organizations to set premiums individually for Medicare-only beneficiaries consistent with their health status. Would also allow individuals to enroll in PACE at any time during the month. In addition, would simplify and expedite the process for organizations to apply for the following: ■ New PACE program ■ New centers for an existing PACE program ■ Expanded service area for an existing PACE center Finally, would allow pilot programs to test the PACE model of care with new populations not currently eligible to participate in PACE. ***Potential CalOptima Impact:*** *Increased number of CalOptima PACE participants; expanded eligibility criteria; new premium development procedure; simplified process to establish new PACE centers.*	**02/10/2022** Introduced; referred to committee	CalOptima: Watch NPA: Support
SB 1342 **Bates**	**Older Adult Care Coordination:** Would allow each county to create a multi-disciplinary team (MDT) for county departments and aging service providers to exchange information about older adults to better address their health and social needs. By eliminating data silos, MDTs could develop coordinated case plans for wraparound services, provide support to caregivers and improve service delivery. ***Potential CalOptima Impact:*** *Participation in Orange County's MDT; improved care coordination for CalOptima's older adult members.*	**02/18/2022** Introduced	CalOptima: Watch County of Orange: Sponsor

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PROVIDERS

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 2581 Salas	**Behavioral Health Provider Credentialing:** Effective January 1, 2023, would require health plans to process credentialing applications from mental health and SUD providers within 45 days of receipt. If not approved or denied within that period, a provider may request a temporary credential to be issued within five business days unless the provider has a history of medical malpractice claims, substance use, mental health issues or disciplinary action. ***Potential CalOptima Impact:*** *Modified provider credentialing processes for Quality Improvement staff.*	**02/18/2022** Introduced	CalOptima: Watch
AB 2659 Patterson	**Access to Midwifery Services:** Would require a Medi-Cal MCP to include at least one licensed midwife (LM) or certified-nurse midwife (CNM) in each county within its provider network. An MCP would be exempt if an LM or CNM is not located within the county or does not accept Medi-Cal payments. ***Potential CalOptima Impact:*** *Additional provider contracting and credentialing; increased access to midwifery services for CalOptima Medi-Cal members.*	**02/18/2022** Introduced	CalOptima: Watch
SB 966 Limón	**Clinic Providers:** Effective 60 days following the termination of the COVID-19 PHE, would allow Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) to be reimbursed for visits with an associate clinical social worker or associate marriage and family therapist when supervised by a licensed behavioral health practitioner. ***Potential CalOptima Impact:*** *Increased member access to behavioral health providers at contracted FQHCs.*	**02/09/2022** Introduced	CalOptima: Watch

REIMBURSEMENT RATES

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 1892 Flora	**California Orthotic and Prosthetic Patient Access and Fairness Act:** Would require reimbursement for prosthetic and orthotic appliances and durable medical equipment to be set at 80% of the lowest maximum allowance for California established by the federal Medicare program. ***Potential CalOptima Impact:*** *Increased cost to CalOptima Medi-Cal due to higher reimbursement to DME providers; adjustment to DHCS capitation rates.*	**02/09/2022** Introduced	CalOptima: Watch
AB 2458 Weber	**Whole Child Model (WCM) Reimbursement Rates:** Effective January 1, 2023, would increase provider reimbursement rates for Whole Child Model services by 25% if provided at a medical practice in which at least 30% of pediatric patients are Medi-Cal beneficiaries. ***Potential CalOptima Impact:*** *Increased cost to CalOptima Medi-Cal due to higher reimbursement to WCM providers; adjustment to DHCS capitation rates.*	**02/17/2022** Introduced	CalOptima: Watch

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Bill Number Author	Bill Summary	Bill Status	Position/Notes
RN 22 08446 Trailer Bill	**FQHC Alternative Payment Methodology (APM) Project:** No sooner than January 1, 2024, would authorize DHCS to permanently implement an APM option for FQHCs to receive value-based payments instead of volume-based payments. Specifically, Medi-Cal MCPs would pay an FQHC a per-member-per-month rate, based on historic utilization, which would be no less than the current amount paid through its Prospective Payment System rate. ***Potential CalOptima Impact:*** *New rate structure and modified contracts for CalOptima's contracted FQHCs who participate in the APM project; increased reporting requirements to DHCS.*	**03/07/2022** Published by the Department of Finance	CalOptima: Watch

SOCIAL DETERMINANTS OF HEALTH

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 379 Barragan (CA) **S. 104 Smith (MN)**	**Improving Social Determinants of Health Act of 2021:** Would require the Centers for Disease Control and Prevention (CDC) to establish a social determinants of health (SDOH) program to coordinate activities to improve health outcomes and reduce health inequities. CDC would be required to consider SDOH in all relevant grant awards and other activities as well as issue new grants of up to $50 million to health agencies, nonprofit organizations and/or institutions of higher education to address or study SDOH. ***Potential CalOptima Impact:*** *Increased availability of federal grants to address SDOH.*	**01/21/2021** Introduced; referred to committees	CalOptima: Watch
H.R. 943 McBath (GA) **S. 851 Blumenthal (CT)**	**Social Determinants for Moms Act:** Would require HHS to convene a task force to coordinate federal efforts on social determinants of maternal health as well as award grants to address SDOH, eliminate disparities in maternal health and expand access to free childcare during pregnancy-related appointments. Would also extend postpartum eligibility for the Special Supplemental Nutrition Program for Women, Infants, and Children from six months postpartum to two years postpartum. ***Potential CalOptima Impact:*** *Additional federal guidance or requirements as well as increased availability of federal grants to address social factors affecting maternal health.*	**02/08/2021** Introduced; referred to committees	CalOptima: Watch
H.R. 2503 Bustos (IL) **S. 3039 Young (IN)**	**Social Determinants Accelerator Act of 2021:** Would establish the Social Determinants Accelerator Interagency Council to award state and local health agencies up to 25 competitive grants totaling no more than $25 million (House version) or $10 million (Senate version) as well as provide technical assistance to improve coordination of medical and non-medical services to a targeted population of high-need Medicaid beneficiaries. ***Potential CalOptima Impact:*** *Increased availability of federal grants to address the SDOH of members with complex needs.*	**07/15/2021** Passed House Energy and Commerce Committee's Subcommittee on Health; referred to full Committee	CalOptima: Watch

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Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 3894 Blunt Rochester (DE)	**Collecting and Analyzing Resources Integral and Necessary for Guidance (CARING) for Social Determinants Act of 2021:** Would require the Centers for Medicare & Medicaid Services (CMS) to update guidance at least once every three years to help states address SDOH in Medicaid and CHIP programs. ***Potential CalOptima Impact:*** *Increased opportunities for CalOptima to address SDOH.*	**12/08/2021** Passed House floor; referred to Senate Committee on Finance	CalOptima: Watch
H.R. 4026 Burgess (TX)	**Social Determinants of Health Data Analysis Act of 2021:** Would require the Comptroller General of the United States to submit a report to Congress outlining the actions taken by HHS to address SDOH. The report would include an analysis of interagency efforts, barriers and potential duplication of efforts as well as recommendations on how to foster private-public partnerships to address SDOH. ***Potential CalOptima Impact:*** *Increased opportunities for CalOptima to address SDOH.*	**11/30/2021** Passed House floor; referred to Senate Committee on Health, Education, Labor, and Pensions	CalOptima: Watch

TELEHEALTH

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 366 Thompson (CA)	**Protecting Access to Post-COVID-19 Telehealth Act of 2021:** Would allow HHS to waive or modify any telehealth service requirements in the Medicare program during a national disaster or PHE and for 90 days after one is terminated. Would also permit Medicare reimbursement for telehealth services provided by an FQHC or RHC as well as allow patients to receive telehealth services in the home without restrictions. ***Potential CalOptima Impact:*** *Continuation and expansion of certain telehealth flexibilities allowed during the COVID-19 pandemic for CalOptima OneCare, OneCare Connect and PACE.*	**01/19/2021** Introduced; referred to committees	CalOptima: Watch
H.R. 1332 Carter (GA) **S. 368 Scott (SC)**	**Telehealth Modernization Act of 2021:** Would permanently extend certain current telehealth flexibilities in the Medicare program, enacted temporarily in response to the COVID-19 pandemic. Specifically, would permanently allow the following: ■ FQHCs and RHCs may serve as the site of a telehealth provider ■ Beneficiaries may receive all telehealth services at any location, including their own homes ■ CMS may retain and expand the list of covered telehealth services ■ CMS may expand the types of providers eligible to provide telehealth services ***Potential CalOptima Impact:*** *Continuation of certain telehealth flexibilities allowed during the COVID-19 pandemic for CalOptima OneCare, OneCare Connect and PACE.*	**02/23/2021** Introduced; referred to committees	CalOptima: Watch

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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 Medicare Advantage (MA) and PACE plans during the COVID-19 PHE. ***Potential CalOptima Impact:*** *For CalOptima OneCare, OneCare Connect and PACE, members' risk scores and risk adjustment payments would accurately reflect diagnoses.*	**03/23/2021** Introduced; referred to committees	**08/05/2021** CalOptima: Support ACAP: Support NPA: Support
H.R. 2903 **Thompson (CA)** **S. 1512** **Schatz (HI)**	**Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act of 2021:** Would expand telehealth services for those receiving Medicare benefits and remove restrictions in the Medicare program that prevent physicians from using telehealth technology. Specifically, would: ■ Remove all geographic restrictions for telehealth services ■ Allow beneficiaries to receive telehealth in their own homes, in addition to other locations determined by HHS ■ Remove restrictions on the use of telehealth in emergency medical care ■ Allow FQHCs and RHCs to provide telehealth services ***Potential CalOptima Impact:*** *Continuation and expansion of telehealth flexibilities for CalOptima OneCare, OneCare Connect and PACE.*	**04/28/2021** Introduced; referred to committees	CalOptima: Watch
H.R. 3447 **Smith (MO)**	**Permanency for Audio-Only Telehealth Act:** Would permanently extend the following current flexibilities, which have been temporarily authorized by CMS during the COVID-19 PHE: ■ Medicare providers may be reimbursed for providing certain services via audio-only telehealth, including evaluation and management, behavioral health and SUD services, or any other service specified by HHS. ■ Medicare beneficiaries may receive telehealth services at any location, including their homes. ***Potential CalOptima Impact:*** *Permanent continuation of certain telehealth flexibilities for CalOptima OneCare, OneCare Connect and PACE.*	**05/20/2021** Introduced; referred to committees	CalOptima: Watch
H.R. 4058 **Matsui (CA)** **S. 2061** **Cassidy (LA)**	**Telemental Health Care Access Act of 2021:** Would remove the requirement that Medicare beneficiaries be seen in-person within six months of being treated for behavioral health services via telehealth. ***Potential CalOptima Impact:*** *For CalOptima OneCare and OneCare Connect, decreased in-person behavioral health encounters and increased telehealth behavioral health encounters.*	**06/22/2021** Introduced; referred to committees	CalOptima: Watch
S. 150 **Cortez Masto (NV)**	**Ensuring Parity in MA for Audio-Only Telehealth Act of 2021:** Would require CMS to include audio-only telehealth diagnoses in the determination of risk adjustment payments for MA plans during the COVID-19 PHE. ***Potential CalOptima Impact:*** *For CalOptima OneCare and OneCare Connect, members' risk scores and risk adjustment payments would accurately reflect diagnoses.*	**02/02/2021** Introduced; referred to committee	CalOptima: Watch ACAP: Support NPA: Support

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Bill Number Author	Bill Summary	Bill Status	Position/Notes
S. 3593 Cortez Masto (NV)	**Telehealth Extension and Evaluation Act:** Would extend current Medicare telehealth payments authorized temporarily in response to the COVID-19 pandemic for two additional years following the termination of the PHE. Would require HHS to study the impact of telehealth flexibilities and report its recommendations for permanent telehealth policies to Congress. ***Potential CalOptima Impact:*** *Continuation of telehealth flexibilities for CalOptima OneCare, OneCare Connect and PACE.*	**02/08/2022** Introduced; referred to committee	CalOptima: Watch
RN 22 09807 Trailer Bill	**Medi-Cal Telehealth Policy:** Would permanently extend or modify certain Medi-Cal telehealth flexibilities currently authorized during the COVID-19 pandemic as follows: ■ DHCS must specify the Medi-Cal covered benefits that may be delivered via telehealth as well as the telehealth provider types allowed in addition to FQHCs and RHCs. ■ Telehealth services may be delivered via video, audio only, remote patient monitoring and other virtual modalities. ■ Video and audio-only telehealth services must be reimbursed at the same rate as in-person services, while remote patient monitoring and other modalities may be reimbursed at different rates. ■ Medi-Cal providers, including FQHCs and RHCs, may establish a new Medi-Cal patient using video telehealth but not audio-only telehealth or other virtual modalities. Finally, would allow Medi-Cal MCPs to include video telehealth encounters when determining compliance with network adequacy requirements. ***Potential CalOptima Impact:*** *Continuation and modification of certain telehealth flexibilities for CalOptima Medi-Cal.*	**03/08/2022** Published by the Department of Finance	CalOptima: Watch

YOUTH SERVICES

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 66 Buchanan (FL)	**Comprehensive Access to Robust Insurance Now Guaranteed (CARING) for Kids Act:** Would permanently extend authorization and funding of CHIP and associated programs, including the Medicaid and CHIP express lane eligibility option, which enables states to expedite eligibility determinations by referencing enrollment in other public programs. ***Potential CalOptima Impact:*** *Continuation of current federal funding and eligibility requirements for CalOptima Medi-Cal members eligible under CHIP.*	**01/04/2021** Introduced; referred to committee	CalOptima: Watch

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Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 1390 **Wild (PA)** **S. 453** **Casey (PA)**	**Children's Health Insurance Program Pandemic Enhancement and Relief (CHIPPER) Act:** Would retroactively extend CHIP's temporary 11.5% FMAP increase, enacted by the HEALTHY KIDS Act (2018), from September 30, 2020, until September 30, 2022, to meet increased health care needs during the COVID-19 PHE. ***Potential CalOptima Impact:*** *Increased federal funds for CalOptima Medi-Cal members eligible under CHIP.*	**02/25/2021** Introduced; referred to committees	CalOptima: Watch

Two-Year Bills

The following bills did not meet the deadline to be passed by both houses of the State Legislature in 2021 but are still eligible for reconsideration in 2022:

- AB 4 (Arambula)
- AB 32 (Aguiar-Curry)
- AB 114 (Maienschein)
- AB 470 (Carrillo)
- AB 540 (Petrie-Norris)
- AB 563 (Berman)
- AB 586 (O'Donnell)
- AB 1132 (Wood)
- SB 17 (Pan)
- SB 56 (Pan)
- SB 250 (Pan)
- SB 256 (Pan)
- SB 293 (Limón)
- SB 316 (Eggman)
- SB 371 (Caballero)
- SB 523 (Leyva)
- SB 562 (Portantino)
- SB 773 (Roth)

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)

Vetoed Bills

- AB 369 (Kamlager)
- AB 523 (Nazarian)
- SB 365 (Caballero)
- SB 682 (Rubio)

Information in this document is subject to change as bills proceed through the legislative process.

ACAP: Association for Community Affiliated Plans
CAHP: California Association of Health Plans
CalPACE: California PACE Association
LHPC: Local Health Plans of California
NPA: National PACE Association

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2022 Federal Legislative Dates

January 3	117th Congress, Second Session convenes
April 11–22	Spring recess
August 1–12	Summer recess for House
August 8–September 5	Summer recess for Senate
December 10	Second Session adjourns

2022 State Legislative Dates

January 3	Legislature reconvenes
January 14	Last day for policy committees to hear and report to fiscal committees any fiscal bills introduced in that house in 2021
January 21	Last day for any committee to hear and report to the floor any bill introduced in that house in 2021
January 31	Last day for each house to pass bills introduced in that house in 2021
February 18	Last day for legislation to be introduced
April 7–18	Spring recess
April 29	Last day for policy committees to hear and report to fiscal committees any fiscal bills introduced in that house in 2022
May 6	Last day for policy committees to hear and report to the floor any non-fiscal bills introduced in that house in 2022
May 20	Last day for fiscal committees to hear and report to the floor any bills introduced in that house in 2022
May 23–27	Floor session only
May 27	Last day for each house to pass bills introduced in that house in 2022
June 15	Budget bill must be passed by midnight
July 1	Last day for policy committees to hear and report bills in their second house to fiscal committees or the floor
July 1–August 1	Summer recess
August 12	Last day for fiscal committees to report bills in their second house to the floor
August 15–31	Floor session only
August 25	Last day to amend bills on the floor
August 31	Last day for each house to pass bills; final recess begins upon adjournment
September 30	Last day for Governor to sign or veto bills passed by the Legislature

Source: 2022 State Legislative Deadlines, California State Assembly: http://assembly.ca.gov/legislativedeadlines

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Board of Directors Meeting
April 7, 2022

CalOptima Community Outreach Summary — March and April 2022

Background

CalOptima is committed to serving the community by sharing information with current and potential members and strengthening relationships with community partners. To do so, CalOptima attends community coalitions, collaborative meetings and advisory groups, and supports our community partners' public activities.

CalOptima's participation in public activities promotes:

- Member interaction/enrollment in a CalOptima program
- Community awareness of CalOptima
- Partnerships that increase positive visibility and relationships with community organizations

CalOptima continues to participate in public activities virtually in most instances with some limited in-person attendance. Participation includes providing CalOptima Medi-Cal educational materials and, if criteria are met, financial support and/or CalOptima-branded items.

Community Outreach Highlight

CalOptima launched the CalFresh Outreach Strategy in March to increase awareness and enrollment rates in CalFresh and address social determinants of health, such as food insecurity, for our members. CalOptima and the County of Orange Social Services Agency identified 344,000 CalOptima members who are potentially eligible for the program and not yet enrolled. The comprehensive outreach strategy includes a text message campaign; direct mailer; staff, member and community stakeholder presentations; and hosting CalFresh enrollment events and outreach activities with the goal of enrolling 100,000 CalOptima members by the end of 2022. The first events scheduled are virtual CalFresh & Healthy Living Presentations for members on April 12, 13 and 14. The presentations will be offered in English, Spanish and Vietnamese with a question and answer portion.

Summary of Public Activities

As of February 23, CalOptima plans to participate in, organize or convene 54 public activities in March and April. In March, there will be 24 public activities: 14 virtual community/collaborative meetings, six community events, three community-based presentations and one Health Network Forum. In April there will be 30 public activities: 20 virtual community/collaborative meetings, eight community events, one Cafecito meeting and one Health Network Forum. CalOptima's participation in community meetings throughout Orange County can be found in the attachment.

Endorsements

CalOptima provided one endorsement since the last reporting period (e.g., letters of support, program/public activity events with support or use of name/logo).

- Letter of Support for the Coalition of Orange County Community Health Centers' application for the 2022 Health Center Controlled Networks funding to support the Orange County Partners in Health - Health Center Controlled Network.

Endorsement requests must meet the requirements of CalOptima Policy AA.1214: Guidelines for Endorsements by CalOptima, for Letters of Support and Use of CalOptima Name and Logo. More information about policy requirements can be found at: https://www.caloptima.org/en/About/CommunityRelations/CommunityOutreach.aspx. For additional information or questions, contact CalOptima Community Relations Manager Tiffany Kaaiakamanu at 657-235-6872 or tkaaiakamanu@caloptima.org.

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List of community events hosted by community partners and CalOptima-hosted events and meetings in March and April 2022:

March 2022			
3/3 1 p.m.–2 p.m.	**CalOptima Medi-Cal English Presentation to Uplift Charity and the County of Orange Social Services Agency Office** Virtual	One staff member presented.	• Community-based organization presentation • Open to members only
3/3 11:30 a.m.–12:30 p.m.	**CalOptima Medi-Cal English Presentation to Orange Coast College** Virtual	One staff member presented.	• Community-based organization presentation • Open to members only
3/9 9 a.m. –10 a.m.	**CalOptima Medi-Cal English Presentation to California State University, Fullerton** Virtual	One staff member presented.	• Community-based organization presentation • Open to members only
3/9 9 a.m.–1 p.m.	**Faith and Mental Health Forum hosted by the OC Sheriff's Department†** Christ Cathedral Arboretum 12141 S. Lewis St., Garden Grove	Two staff members attended (in-person).	• Health/resource fair • Open to the public
3/12 9 a.m.–1 p.m.	**Vaccine Event hosted by OC Health Care Agency and CalOptima*** Golden West College Building 95 (MPR 100) 15751 Gothard St., Huntington Beach	At least 10 staff members attended (in-person).	• Health/resource fair • Open to the public
3/15 1:30 p.m. –3 p.m.	**InfoSeries: United to End Homelessness*** Virtual	At least 10 staff members attended.	• Forum • Open to health and human service providers Registration required
3/17 9 a.m. –11 a.m.	**Health Network Forum*** Virtual	At least three staff members attended.	• Forum • Open to health and human service providers
3/19 9 a.m.–1 p.m.	**Vaccine Event hosted by OC Health Care Agency and CalOptima*** St. Anthony Claret Catholic Church 1450 E. La Palma Ave., Anaheim	At least 10 staff members attended (in-person).	• Health/resource fair • Open to the public
3/26 9 a.m.–1 p.m.	**School Readiness Fair hosted by Pretend City Children's Museum†** 29 Hubble, Irvine	Two staff members attended (in-person).	• Health/resource fair • Open to the public

* CalOptima Hosted
† Exhibitor/Attendee

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3/26 9 a.m.–1 p.m.	**Vaccine Event hosted by OC Health Care Agency and CalOptima*** County of Orange Social Services Agency Central Regional Office 2020 W. Walnut St., Santa Ana	At least 10 staff members attended (in-person).	• Health/resource fair • Open to the public
April 2022			
4/9 11 a.m.–1 p.m.	**Spring Fling Health and Resource Fair hosted by Grandma's House of Hope†** The Crossings at Cherry Orchard 2748 W Lincoln Ave., Anaheim	At least 2 staff members to attend (in-person). Sponsorship fee: $700 (includes resource table at event, logo promotion on website and social media channels).	• Health/resource fair • Open to the public
4/9 9 a.m.–1 p.m.	**Vaccine Event hosted by OC Health Care Agency and CalOptima*** Golden West College Building 95 (MPR 100) 15751 Gothard St., Huntington Beach	At least 10 staff members to attend (in - person).	• Health/resource fair • Open to the public
4/12 6 p.m.–7 p.m.	**CalFresh & Healthy Living Presentation (English)*** Virtual	At least 3 staff members to attend.	• Community presentation • Open to the public
4/13 6 p.m.–7 p.m.	**CalFresh & Healthy Living Presentation (Spanish)*** Virtual	At least 3 staff members to attend.	• Community presentation • Open to the public
4/14 6 p.m.–7 p.m.	**CalFresh & Healthy Living Presentation (Vietnamese)*** Virtual	At least 3 staff members to attend.	• Community presentation • Open to the public
4/15 8 a.m.–5 p.m.	**Meeting of the Minds Mental Health Conference hosted by Mental Health Association OC†** Anaheim Marriott Hotel 700 W. Convention Way, Anaheim	At least 2 staff members to attend (in-person). Sponsorship fee: $1,000 (includes resource table, being featured as supporting sponsor in event program and in all media for the event, program acknowledgement on quarter page, CalOptima logo on MHA's web site through 2022, and admission for 5).	• Health/resource fair • Open to the public
4/16 9 a.m.–1 p.m.	**Vaccine Event hosted by OC Health Care Agency and CalOptima*** St. Anthony Claret Catholic Church 1450 E. La Palma Ave., Anaheim	At least 10 staff members to attend (in-person).	• Health/resource fair • Open to the public
4/21 9 a.m. –11 a.m.	**Health Network Forum*** Virtual	At least 10 staff members to attend.	• Forum • Open to health and human service providers

* CalOptima Hosted
† Exhibitor/Attendee

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4/23 9 a.m.–1 p.m.	**Vaccine Event hosted by OC Health Care Agency and CalOptima*** County of Orange Social Services Agency Central Regional Office 2020 W. Walnut St., Santa Ana	At least 10 staff members to attend (in-person).	• Health/resource fair • Open to the public

These sponsorship request(s) and community event(s) met the requirements of CalOptima 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 Board Action Agenda Referral

Action To Be Taken April 7, 2022
Regular Meeting of the CalOptima Board of Directors

Report Item

14. Approve CalOptima Position on Proposed Legislation

Contacts

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

Recommended Actions

1. Approve CalOptima's formal position on proposed Fiscal Year (FY) 2022–23 California state budget trailer bill language as follows:
    a. Alternative Health Care Services Plan (RN 22 08897): OPPOSE UNLESS AMENDED
2. Authorize the Chief Executive Officer (CEO), or designee, to implement legislative advocacy efforts in alignment with the approved CalOptima position.
3. Direct the CEO to collaborate with the County Executive Office of the County of Orange to request and secure an aligned position from the Orange County Board of Supervisors.

Background

On April 1, 2021, the Board of Directors (Board) adopted CalOptima's 2021–22 Legislative Priorities and Legislative Platform to help guide legislative advocacy efforts by staff. Subject to Board direction, these efforts may include advocating for or against legislation in the United States Congress and California State Legislature in alignment with CalOptima's 2020–22 Strategic Plan, 2021–22 Legislative Platform and/or other agency goals and policy priorities.

After the Governor's annual state budget proposal in January, executive departments release proposed trailer bill language containing statutory policy changes that support implementation of the proposed state budget. Subject to approval by the State Legislature, proposed trailer bill language may be included in the final trailer bills that accompany the enacted budget.

Discussion

On February 17, 2022, the California Department of Health Care Services (DHCS) released trailer bill language entitled Alternative Health Care Services Plan (RN 22 08897). The proposal would authorize DHCS to contract directly with Kaiser Permanente as a Medi-Cal managed care plan in any county. This would *de facto* terminate the County Organized Health System model by allowing an additional Medi-Cal plan to operate in Orange County. A CalOptima-specific fact sheet and the current text of the proposed trailer bill language are included as attachments. Given the potential negative impacts to CalOptima, its members and providers, staff recommends the Board formally adopt a position of *oppose unless amended (OUA)* to exempt County Organized Health Systems from the provisions of the proposed trailer bill language.

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Staff also recommends authorizing the CEO, or designee, to implement legislative advocacy efforts in alignment with the approved OUA position. These efforts may include executing letters expressing CalOptima's position to legislators or other government officials, meeting with such officials or their staff, and/or directing CalOptima's contracted lobbyists to advocate the approved position on behalf of CalOptima.

Lastly, staff recommends directing the CEO to collaborate with the County Executive Office of the County of Orange to facilitate consideration by the Orange County Board of Supervisors to adopt an aligned OUA position on the proposed trailer bill language. Along with CalOptima's state trade association Local Health Plans of California, several Medi-Cal managed care plans and counties across the state have already opposed the proposed trailer bill language. A list of opposed entities, as of March 27, is included as Attachment 3. Securing the joint OUA position of CalOptima and the County of Orange will help contribute to a united front, expand lobbying capabilities and may increase the likelihood of the proposal's modification or defeat.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
Educating stakeholders and engaging proactively with trade associations, advocates and elected officials is critical to influencing policy decisions that are likely to impact CalOptima. Based on discussions with CalOptima's contracted lobbyists and trade associations, staff recommends that CalOptima take a formal position on the referenced proposed trailer bill language.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. CalOptima Fact Sheet: No Bid-Statewide Medi-Cal Contract for Kaiser Proposal
2. Current Text of RN 22 08897 (published as of March 10, 2022)
3. List of Opposed Entities (as of March 27, 2022)

/s/ Michael Hunn — *03/31/2022*
Authorized Signature — **Date**

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No-Bid Statewide Medi-Cal Contract for Kaiser Proposal

Background

- In January, California introduced trailer bill legislation to authorize the Department of Health Care Services to contract with an Alternative Health Care Service Plan (AHCSP) for Medi-Cal. Kaiser is the only AHCSP in California. The proposed no-bid statewide contract would be effective January 1, 2024.
- Per the trailer bill, an AHCSP is a nonprofit health care plan with at least 4 million enrollees statewide, owns or operates pharmacies, and provides professional medical services to enrollees in specific geographic regions through an exclusive contract with a single medical group in each specific geographic region in which it is licensed.
- In Orange County, Kaiser currently cares for **54,000 CalOptima members** in a fully delegated contract with CalOptima.
- The proposal includes a commitment to grow Kaiser's Medi-Cal membership by at least 25%, including competing with local plans for Medi-Cal enrollment. It also limits Kaiser's enrollment to:
  - » Previous Kaiser enrollees
  - » Dual eligible for Medi-Cal and Medicare individuals
  - » Foster youth
- Kaiser Medi-Cal enrollment is allowed to expand into any areas Kaiser Permanente has commercial business, including areas where Kaiser does not currently participate in Medi-Cal.
- Contract is expected to result in nearly $5 billion of combined Medi-Cal and Medicare revenue for Kaiser.

Key Message Points

- As the AHCSP trailer bill represents a departure in the delivery of Medi-Cal services, CalOptima has taken a position regarding the proposal. While we respect our Kaiser colleagues and caregivers and recognize the quality care that they provide, CalOptima is disappointed in the state's proposal to directly contract with Kaiser Permanente through a no-bid process lacking transparency. Of particular concern are these issues:
  - » The direct contract with the state creates a two-tiered public health system. Tier 1 is run by a private "exclusive" plan that "cherry picks" the members it enrolls, opening and closing enrollment based on business goals. Tier 2 is the public and community health system through CalOptima, which accepts all eligible members at any time without barriers.
  - » Our doctors, hospitals, community clinics and other provider partners serve ALL Medi-Cal members in Orange County, including the most underserved and under-resourced members, by addressing medical and social determinants of health. Kaiser's exclusive enrollment policy that allows them to serve healthier members should not be rewarded with equal reimbursement. The high-risk members will need to be cared for by the community and safety net physicians, thereby destabilizing these providers. Kaiser's ability to cherry pick puts our safety net providers at risk and is detrimental to the public's health.
  - » CalOptima members have broad choice of providers across all of Orange County and can find access in every ZIP code. Kaiser's delivery system limits choice by both location and by number of providers in Orange County.

An act to add Section 14197.11 to the Welfare and Institutions Code, relating to Medi-Cal.

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 14197.11 is added to the Welfare and Institutions Code, to read:

14197.11. (a) Notwithstanding any other law, subject to subdivision (e), the department may enter into one or more comprehensive risk contracts with an alternate health care service plan (AHCSP) to serve as a primary Medi-Cal managed care plan for eligible beneficiaries described in subdivision (b) in geographic regions designated by the department pursuant to subdivision (c).

(b) The following beneficiary populations enrolling in Medi-Cal managed care shall be eligible to enroll, or chose to maintain their enrollment, in an AHCSP contracted with the department pursuant to subdivision (a):

(1) A beneficiary who was previously enrolled in the AHCSP as their primary Medi-Cal managed care plan on or before December 31, 2023.

(2) An existing member of the AHCSP who is transitioning into Medi-Cal managed care.

(3) A beneficiary who was a member of the AHCSP at any time during the 12 months immediately preceding the effective date of the beneficiary's Medi-Cal eligibility.

(4) A beneficiary with an AHCSP family linkage.

(5) A beneficiary who was previously enrolled in a primary Medi-Cal managed care plan other than the AHCSP on or before December 31, 2023, but who was assigned to and made the responsibility of the AHSCP under a subcontract with the Medi-Cal managed care plan.

(6) A dual eligible beneficiary residing in a geographic region approved by the department for purposes of this subdivision and for which the department has contracted with the AHCSP pursuant to subdivision (a).

(7) A beneficiary eligible on the basis of their receipt of services through a state foster care program or eligible pursuant to Section 14005.28 residing in a geographic region approved by the department for purposes of this subdivision and for which the department has contracted with the AHCSP pursuant to subdivision (a).

(c) Notwithstanding any other law, the department may contract with an AHCSP as a Medi-Cal managed care plan in any geographic region of the state for which federal approval is available and received pursuant to subdivision (e). To the extent permissible under federal law, the department may enter into either a single comprehensive risk contract for all geographic areas where the AHCSP is approved to operate as a Medi-Cal managed care plan or multiple contracts to serve the different geographic areas.

(d) Except where an AHCSP was already contracted with the department as a Medi-Cal managed care plan as of January 1, 2022, contracts entered into pursuant to subdivision (a) shall be effective no sooner than January 1, 2024.

(e) The department shall seek any federal approvals it deems necessary to implement this section. This section shall be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available and is not otherwise jeopardized.

(f) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret,

or make specific this section, in whole or in part, by means of plan letters or other similar instructions, without taking any further regulatory action.

(g) Notwithstanding any other law, contracts entered into or amended pursuant to this section shall be exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and the State Administrative Manual, and shall be exempt from the review or approval of any division of the Department of General Services.

(h) For purposes of this section, the following definitions shall apply:

(1) "Alternate health care service plan" means a nonprofit health care service plan with at least 4,000,000 enrollees statewide that owns or operates pharmacies and provides professional medical services to enrollees in specific geographic regions through an exclusive contract with a single medical group in each specific geographic region in which it is licensed.

(2) "AHCSP family linkage" includes when a beneficiary's parent, guardian, minor child, or minor sibling is enrolled in or has been enrolled in the AHCSP at any time during the 12 months immediately preceding the effective date of the beneficiary's Medi-Cal eligibility.

(3) "Comprehensive risk contract" has the same meaning as set forth in Section 438.2 of Title 42 of the Code of Federal Regulations.

(4) "Dual eligible beneficiary" has the same meaning as set forth in paragraph (1) of subdivision (f) of Section 14184.200.

(5) "Medi-Cal managed care plan" has the same meaning as set forth in subdivision (j) of Section 14184.101.

LEGISLATIVE COUNSEL'S DIGEST

Bill No.
as introduced, _____.
General Subject: Medi-Cal: alternate health care service plan.

Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services through various health care delivery systems, including managed care pursuant to Medi-Cal managed care plan contracts. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.

This bill would authorize the department to enter into one or more comprehensive risk contracts with an alternate health care service plan to serve as a primary Medi-Cal managed care plan for specified eligible beneficiaries in geographic regions designated by the department. The bill would authorize the department to contract with an alternate health care service plan as a Medi-Cal managed care plan in any geographic region of the state for which federal approval is available, as specified. The bill would authorize the department to implement those provisions by means of plan letters or other similar instructions. The bill would require the department to seek federal approval to implement those provisions and would condition the implementation of the provisions on that federal approval.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

List of Opposed Entities

As of March 27, 2022

Alternative Health Care Services Plan (RN 22 08897)	
Opposed Entity	**Date of Opposition**
Trade Associations	
Local Health Plans of California	3/8/22
Local Medi-Cal Plans	
Central California Alliance for Health	3/1/22
Inland Empire Health Plan	3/9/22
L.A. Care Health Plan	3/9/22
Counties	
Monterey	3/11/22
San Mateo	3/11/22
Santa Barbara	3/11/22
Santa Cruz	3/11/22
Sonoma	3/11/22
Ventura	3/11/22
Yolo	3/15/22
Mariposa	3/22/22
Santa Clara	3/22/22

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 7, 2022
Regular Meeting of the CalOptima Board of Directors

Report Item

15. Authorize Appropriation of Funds, Unbudgeted Expenditures and a Grant Agreement with the Coalition of Orange County Community Health Centers for Population Health and Value-Based Care Transformation

Contacts

Richard Pitts, D.O., Ph.D., Chief Medical Officer, (714) 246-8491
Yunkyung Kim, Chief Operating Officer, (714) 246-8408

Recommended Action(s)

1. Authorize the Chief Executive Officer to develop and execute a five (5) year Grant Agreement with the Coalition of Orange County Community Health Centers for Population Health and Value-Based Care Transformation for Medi-Cal members and Medi-Cal eligible individuals;
2. Appropriate funds and authorize unbudgeted expenditures in the amount of up to $50 million from existing reserves to fund the Grant Agreement with the Coalition of Orange County Community Health Centers; and
3. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima's mission and purpose.

Background and Discussion

CalOptima proposes to launch a five (5) year, $50 million initiative with community health centers to enhance access, quality, and further strengthen the safety net system across Orange County.

In Orange County, 29 community health center organizations provide care for over 250,000 CalOptima members. Community health centers form the backbone of the safety net system by providing care to underserved communities. They serve individuals with the most complex needs and the least resources, often acting as one-stop shops for physical, oral, and behavioral/mental health, and social and non-medical needs. They are also leaders in their communities, formed out of local needs, and continue to advocate for their patients and communities.

The Coalition of Orange County Community Health Centers (Coalition) is Orange County's membership organization for community health centers. The Coalition membership includes 26 of the 29 community health centers that provide care to CalOptima members.

CalOptima proposes to enter into a 5-year Population Health and Value-Based Care Transformation grant with the Coalition. The grant will support three domains of health center development:

1. Enhance and strengthen primary care safety net quality infrastructure;
2. Enhance and strengthen safety net primary care delivery systems; and
3. Enhance and strengthen processes for people who receive, provide and lead care at health centers and partner organizations to support the goals of high value care.

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Community health centers and their workforce reflect the communities they serve. They vary in terms of structure, capabilities, resources, and the patient populations they serve. In recognition of this diversity, the grant will allow each participating community health center to select the domain(s), change area(s), and the level of support needed. The Coalition will work with each health center – both member and non-members of the Coalition – to assess capabilities and needs and design a health center-specific implementation plan, outcome measures and targets, and evaluation plan.

Throughout this grant period, CalOptima expects to see demonstrable improvements in patient experience, health outcomes, and provider and care team satisfaction. Participating health centers will select and be measured on outcome measures that include, but are not limited to:

- Establish and maintain medical homes for select populations including individuals experiencing homelessness
- Improved and timely access to care and facilitation of care, including care that will improve chances for individuals to return to the workforce
- Reduced avoidable acute care and readmissions
- Participation in a health information exchange and data interoperability
- Improve quality of systems, processes, and overall performance

The grant will be structured to provide up to $10 million each year for 5 years. Funding distribution over the grant period is proposed as follows:

- 75% dedicated to direct support to health centers;
- 13% for programmatic support (i.e., professional services, technology, tools) for health centers; and
- 12% for Coalition staffing, grant administration, oversight, and reporting.

CalOptima will release Year 1 funding of $10 million upon execution of the grant agreement. Funding for Years 2 through 5 will be released annually upon submission of annual reports and satisfactory completion of annual performance targets. Staff request the Board to authorize the Chief Executive Officer to develop and execute a grant agreement with these parameters and requirements. CalOptima and the Coalition will launch the program upon execution of the grant agreement. Staff will report back to the Board the details of the grant agreement and will provide regular updates on implementation and outcomes.

CalOptima values the role of community health centers in ensuring care for our members and community. Staff will work with the Coalition and the health centers to identify opportunities for continued support and collaboration.

Fiscal Impact

The recommended action is unbudgeted. An appropriation of up to $50 million from existing reserves will fund the grant agreement for the five (5) year period.

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Rationale for Recommendation

Community health centers form the backbone of the safety net health system. The Population Health and Value-Based Care Transformation grant program will enhance access, quality, and further strengthen the safety net system across Orange County. Through this program, CalOptima seeks to ensure that the community health centers remain strong, quality partners in care for all CalOptima members.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

None

/s/ Michael Hunn *03/31/2022*
Authorized Signature **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 7, 2022
Regular Meeting of the CalOptima Board of Directors

Report Item

16. Authorize Appropriation of Funds from the Homeless Health Initiatives, and a Grant Agreement with the County of Orange to fund the Expansion of the Outreach and Engagement Team to Enhance to Facilitate Identification and Enrollment of Potential Medi-Cal Eligible Members

Contacts

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

Recommended Actions

1. Authorize expansion of the Board-approved homeless health initiative category "Residential support services and housing navigation" to "Residential support services, housing navigation, and outreach and engagement;
2. Authorize the Chief Executive Officer to develop and execute a Grant Agreement with the Orange County Health Care Agency (HCA) to commit up to $7 million from the restricted Homeless Health Initiatives Reserve to fund the expansion of the Outreach and Engagement Team to facilitate identification and enrollment of potential Medi-Cal eligible members; and
3. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima's mission and purpose.

Background and Discussion

In March of 2019, CalOptima's Board of Directors approved the launch of a clinical field team pilot program and the homeless response team in partnership with community health centers to mobilize doctors and medical assistants to provide urgent care services in the community.

In coordination with HCA, CalOptima staff recommends funding the expansion of the Outreach and Engagement (O&E) team that provides field-based access, treatment referrals, and support services for individuals experiencing homeless, or are at risk of homelessness, and have a mental health and/or substance use concern of any age in any city in Orange County.

The O&E team connects with unsheltered individuals through street outreach and at locations likely to be frequented by the population such as homeless serving providers. The team also connects with individuals in shelters and interim housing locations. Individuals can self-refer, be referred by community members, providers, law enforcement/first responders, or other outreach team. Referrals are received by calling the program's 800 line to arrange for a field response and to learn about resources for immediate assistance

Current outreach services are focused on ensuring linkage to ongoing mental health, substance use recovery, and support services through progressive engagement, case management, and addressing barriers. This expansion will allow O&E to address the physical needs of the population by integrating the street medicine team into services to ensure linkage, treatment, and engagement with a physical

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health provider. The expansion also allows for more collaboration, increased hours, and an expanded scope of services to effectively serve more individuals for improved health outcomes and well-being.

This action will fund three (3) teams that will work in conjunction with the Street Medicine and Clinical Field Teams to improve the community health of Orange County. Each team will be dedicated to a geographic target – Central Orange County, North Orange County, and South Orange County. Each team will be comprised of a behavioral health clinician and seven (7) to nine (9) outreach specialists and workers. The teams will have access to consultative services of a psychiatric nurse practitioner.

The program will use a tiered approach at start up to ensure staff and resource needs are met. Services will begin in Central Orange County and grow in the regional areas as staff are onboarded and resources acquired. BHS O&E existing staff will be used at the launch of the expansion to cover response services and extended hours in the first regional city until new staff are hired and trained.

Staff requests authority to develop and execute grant agreement with the above parameters. Program launch will begin upon execution of the grant agreement and in coordination with the implementation of the CalOptima street medicine program.

On June 27, 2019, the Board approved an allocation of $20 million within the restricted Homeless Health Initiatives Reserve to the category “Residential support services and housing navigation.” Staff requests the Board to expand this category to include outreach and engagement services.

Fiscal Impact

Upon Board approval, a commitment of up to $7 million from the expanded “Residential support services, housing navigation, and outreach and engagement” category will fund the grant agreement.

Rationale for Recommendation

The requested funding to expand the O&E services will ensure extended geographic and hours availability of field-based access, treatment referrals, and support services for CalOptima members experiencing homeless, are at risk of homelessness, and to facilitate identification and enrollment of potential Medi-Cal eligible members. The team developed under this grant agreement will provide a critical connection point for the CalOptima street medicine program, and will ensure continuity of services for individuals.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

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Attachments
None

/s/ Michael Hunn *03/31/2022*
Authorized Signature **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 7, 2022
Regular Meeting of the CalOptima Board of Directors

Report Item
17. Authorize Actions Related to CalAIM for Community Supports Services

Contact
Yunkyung Kim, Chief Operating Officer, (714) 246-8408

Recommended Actions
1. Authorize the Chief Executive Officer to execute contracts with any willing, qualified, and credentialed provider to provide Community Support Services pursuant to the effective dates approved by Department of Health Care Services (DHCS)
2. Authorize the Chief Executive Officer to execute an amendment to the contract with the County of Orange Health Care Agency to provide Community Supports Services

Background and Discussion
On November 4, 2021, the CalOptima Board of Directors approved CalOptima to execute contracts with providers who were currently engaged with the County of Orange Whole Person Care (WPC) program for the provision of Community Supports Services effective January 1, 2022. Those services included:
1. Housing Transition Navigation Services;
2. Housing Tenancy and Sustaining Services;
3. Housing Deposits; and
4. Recuperative Care (Medical Respite).

Following the initial launch staff informed the Board of Directors it would explore expanding the network of providers and Community Supports Services beyond those that were under the County's WPC Pilot Program. Several providers have expressed interest in contracting with CalOptima to provide the services listed above and staff believes the expansion of providers will allow our members to have an adequate network to receive these services.

Staff is also now prepared to expand CalOptima's CalAIM program to make the remaining DHCS pre-approved Community Supports Services available to eligible members on the following implementation schedule:

Effective July 1, 2022:
1. Short-Term Post-Hospitalization Housing: provides members the opportunity to enter short term housing for up to six months who do not have a residence after exiting inpatient hospital or residential recovery facilities psychiatric or substance use disorders.
2. Medically-Tailored Meals/Medically Supportive Food: allows meals to be delivered to members' homes tailored to meet their dietary needs for those with chronic diseases;
3. Sobering Centers: provides members, primarily those who are homeless or those with unstable living situations, with a safe, supportive environment to become sober up to a 24 hour period;
4. Personal Care/Homemaker Services: for members who need assistance with Activities of Daily Living (ADLs) and can also include assistance with meal preparation, grocery shopping, and money management;

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5. Day Habilitation Programs: assists members in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in the person's natural environment.

Effective January 1, 2023:

6. Respite Services: allows caregivers of members to have intermittent temporary relief of those persons normally providing the care;
7. Nursing Facility Transition for Elderly and Adult Residential Facilities: assists members when transitioning from a facility into a home-like setting to prevent future skilled nursing admissions;
8. Community Transition Services/Nursing Facility Transition to Home: assists members to live in the community and avoid further institutionalization;
9. Environmental Accessibility Adaptions (Home Modifications): physical adaptations to a home that are necessary to ensure better health conditions for members; and
10. Asthma Remediation: physical modifications to a home environment such as high filter vacuums, de-humidifiers, and air filters.

In addition, on December 20, 2021, the CalOptima Board of Directors approved the County of Orange Health Care Agency (HCA) to provide Enhanced Care Management (ECM) to members experiencing Severe Mental Illness (SMI) and Substance Use Disorders (SUD). Many of the members receiving ECM services from HCA will also benefit from Community Supports Services (Housing Transition Navigation Services, Housing Deposits, and Housing Tenancy and Sustainability Services, Recuperative Care, Medically-Tailored Meals/Medically Supportive Food, Day Habilitation, Nursing Facility Transition/Diversion to Assisted Living Facilities, Community Transition Services/Nursing Facility Transition to Home). Staff request authority to amend the contract with HCA to include provision of the above Community Support Services. Similar to other Community Support providers, HCA will seek prior authorizations, perform and oversee services, and bill to CalOptima.

CalOptima will ensure that all providers of Community Supports Services have the experience and training necessary to offer Community Supports Services and provide the services in a culturally and linguistically appropriate manner.

By way of the CEO's monthly report staff will keep the Board updated on the additional Community Support providers.

Fiscal Impact

The fiscal impact of the Community Supports Services in Fiscal Year (FY) 2022-23 is approximately $30 million. Management will include expenses associated with the Community Supports Services in the upcoming FY 2022-23 Operating Budget. DHCS will not provide CalOptima with funding for Community Supports Services. Instead, DHCS assumes decreased utilization in Medi-Cal covered services will sufficiently offset the additional costs for these services. Staff will monitor actual cost and utilization of these services as they are implemented, and as reliable data becomes available. To the extent there is any additional fiscal impact, staff will request funding through separate Board actions.

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Rationale for Recommendation

Authorizing the CEO to execute contracts with any willing, qualified, and credentialed providers of CalAIM Community Supports services will allow CalOptima to provide the full array of Community Support services to eligible members.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Entities Covered by this Recommended Board Action
2. DHCS Community Supports Policy Guide
3. Proposed Community Supports Base Agreement
4. Proposed Amendment to Contact with County of Orange Health Care Agency

/s/ Michael Hunn *03/31/2022*

Authorized Signature **Date**

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Attachment to the April 7, 2022 Board of Directors Meeting – Agenda 17

CONTRACTED/ IMPACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Medical Group	Address	City	State	Zip Code
Orange County Health Care Agency	N/A	405 W. 5th St.	Santa Ana	CA	92701

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State of California—Health and Human Services Agency
Department of Health Care Services

Michelle Baass
DIRECTOR

GAVIN NEWSOM
GOVERNOR

Medi-Cal Community Supports, or In Lieu of Services (ILOS), Policy Guide

December 2021

Table of Contents

I. Introduction to Community Supports (ILOS)

California Advancing and Innovating Medi-Cal (CalAIM), establishes the framework to address social determinants of health and improve health equity statewide. A key feature of CalAIM is the introduction of a menu of Community Supports, or in lieu of services (ILOS), in managed care.

What are Community Supports?

Community Supports are services or settings that MCPs may offer in place of services or settings covered under the California Medicaid State Plan and that are a medically appropriate, cost-effective alternative to a State Plan Covered Service. Community Supports are optional for MCPs to offer and for Members to utilize. MCPs may not require Members to use a Community Support instead of a service or setting listed in the Medicaid State Plan.

This Program Guide

Community Supports are a significant change and a high priority for DHCS. DHCS recognizes the work California MCPs and communities will be doing to operationalize these new initiatives under CalAIM and transition smoothly services provided under the Whole Person Care Pilots and Health Home Program even as they continue to address the COVID-19 Public Health Emergency.

Throughout 2021, DHCS is offering a range of technical assistance and support including detailed implementation requirements and guidance presented in this Program Guide. In addition, DHCS is making available materials posted on the DHCS CalAIM ECM and Community Supports website, webinars, non-binding Community Supports pricing information, and other opportunities for discussion to support the implementation of these initiatives. All information provided in this fact sheet is preliminary and subject to change. This Program Guide is for informational purposes and is not intended to replace future guidance and state and/or federal requirements.

For specific questions about Community Supports, please submit to: CalAIMECMILOS@dhcs.ca.gov. Questions about CalAIM generally should be submitted to: CalAIM@dhcs.ca.gov.

An FAQ which provides up-to-date information about the Community Supports implementation and will be updated regularly and is available from the Community Supports Resource Directory.

Requirements for Providing Community Supports

Pursuant to 42 CFR 438.3, MCPs may not provide Community Supports without first applying to the State and obtaining State approval to offer the Community Support by demonstrating all of the requirements will be met. MCPs may voluntarily agree to provide any service to a Member outside of an approved Community Supports construct; however, the cost of any such voluntary services may not be included in determining MCP rates.

Once approved by DHCS, the Community Support will be added to the MCP's contract and posted on the DHCS website as a State-Approved ILOS.

Community Supports may be offered by MCPs beginning January 1, 2022. Additional Community Supports may be added thereafter on a 6-month cadence.

II. What are Community Supports, or ILOS?

April 7, 2021

Introduction

CalAIM is a new initiative by the Department of Health Care Services (DHCS) to improve the quality of life and health outcomes of Medi-Cal beneficiaries by implementing broad delivery system, programmatic, and payment system reforms. A key feature of CalAIM is the introduction of a new menu of in lieu of services (ILOS), or Community Supports, which, at the option of a Medi-Cal managed care health plan (MCP) and a Member, can substitute for covered Medi-Cal services as cost-effective alternatives. MCPs will be responsible for administering Community Supports. For more information about CalAIM, see DHCS' Revised CalAIM Proposal released on 1/8/21.[1]

Overview of Community Supports

Community Supports are medically appropriate and cost-effective alternatives to services covered under the State Plan. Federal regulation allows states permit Medicaid managed care organizations to offer Community Supports as an option to Members.[2] Community Supports can substitute for and potentially decrease utilization of a range of covered Medi-Cal benefits, such as hospital care, nursing facility care, and emergency department (ED) use.

Community Supports are an important part of care delivery for Members enrolled in Enhanced Care Management (ECM), another CalAIM initiative that will address the clinical and non-clinical needs of high-need, high-cost Medi-Cal Members through systematic coordination of services and comprehensive care management.[3] As such, DHCS encourages MCPs to offer a robust menu of 14 pre-approved Community Supports to comprehensively address the needs of Members—including those with the most complex challenges affecting health such as homelessness, unstable and unsafe housing, food insecurity, and/or other social needs.

By design, the list of pre-approved Community Supports are drawn in part from the foundational work done as part of the Whole Person Care (WPC) Pilots and Health Home Program (HHP). A key goal of Community Supports is to allow Members to obtain care in the least restrictive setting possible and to keep them in the community as medically appropriate. Community Supports will build on WPC and HHP efforts and activities and expand access to services that were previously available only through home and community-based services initiatives while addressing health-related social needs.

MCPs will have the opportunity to provide details on their elected Community Supports to DHCS as part of their Model of Care (MOC) responses to DHCS. MCPs in all Counties are encouraged to offer one or more of the following Community Supports starting on January 1, 2022:[4]

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[1] Revised CalAIM Proposal, January 2021.
[2] 42 CFR 438.3(e)(2).
[3] ECM Fact Sheet
[4] See the Community Supports Service Descriptions for more detail about each Community Support option.

- Housing Transition Navigation Services;
- Housing Deposits;
- Housing Tenancy and Sustaining Services;
- Short-Term Post-Hospitalization Housing;
- Recuperative Care (Medical Respite);
- Respite Services;
- Day Habilitation Programs;
- Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for the Elderly (RCFE) and Adult Residential Facilities (ARF);
- Community Transition Services/Nursing Facility Transition to a Home;
- Personal Care and Homemaker Services;
- Environmental Accessibility Adaptations (Home Modifications);
- Medically-Supportive Food/Meals/Medically Tailored Meals;
- Sobering Centers; and
- Asthma Remediation.

Community Supports are Optional, but Strongly Encouraged

MCPs are strongly encouraged to elect to offer some or all of these pre-approved Community Supports and are expected to detail their Community Supports offerings in their MOC. As part of the MOC response, MCPs will describe which Community Supports they will offer, the date each elected Community Support is expected to launch, and the MCP's plans for operationalizing the Community Support including the Community Support provider network. DHCS expects that MCPs in WPC and HHP counties will offer the pre-approved Community Supports that correspond to the services previously offered through those programs to ensure a seamless transition for those Members. MCPs may propose additional Community Supports to DHCS for review and approval. MCPs may choose to offer different Community Supports in different Counties. MCPs may add or remove Community Supports at defined intervals: every six (6) months for an addition and annually for removal of a previously offered Community Support.

Community Supports Implementation Timeline

MCPs in all Counties may launch pre-approved Community Supports beginning January 1, 2022. DHCS strongly encourages all MCPs to begin offering Community Supports at this time. The timely offering of Community Supports will help to improve care for Members, support the goals of CalAIM, and contribute to the smooth transition of Members receiving services through WPC Pilots into Medi-Cal managed care.

III. Community Supports – Service Definitions

Community Supports are alternative services covered under the Medi-Cal State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. Community Supports can only be covered if: 1) the State determines they are medically-appropriate and cost-effective substitutes or settings for the State Plan service, 2) Members are not required to use the Community Supports and 3) the Community Supports are authorized and identified in the managed care plan contracts.

Each set of pre-approved services is described in detail below:

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-Term Post-Hospitalization Housing
- Recuperative Care (Medical Respite)
- Respite Services
- Day Habilitation Programs
- Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly (RCFE) and Adult Residential Facilities (ARF)
- Community Transition Services/Nursing Facility Transition to a Home
- Personal Care and Homemaker Services
- Environmental Accessibility Adaptations (Home Modifications)
- Medically-Supportive Food/Meals/Medically Tailored Meals
- Sobering Centers
- Asthma Remediation

Housing Transition Navigation Services

Description/Overview

Housing transition services assist Members with obtaining housing and include:

1. Conducting a tenant screening and housing assessment that identifies the member's preferences and barriers related to successful tenancy. The assessment may include collecting information on the member's housing needs, potential housing transition barriers, and identification of housing retention barriers.
2. Developing an individualized housing support plan based upon the housing assessment that addresses identified barriers, includes short- and long-term measurable goals for each issue, establishes the member's approach to meeting the goal, and identifies when other providers or services, both reimbursed and not reimbursed by Medi-Cal, may be required to meet the goal.
3. Searching for housing and presenting options.
4. Assisting in securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).
5. Assisting with benefits advocacy, including assistance with obtaining identification and documentation for SSI eligibility and supporting the SSI application process. Such service can be subcontracted out to retain needed specialized skillset.
6. Identifying and securing available resources to assist with subsidizing rent (such as HUD's Housing Choice Voucher Program (Section 8), or state and local assistance programs) and matching available rental subsidy resources to Members.
7. Identifying and securing resources to cover expenses, such as security deposit, moving costs, adaptive aids, environmental modifications, moving costs, and other one-time expenses.[5]
8. Assisting with requests for reasonable accommodation, if necessary.[6]
9. Landlord education and engagement
10. Ensuring that the living environment is safe and ready for move-in.
11. Communicating and advocating on behalf of the Member with landlords.

[5] Actual payment of these housing deposits and move-in expenses is a separate in-lieu service underHousing Deposits.

[6] Related to expenses incurred by the housing navigator supporting the member moving into the home

12. Assisting in arranging for and supporting the details of the move.
13. Establishing procedures and contacts to retain housing, including developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized.[7]
14. Identifying, coordinating, securing, or funding non-emergency, non-medical transportation to assist Members' mobility to ensure reasonable accommodations and access to housing options prior to transition and on move in day.
15. Identifying, coordinating, securing, or funding environmental modifications to install necessary accommodations for accessibility (see Environmental Accessibility Adaptations Community Support).

The services provided should be based on individualized assessment of needs and documented in the individualized housing support plan. Members may require and access only a subset of the services listed above.

The services provided should utilize best practices for Members who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions. Examples of best practices include Housing First Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma-Informed Care.

The services may involve additional coordination with other entities to ensure the individual has access to supports needed for successful tenancy. These entities may include County Health, Public Health, Substance Use, Mental Health and Social Services Departments; County and City Housing Authorities; Continuums of Care and Coordinated Entry System; Sheriff's Department and Probation Officers, as applicable and to the extent possible; local legal service programs, community-based organizations housing providers, local housing agencies, and housing development agencies. For Members who will need rental subsidy support to secure permanent housing, the services will require close coordination with local Coordinated Entry Systems, homeless services authorities, public housing authorities, and other operators of local rental subsidies. Some housing assistance (including recovery residences and emergency assistance or rental subsidies for Full Service Partnership Members) is also funded by county behavioral health agencies, and Medi-Cal managed care plans and their contracted Community Supports providers should expect to coordinate access to these housing resources through county behavioral health when appropriate.

Final program guidelines should adopt, as a standard, the demonstrated need to ensure seamless service to Members experiencing homelessness entering the Housing Transition Navigation Services Community Support.

[7] The services associated with the crisis plan are a separate in-lieu service under Housing Tenancy and Sustaining Services.

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Services do not include the provision of room and board or payment of rental costs. Coordination with local entities is crucial to ensure that available options for room and board or rental payments are also coordinated with housing services and supports.

Eligibility (Population Subset)

- Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable individuals with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services as a result of a substance use disorder and/or is exiting incarceration; or
- Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institutions for Mental Disease, and State Hospitals; or
- Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:
    - (1) An individual or family who:
        - Has an annual income below 30 percent of median family income for the area, as determined by HUD;
        - Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the “Homeless” definition in this section; and
            - Meets one of the following conditions:
                - Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;
                - Is living in the home of another because of economic hardship;
                - Has been notified in writing that their right to occupy their current housing or living situation will be

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terminated within 21 days after the date of application for assistance;

- Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;
- Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;
- Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or
- Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;

- (2) A child or youth who does not qualify as “homeless” under this section, but qualifies as “homeless” under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or
- (3) A child or youth who does not qualify as “homeless” under this section, but qualifies as “homeless” under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him.

Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Housing Transition Navigation services if they have significant barriers to housing stability and meet at least one of the following:

- Have one or more serious chronic conditions;
- Have a Serious Mental Illness;
- Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder o Have a Serious Emotional Disturbance (children and adolescents);

- Are receiving Enhanced Care Management; or
- Are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking or domestic violence.

Restrictions and Limitations

Housing Transition/Navigation services must be identified as reasonable and necessary in the individual's individualized housing support plan. Service duration can be as long as necessary.

Individuals may not be receiving duplicative support from other State, local tax, or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contractwith, but it is not an exhaustive list of providers who may offer the services.

Providers must have demonstrated experience with providing housing-related services and supports and may include providers such as:

- Vocational services agencies;
- Providers of services for individuals experiencing homelessness;
- Life skills training and education providers;
- County agencies;
- Public hospital systems;
- Mental health or substance use disorder treatment providers, including county behavioral health agencies;
- Social services agencies;
- Affordable housing providers;
- Supportive housing providers; and
- Federally qualified health centers and rural health clinics.

Medi-Cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is

no state-level enrollment pathway, managed care plans must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be an Community Supports Provider. Members who meet the eligibility requirements for Housing Transition/Navigation services should also be assessed for enhanced care management and Housing and Tenancy Support Services (if provided in their county). When enrolled in enhanced care management, Community Supports should be managed in coordination with enhanced care management providers. When members receive more than one of these services, the managed care plan should ensure it is coordinated by an enhanced care management provider whenever possible to minimize the number of care/case management transitions experienced by members and to improve overall care coordination and management.[8]

If the Medi-Cal managed care plan case manager, care coordinator or housing navigator is providing the service, that individual must have demonstrated experience working with individuals experiencing homelessness or with the provision of housing-related services and supports to vulnerable populations.

State Plan Service(s) that are likely to be Avoided

Examples of State Plan services that have the potential to be avoided if a Member receives Community Support services, include but are not limited to inpatient and outpatient Hospital services, emergency department services, emergency transport services, and skilled nursing facility services.

[8] One exception to this is for benefits advocacy, which may require providers with a specialized skill set.

Housing Deposits

Description/Overview

Housing Deposits assist with identifying, coordinating, securing, or funding one-time services and modifications necessary to enable a person to establish a basic household that do not constitute room and board, such as:

1. Security deposits required to obtain a lease on an apartment or home.
2. Set-up fees/deposits for utilities or service access and utility arrearages.
3. First month coverage of utilities, including but not limited to telephone, gas, electricity, heating, and water.
4. First month's and last month's rent as required by landlord for occupancy.
5. Services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy.
6. Goods such as an air conditioner or heater, and other medically-necessary adaptive aids and services, designed to preserve an individuals' health and safety in the home such as hospital beds, Hoyer lifts, air filters, specialized cleaning or pest control supplies etc., that are necessary to ensure access and safety for the individual upon move-in to the home.

The services provided should be based on individualized assessment of needs and documented in the individualized housing support plan. Individuals may require, and access only a subset of the services listed above.

The services provided should utilize best practices for Members who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma-Informed Care.

Services do not include the provision of room and board or payment of ongoing rental costs beyond the first and last month's coverage as noted above.

Eligibility (Population Subset)

- Any individual who received Housing Transition/Navigation Services Community Support in counties that offer Housing Transition/Navigation Services.
- Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable individuals with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services as a result of a substance use disorder and/or is exiting incarceration; or

- Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals.

Restrictions and Limitations

Housing Deposits are available once in an individual's lifetime. Housing Deposits can only be approved one additional time with documentation as to what conditions have changed to demonstrate why providing Housing Deposits would be more successful on the second attempt. Plans are expected to make a good faith effort to review information available to them to determine if individual has previously received services.

These services must be identified as reasonable and necessary in the individual's individualized housing support plan and are available only when the Member is unable to meet such expense.

Individuals must also receive Housing Transition/Navigation services (at a minimum, the associated tenant screening, housing assessment and individualized housing support plan) in conjunction with this service.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing and Allowable Providers

Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

The entity that is coordinating an individual's Housing Transition Navigation Services, or the Medi-Cal managed care plan case manager, care coordinator, or housing navigator may coordinate these services and pay for them directly (e.g., to the landlord, utility company, pest control company, etc.) or subcontract the services.

Providers must have demonstrated or verifiable experience and expertise with providing these unique services.

Medi-Cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs including Provider

Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, managed care plans must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

State Plan Service(s) that are likely to be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, emergency department services, emergency transport services, and skilled nursing facility services.

Housing Tenancy and Sustaining Services

Description/Overview

This service provides tenancy and sustaining services, with a goal of maintaining safe and stable tenancy once housing is secured.

Services include:

1. Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment, hoarding, substance use, and other lease violations.
2. Education and training on the role, rights, and responsibilities of the tenant and landlord.
3. Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy.
4. Coordination with the landlord and case management provider to address identified issues that could impact housing stability.
5. Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action including developing a repayment plan or identifying funding in situations in which the Member owes back rent or payment for damage to the unit.
6. Advocacy and linkage with community resources to prevent eviction when housing is or may potentially become jeopardized.
7. Assisting with benefits advocacy, including assistance with obtaining identification and documentation for SSI eligibility and supporting the SSI application process. Such service can be subcontracted out to retain needed specialized skillset.
8. Assistance with the annual housing recertification process.
9. Coordinating with the tenant to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers.
10. Continuing assistance with lease compliance, including ongoing support with activities related to household management.
11. Health and safety visits, including unit habitability inspections[9].
12. Other prevention and early intervention services identified in the crisis plan that are activated when housing is jeopardized (e.g., assisting with reasonable accommodation requests that were not initially required upon move-in).

[9] Does not include housing quality inspections.

13. Providing independent living and life skills including assistance with and training on budgeting, including financial literacy and connection to community resources.

The services provided should be based on individualized assessment of needs and documented in the individualized housing support plan. Individuals may require and access only a subset of the services listed above.

The services provided should utilize best practices for Members who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma-Informed Care.

The services may involve coordination with other entities to ensure the individual has access to supports needed to maintain successful tenancy. Final program guidelines should adopt, as a standard, the demonstrated need to ensure seamless serving to Members experiencing homelessness entering the Housing Tenancy and Sustaining Services Community Support.

Services do not include the provision of room and board or payment of rental costs.

Eligibility (Population Subset)

- Any individual who received Housing Transition/Navigation Services Community Support in counties that offer Housing Transition/Navigation Services.
- Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable individuals with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services as a result of a substance use disorder and/or is exiting incarceration; or
- Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals; or
- Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:
    - (1) An individual or family who:
        - Has an annual income below 30 percent of median family income for the

area, as determined by HUD;

- Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the “Homeless” definition in this section; and

    - Meets one of the following conditions:

        - Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;

        - Is living in the home of another because of economic hardship;

        - Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance;

    - Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;

    - Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;

    - Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or

    - Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;

- (2) A child or youth who does not qualify as “homeless” under this section, but qualifies as “homeless” under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of

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the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or

- (3) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him.

Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Housing Tenancy and Sustaining services if they have significant barriers to housing stability and meet at least one of the following:

- Have one or more serious chronic conditions;
- Have a Serious Mental Illness;
- Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder o Have a Serious Emotional Disturbance (children and adolescents);
- Are receiving Enhanced Care Management; or
- Are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking or domestic violence.

Restrictions/Limitations

These services are available from the initiation of services through the time when the individual's housing support plan determines they are no longer needed. They are only available for a single duration in the individual's lifetime. Housing Tenancy and Sustaining Services can be approved one additional time with documentation as to what conditions have changed to demonstrate why providing Housing Tenancy and Sustaining Services would be more successful on the second attempt. Plans are expected to make a good faith effort to review information available to them to determine if individual has previously received services. Service duration can be as long as necessary.

These services must be identified as reasonable and necessary in the individual's individualized housing support plan and are available only when the enrollee is unable to successfully maintain longer-term housing without such assistance.

Many individuals will have also received Housing Transition/Navigation services (at a minimum, the associated tenant screening, housing assessment, and individualized housing support plan) in conjunction with this service, but it is not a prerequisite for eligibility.

Individuals may not be receiving duplicative support from other State, local, or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

Providers must have demonstrated or verifiable experience or expertise with providing housing-related services and supports and may include providers such as:

- Vocational services agencies
- Providers of services for individuals experiencing homelessness
- Life skills training and education providers
- County agencies
- Public hospital systems
- Mental health or substance use disorder treatment providers, including county behavioral health agencies
- Supportive housing providers
- Federally qualified health centers and rural health clinics

Medi-Cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, managed care plans must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

If the Medi-Cal managed care plan case manager, care coordinator or housing navigator is providing the service, that individual must have demonstrated experiencing working with individuals experiencing homelessness or with the provision of housing-related services and supports to vulnerable populations. Medi-Cal managed care plans should coordinate with county homelessness entities to provide these services.

Members who meet the eligibility requirements for Housing and Tenancy Support Services should also be assessed for enhanced care management and may have received Housing Transition/Navigation services (if provided in their county). When enrolled in enhanced care management, Community Supports should be managed in coordination with enhanced care management providers. When Members receive more

than one of these services, the managed care plan should ensure coordination by an enhanced care management provider whenever possible to minimize the number of care/case management transitions experienced by Members and to improve overall care coordination and management.

State Plan Service(s) that are likely to be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, emergency department services, emergency transport services, and skilled nursing facility services.

Short-Term Post-Hospitalization Housing

Description/Overview

Short-Term Post-Hospitalization housing provides Members who do not have a residence and who have high medical or behavioral health needs with the opportunity to continue their medical/psychiatric/substance use disorder recovery immediately after exiting an inpatient hospital (either acute or psychiatric or Chemical Dependency and Recovery hospital), residential substance use disorder treatment or recovery facility, residential mental health treatment facility, correctional facility, nursing facility, or recuperative care and avoid further utilization of State plan services.[10]

This setting must provide individuals with ongoing supports necessary for recuperation and recovery such as gaining (or regaining) the ability to perform activities of daily living, receiving necessary medical/psychiatric/substance use disorder care, case management, and beginning to access other housing supports such as Housing Transition Navigation.[11]

This setting may include an individual or shared interim housing setting, where residents receive the services described above.

Members must be offered Housing Transition Navigation supports during the period of Short-Term Post-Hospitalization housing to prepare them for transition from this setting. These services should include a housing assessment and the development of individualized housing support plan to identify preferences and barriers related to successful housing tenancy after Short-Term Post-Hospitalization housing.[12]

The services provided should utilize best practices for Members who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma-Informed Care.

Eligibility (Population Subset)

- Individuals exiting recuperative care.
- Individuals exiting an inpatient hospital stay (either acute or psychiatric or Chemical Dependency and Recovery hospital), residential substance use disorder treatment or recovery facility, residential mental health treatment facility, correctional facility, or nursing facility and who meet any of the following criteria:
- Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of

[10] Up to 90 days of recuperative care is available under specified circumstances as a separate in-lieu of service.
[11] Housing Transition/Navigation is a separate in-lieu of service.
[12] The development of a housing assessment and individualized support plan are covered as a separate in-lieu service under Housing Transition/Navigation Services.

days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals;

- Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:
    - (1) An individual or family who:
        - Has an annual income below 30 percent of median family income for the area, as determined by HUD;
        - Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the "Homeless" definition in this section; and
            - Meets one of the following conditions:
                - Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;
                - Is living in the home of another because of economic hardship;
                - Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance;
            - Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;
            - Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;
            - Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or

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institution); or

- Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;

- (2) A child or youth who does not qualify as “homeless” under this section, but qualifies as “homeless” under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or

- (3) A child or youth who does not qualify as “homeless” under this section, but qualifies as “homeless” under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him.

Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Short-Term Post-Hospitalization services if they have significant barriers to housing stability and meet at least one of the following:

- Have one or more serious chronic conditions;

- Have a Serious Mental Illness;

- Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder o Have a Serious Emotional Disturbance (children and adolescents);

- Are receiving Enhanced Care Management; or

- Are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking or domestic violence.

In addition to meeting one of these criteria at a minimum, individuals must have medical/behavioral health needs such that experiencing homelessness upon discharge from the hospital, substance use or mental health treatment facility, correctional facility, nursing facility, or recuperative care would likely result in hospitalization, re-hospitalization, or institutional readmission.

Restrictions/Limitations

Short-Term Post-Hospitalization services are available once in an individual's lifetime and are not to exceed a duration of six (6) months (but may be authorized for a shorter period based on individual needs). Plans are expected to make a good faith effort to review information available to them to determine if individual has previously received services.

The service is only available if enrollee is unable to meet such an expense.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. The below list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with but is not an exhaustive list of providers who may offer the services.

- Interim housing facilities with additional on-site support
- Shelter beds with additional on-site support
- Converted homes with additional on-site support
- County directly operated or contracted recuperative care facilities
- Supportive Housing providers
- County agencies
- Public Hospital Systems
- Social service agencies
- Providers of services for individuals experiencing homelessness

Facilities may be unlicensed. Medi-Cal managed care plans must apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. Managed care plans can adopt or adapt local or national standards for short-term post-hospitalization housing. Medi-Cal managed care plans shall monitor the provision of all the services included above.

Medi-Cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, managed care plans must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

State Plan Service(s) that are likely to be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, emergency department services, emergency transport services, and skilled nursing facility services.

Recuperative Care (Medical Respite)

Description/Overview

Recuperative care, also referred to as medical respite care, is short-term residential care for individuals who no longer require hospitalization, but still need to heal from an injury or illness (including behavioral health conditions) and whose condition would be exacerbated by an unstable living environment. An extended stay in a recovery care setting allows individuals to continue their recovery and receive post-discharge treatment while obtaining access to primary care, behavioral health services, case management and other supportive social services, suchas transportation, food, and housing.

At a minimum, the service will include interim housing with a bed and meals and ongoing monitoring of the individual's ongoing medical or behavioral health condition (e.g., monitoring of vital signs, assessments, wound care, medication monitoring). Based on individual needs, the service may also include:

1. Limited or short-term assistance with Instrumental Activities of Daily Living &/or ADLs
2. Coordination of transportation to post-discharge appointments
3. Connection to any other on-going services an individual may require including mental health and substance use disorder services
4. Support in accessing benefits and housing
5. Gaining stability with case management relationships and programs

Recuperative care is primarily used for those individuals who are experiencing homelessness or those with unstable living situations who are too ill or frail to recover from an illness (physical or behavioral health) or injury in their usual living environment; but are not otherwise ill enough to be in a hospital.

The services provided to an individual while in recuperative care should not replace or be duplicative of the services provided to members utilizing the enhanced care management program. Recuperative Care may be utilized in conjunction with other housing Community Supports. Whenever possible, other available housing Community Supports should be provided to Members onsite in the recuperative care facility. When enrolled in enhanced care management, Community Supports should be managed in coordination with enhanced care management providers.

The services provided should utilize best practices for Members who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma-Informed Care.

Eligibility (Population Subset)

- Individuals who are at risk of hospitalization or are post-hospitalization, and
- Individuals who live alone with no formal supports; or
- Individuals who face housing insecurity or have housing that would jeopardize their health and safety without modification. [13]
- Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals;
- Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:
    - (1) An individual or family who:
        - Has an annual income below 30 percent of median family income for the area, as determined by HUD;
        - Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the “Homeless” definition in this section; and
            - Meets one of the following conditions:
                - Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;
                - Is living in the home of another because of economic hardship;
                - Has been notified in writing that their right to occupy their current housing or living situation will be

[13] For this population, the service could be coordinated with home modifications (which are covered as a separate Community Support) and serve as a temporary placement until the Member can safely return home.

terminated within 21 days after the date of application for assistance;

- Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;
- Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;
- Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or
- Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;

- (2) A child or youth who does not qualify as “homeless” under this section, but qualifies as “homeless” under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or
- (3) A child or youth who does not qualify as “homeless” under this section, but qualifies as “homeless” under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him.

Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Recuperative Care services if they have significant barriers to housing stability and meet at least one of the following:

- Have one or more serious chronic conditions;
- Have a Serious Mental Illness;
- Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder o Have a Serious Emotional Disturbance (children and adolescents);

- Are receiving Enhanced Care Management; or
- Are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking or domestic violence.

Restrictions/Limitations

Recuperative care/medical respite is an allowable Community Supports service if it is 1) necessary to achieve or maintain medical stability and prevent hospital admission or re-admission, which may require behavioral health interventions, 2) not more than 90 days in continuous duration, and 3) does not include funding for building modification or building rehabilitation.

Individuals may not be receiving duplicative support from other State, local, or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Interim housing facilities with additional on-site support
- Shelter beds with additional on-site support
- Converted homes with additional on-site support
- County directly operated or contracted recuperative care facilities

Facilities are unlicensed. Medi-Cal managed care plans must apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. Managed care plans can adopt or adapt local or national standards for recuperative care or interim housing. Managed care plans shall monitor the provision of all the services included above.

Medi-Cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, managed care plans must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

State Plan Service(s) that are likely to be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, skilled nursing facility, and emergency department services.

Respite Services

Description/Overview

Respite services are provided to caregivers of Members who require intermittent temporary supervision. The services are provided on a short-term basis because of the absence or need for relief of those persons who normally care for and/or supervise them and are non-medical in nature. This service is distinct from medical respite/recuperative care and is rest for the caregiver only.

Respite services can include any of the following:

1. Services provided by the hour on an episodic basis because of the absence of or need for relief for those persons normally providing the care to individuals.
2. Services provided by the day/overnight on a short-term basis because of the absence of or need for relief for those persons normally providing the care to individuals.
3. Services that attend to the Member's basic self-help needs and other activities of daily living, including interaction, socialization and continuation of usual daily routinesthat would ordinarily be performed by those persons who normally care for and/or supervise them.

Home Respite services are provided to the Member in his or her own home or another location being used as the home.

Facility Respite services are provided in an approved out-of-home location.

Respite should be made available when it is useful and necessary to maintain a person in their own home and to preempt caregiver burnout to avoid institutional services for which the Medi-Cal managed care plan is responsible.

Eligibility (Population Subset)

Individuals who live in the community and are compromised in their Activities of Daily Living (ADLs) and are therefore dependent upon a qualified caregiver who provides most of their support, and who require caregiver relief to avoid institutional placement.

Other subsets may include children who previously were covered for Respite Services under the Pediatrics Palliative Care Waiver, foster care program beneficiaries, Members enrolled in California Children's Services, and Genetically Handicapped Persons Program (GHPP), and Members with Complex Care Needs.

Restrictions/Limitations

In the home setting, these services, in combination with any direct care services the Member is receiving, may not exceed 24 hours per day of care.

Service limit is up to 336 hours per calendar year. The service is inclusive of all in-home and in-facility services. Exceptions to the 336 hour per calendar year limit can be made, with Medi-Cal managed care plan authorization, when the caregiver experiences an episode, including medical treatment and hospitalization that leaves a Medicaid member without their caregiver. Respite support provided during these episodes can be excluded from the 336-hour annual limit.

This service is only to avoid placements for which the Medi-Cal managed care plan would be responsible.

Individuals may not be receiving duplicative support from other State, local, or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Home health or respite agencies to provide services in:
  - Private residence
  - Residential facility approved by the State, such as, Congregate Living HealthFacilities (CLHFs)
  - Providers contracted by county behavioral health

Other community settings that are not a private residence, such as:

- Adult Family Home/Family Teaching Home
- Certified Family Homes for Children
- County Agencies
- Residential Care Facility for the Elderly (RCFE)
- Child Day Care Facility; Child Day Care Center; Family Child Care Home
- Respite Facility; Residential Facility: Small Family Homes (Children Only)
- Respite Facility; Residential Facility: Foster Family Agency (FFA)-Certified Family Homes (Children Only)
- Respite Facility; Residential Facility: Adult Residential Facilities (ARF)
- Respite Facility; Residential Facility: Group Homes (Children Only)
- Respite Facility; Residential Facility: Family Home Agency (FHA): Adult Family Home (AFH)/Family Teaching Home (FTH)

- Respite Facility; Residential Facility: Adult Residential Facility for Persons with Special Health Care Needs
- Respite Facility; Residential Facility: Foster Family Homes (FFHs) (Children Only)
- Short-term Residential Therapeutic Program Providers or other care providers who are serving youth with complex needs

Medi-Cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, managed care plans must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

State Plan Service(s) that are likely to be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, emergency department services, and skilled nursing or other institutional care.

Day Habilitation Programs

Description/Overview

Day Habilitation Programs are provided in a Member's home or an out-of-home, non-facility setting. The programs are designed to assist the Member in acquiring, retaining,and improving self-help, socialization, and adaptive skills necessary to reside successfully in the person's natural environment. The services are often considered as peer mentoring when provided by an unlicensed caregiver with the necessary training and supervision. For Members experiencing homelessness who are receiving enhanced care management or other Community Supports, day habilitation programs can provide a physical location for Members to meet with and engage with these providers. When possible, these services should be provided by the same entity to minimize the number of care/case management transitions experienced by Members and to improve overall care coordination and management.

Day Habilitation Program services include, but are not limited to, training on:

1. The use of public transportation;
2. Personal skills development in conflict resolution;
3. Community participation;
4. Developing and maintaining interpersonal relationships;
5. Daily living skills (cooking, cleaning, shopping, money management); and,
6. Community resource awareness such as police, fire, or local services to support independence in the community.

Programs may include assistance with, but not limited to, the following:

1. Selecting and moving into a home;[14]
2. Locating and choosing suitable housemates;
3. Locating household furnishings;
4. Settling disputes with landlords;[15]
5. Managing personal financial affairs;
6. Recruiting, screening, hiring, training, supervising, and dismissing personal attendants;
7. Dealing with and responding appropriately to governmental agencies and personnel;
8. Asserting civil and statutory rights through self-advocacy;

[14] Refer to the Housing Transition/Navigation Services Community Support
[15] Refer to the Housing- Tenancy and Sustaining Services Community Support

9. Building and maintaining interpersonal relationships, including a circle of support;
10. Coordination with Medi-Cal managed care plan to link Member to any Community Supports and/or enhanced care management services for which the Member may be eligible;
11. Referral to non-Community Supports housing resources if Member does not meet Housing Transition/Navigation Services Community Support eligibility criteria;
12. Assistance with income and benefits advocacy including General Assistance/ General Relief and SSI if Member is not receiving these services through Community Supports or Enhanced Care Management; and
13. Coordination with Medi-Cal managed care plan to link Member to health care, mental health services, and substance use disorder services based on the individual needs of the Member for Members who are not receiving this linkage through Community Supports or enhanced care management.

The services provided should utilize best practices for Members who are experiencing homelessness or formerly experienced homelessness including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma-Informed Care.

Program services are available for as long as necessary. Services can be provided continuously, or through intermittent meetings, in an individual or group setting.

Eligibility (Population Subset)

Individuals who are experiencing homelessness, individuals who exited homelessness and entered housing in the last 24 months, and individuals at risk of homelessness or institutionalization whose housing stability could be improved through participation in a day habilitation program.

Restrictions/Limitations

Individuals may not be receiving duplicative support from other State, local, or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Mental health or substance use disorder treatment providers, including county behavioral health agencies
- Licensed Psychologists

- Licensed Certified Social Workers
- Registered Nurses
- Home Health Agencies
- Professional Fiduciary
- Vocational Skills Agencies

Medi-Cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, managed care plans must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

State Plan Service(s) that are likely to be Avoided

Examples of State Plan services to be avoided include but are not limited to: Inpatient and outpatient hospital services, skilled nursing facility, emergency department services.

Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly and Adult Residential Facilities

Description/Overview

Nursing Facility Transition/Diversion services assist individuals to live in the community and/or avoid institutionalization when possible.

The goal is to both facilitate nursing facility transition back into a home-like, community setting and/or prevent skilled nursing admissions for Members with an imminent need for nursing facility level of care (LOC). Individuals have a choice of residing in an assisted living setting as an alternative to long-term placement in a nursing facility when they meet eligibility requirements.

The assisted living provider is responsible for meeting the needs of the Member, including Activities of Daily Living (ADLs), Instrumental ADLs (IADLs), meals, transportation, and medication administration, as needed.

For individuals who are transitioning from a licensed health care facility to a living arrangement in a Residential Care Facilities for Elderly (RCFE) and Adult Residential Facilities (ARF). Includes wrap-around services, including: assistance w/ ADLs and IADLs as needed, companion services, medication oversight, and therapeutic social and recreational programming provided in a home-like environment. Includes 24-hour direct care staff on-site to meet scheduled unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety, and security. Allowable expenses are those necessary to enable a person to establish a community facility residence (except room and board), including, but not limited to:

1. Assessing the Member's housing needs and presenting options.[16]
2. Assessing the service needs of the Member to determine if the Member needs enhanced onsite services at the RCFE/ARF so the Member can be safely and stably housed in an RCFE/ARF.
3. Assisting in securing a facility residence, including the completion of facility applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).
4. Communicating with facility administration and coordinating the move.
5. Establishing procedures and contacts to retain facility housing.
6. Coordinating with the Medi-Cal managed care plan to ensure that the needs of Members who need enhanced services to be safely and stably housed in RCFE/ ARF settings have Community Supports and/or Enhanced Care Management services that provide the necessary enhanced services.
    A. Managed care plans may also fund RCFE/ARF operators directly to provide these enhanced services.

[16] Refer to Housing Transition/Navigation Services Community Support for additional details.

Eligibility (Population Subset)

A. For Nursing Facility Transition:
    1. Has resided 60+ days in a nursing facility;
    2. Willing to live in an assisted living setting as an alternative to a Nursing Facility; and
    3. Able to reside safely in an assisted living facility with appropriate and cost-effective supports.

B. For Nursing Facility Diversion:
    1. Interested in remaining in the community;
    2. Willing and able to reside safely in an assisted living facility with appropriate and cost-effective supports and services; and
    3. Must be currently receiving medically necessary nursing facility LOC or meet the minimum criteria to receive nursing facility LOC services and in lieu of going into a facility, is choosing to remain in the community and continue to receive medically necessary nursing facility LOC services at an Assisted Living Facility.

Restrictions/Limitations

Individuals are directly responsible for paying their own living expenses.

Individuals may not be receiving duplicative support from other State, local, or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner. The below list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with but is not an exhaustive list of providers who may offer the services.

- Case management agencies
- Home Health agencies
- Medi-Cal managed care plans
- ARF/RCFE Operators

Medi-Cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is

no state-level enrollment pathway, managed care plans must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

RCFE/ARFs are licensed and regulated by the California Department of Social Services, Community Care Licensing (CCL) Division.

State Plan Service(s) that are likely to be Avoided

Examples of State Plan services to be avoided include but are not limited to skilled nursing facility services, inpatient hospital services, and psychiatric inpatient stays.

Community Transition Services/Nursing Facility Transition to a Home

Description/Overview

Community Transition Services/Nursing Facility Transition to a Home helps individuals to live in the community and avoid further institutionalization.

Community Transition Services/Nursing Facility Transition to a Home are non-recurring set-up expenses for individuals who are transitioning from a licensed facility to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and include:

1. Assessing the Member's housing needs and presenting options.[17]
2. Assisting in searching for and securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).
3. Communicating with landlord (if applicable) and coordinating the move.
4. Establishing procedures and contacts to retain housing.
5. Identifying, coordinating, securing, or funding non-emergency, non-medical transportation to assist Members' mobility to ensure reasonable accommodations and access to housing options prior to transition and on move-in day.
6. Identifying the need for and coordinating funding for environmental modifications to install necessary accommodations for accessibility.[18]

Identifying the need for and coordinating funding for services and modifications necessary to enable a person to establish a basic household that does not constitute room and board, such as: security deposits required to obtain a lease on an apartment or home; set-up fees for utilities or service access; first month coverage of utilities, including telephone, electricity, heating and water; services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy; home modifications, such as an air conditioner or heater; and other medically-necessary services, such as hospital beds, Hoyer lifts, etc. to ensure access and reasonable accommodations.[19]

Eligibility (Population Subset)

1. Currently receiving medically necessary nursing facility Level of Care (LOC)

[17] Refer to the Housing Transition/Navigation Services and/or Housing Tenancy/Sustaining Services Community Support for additional details.

[18] Refer to the Environmental Accessibility Adaptations and/or Asthma Remediation Community Support for additional details.

[19] Refer to the Housing Deposits Community Support for additional details.

services and, in lieu of remaining in the nursing facility or Medical Respite setting, is choosing to transition home and continue to receive medically necessary nursing facility LOC services; and

2. Has lived 60+ days in a nursing home and/or Medical Respite setting; and
3. Interested in moving back to the community; and
4. Able to reside safely in the community with appropriate and cost-effective supports and services.

Restrictions/Limitations

- Community Transition Services do not include monthly rental or mortgage expense, food, regular utility charges, and/or household appliances or items that are intended for purely diversionary/recreational purposes.
- Community Transition Services are payable up to a total lifetime maximum amount of $7,500.00. The only exception to the $7,500.00 total maximum is if the Member is compelled to move from a provider-operated living arrangement to a living arrangement in a private residence through circumstances beyond his or her control.
- Community Transition Services must be necessary to ensure the health, welfare, and safety of the Member, and without which the Member would be unable to move to the private residence and would then require continued or re- institutionalization.

Individuals may not be receiving duplicative support from other State, local, or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. The list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Case management agencies
- Home Health agencies
- Medi-Cal managed care plans
- County mental health providers
- 1915c HCBA/ALW providers
- CCT/Money Follows the Person providers

Medi-Cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, managed care plans must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

State Plan Service(s) that are likely to be Avoided

Examples of State Plan services to be avoided include but are not limited to skilled nursing facility services.

Personal Care and Homemaker Services

Description/Overview

Personal Care Services and Homemaker Services provided for individuals who need assistance with Activities of Daily Living (ADLs) such as bathing, dressing, toileting, ambulation, or feeding. Personal Care Services can also include assistance with Instrumental Activities of Daily Living (IADLs) such as meal preparation, grocery shopping, and money management.

Includes services provided through the In-Home Support Services (In-Home Supportive Services) program include house cleaning, meal preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, bathing, grooming, and paramedical services), accompaniment to medical appointments, and protective supervision for the mentally impaired.

Services also include help with tasks such as cleaning and shopping, laundry, and grocery shopping. Personal Care and Homemaker programs aid individuals who could otherwise not remain in their homes.

The Personal Care and Homemaker Services Community Support can be utilized:

- Above and beyond any approved county In-Home Supportive Services hours, when additional hours are required and if In-Home Supportive Services benefits are exhausted; and
- As authorized during any In-Home Supportive Services waiting period (Member must be already referred to In-Home Supportive Services); this approval time period includes services prior to and up through the In-Home Supportive Services application date.
- For Members not eligible to receive In-Home Supportive Services, to help avoid a short-term stay in a skilled nursing facility (not to exceed 60 days).

Similar services available through In-Home Supportive Services should always be utilized first. These Personal Care and Homemaker services should only be utilized if appropriate and if additional hours/supports are not authorized by In-Home Supportive Services.

Eligibility (Population Subset)

- Individuals at risk for hospitalization, or institutionalization in a nursing facility; or
- Individuals with functional deficits and no other adequate support system; or
- Individuals approved for In-Home Supportive Services. Eligibility criteria can be found at: http://www.cdss.ca.gov/In-Home-Supportive-Services.

Restrictions/Limitations

This service cannot be utilized in lieu of referring to the In-Home Supportive Services program. Member must be referred to the In-Home Supportive Services program when they meet referral criteria.

If a Member receiving Personal Care and Homemaker services has any change in their current condition, they must be referred to In-Home Supportive Services for reassessment and determination of additional hours. Members may continue to receive the Personal Care and Homemaker Services Community Support during this reassessment waiting period.

Individuals may not be receiving duplicative support from other State, local, or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Home health agencies
- County agencies
- Personal care agencies
- AAA (Area Agency on Aging)

Medi-Cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, managed care plans must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

State Plan Service(s) that are likely to be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, emergency department services, and skilled nursing facility services.

Environmental Accessibility Adaptations (Home Modifications)

Description/Overview

Environmental Accessibility Adaptations (EAAs also known as Home Modifications) are physical adaptations to a home that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function with greater independence in the home: without which the Member would require institutionalization.

Examples of environmental accessibility adaptions include:

- Ramps and grab-bars to assist Members in accessing the home;
- Doorway widening for Members who require a wheelchair;
- Stair lifts;
- Making a bathroom and shower wheelchair accessible (e.g., constructing a roll-in shower).
- Installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies of the Member; and
- Installation and testing of a Personal Emergency Response System (PERS) for Members who are alone for significant parts of the day without a caregiver and who otherwise require routine supervision (including monthly service costs, as needed).

The services are available in a home that is owned, rented, leased, or occupied by the Member. For a home that is not owned by the Member, the Member must provide written consent from the owner for physical adaptations to the home or for equipment that is physically installed in the home (e.g., grab bars, chair lifts, etc.).

When authorizing environmental accessibility adaptations as a Community Support, the managed care plan must receive and document an order from the Member's current primary care physician or other health professional specifying the requested equipment or service as well as documentation from the provider of the equipment or service describing how the equipment or service meets the medical needs of the Member, including any supporting documentation describing the efficacy of the equipment where appropriate. Brochures will suffice in showing the purpose and efficacy of the equipment; however, a brief written evaluation specific to the Member describing how and why the equipment or service meets the needs of the Member will still be necessary.

The managed care plan must also receive and document:

1. A physical or occupational therapy evaluation and report to evaluate the medical necessity of the requested equipment or service unless the managed care plan determines it is appropriate to approve without an evaluation. This should typically come from an entity with no connection to the provider of the requested equipment or service. The physical or occupational therapy evaluation and report should

contain at least the following:

A. An evaluation of the Member and the current equipment needs specific to the Member, describing how/why the current equipment does not meet the needs of the Member;

B. An evaluation of the requested equipment or service that includes a description of how/why it is necessary for the Member *and reduces the risk of institutionalization*. This should also include information on the ability of the Member and/or the primary caregiver to learn about and appropriately use any requested item, and

C. A description of similar equipment used either currently or in the past that has demonstrated to be inadequate for the Member and a description of the inadequacy.

2. If possible, a minimum of two bids from appropriate providers of the requested service, which itemize the services, cost, labor, and applicable warranties; and

3. That a home visit has been conducted to determine the suitability of any requested equipment or service.

The assessment and authorization for EAAs must take place within a 90-day time frame beginning with the request for the EAA, unless more time is required to receive documentation of homeowner consent, or the individual receiving the service requests a longer time frame.

Eligibility (Population Subset)

Individuals at risk for institutionalization in a nursing facility.

Restrictions/Limitations

- If another State Plan service such as Durable Medical Equipment, is available and would accomplish the same goals of independence and avoiding institutional placement, that service should be used.
- EAAs must be conducted in accordance with applicable State and local building codes.
- EAAs are payable up to a total lifetime maximum of $7,500. The only exceptions to the $7,500 total maximum are if the Member's place of residence changes or if the Member's condition has changed so significantly that additional modifications are necessary to ensure the health, welfare, and safety of the Member, or are necessary to enable the Member to function with greater independence in the home and avoid institutionalization or hospitalization.
- EAAs may include finishing (e.g., drywall and painting) to return the home to a

habitable condition, but do not include aesthetic embellishments.

- Modifications are limited to those that are of direct medical or remedial benefit to the Member and exclude adaptations or improvements that are of general utilityto the household. Adaptations that add to the total square footage of the home are excluded except when necessary to complete an adaptation (e.g., to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).
- Before commencement of a physical adaptation to the home or equipment that is physically installed in the home (e.g., grab bars, chair lifts, etc.), the managed care plan must provide the owner and Member with written documentation that the modifications are permanent, and that the State is not responsible for maintenance or repair of any modification nor for removal of any modification if the Member ceases to reside at the residence.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Calfunding.

Licensing/Allowable Providers

The Medi-Cal managed care plan may manage these services directly or may coordinate with a provider to manage the service.

Medi-Cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, managed care plans must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Area Agencies on Aging (AAA)
- Local health departments
- Community-based providers and organizations

All EAAs that are physical adaptations to a residence must be performed by an individual holding a California Contractor's License with the exception of a PERS installation, which may be performed in accordance with the system's installation requirements.

State Plan Service(s) that are likely to be Avoided

Examples of State Plan services to be avoided include but are not limited to nursing facility services, inpatient and outpatient hospital services, emergency department services, and emergency transport services.

Medically Tailored Meals/Medically-Supportive Food

Description/Overview

Malnutrition and poor nutrition can lead to devastating health outcomes, higher utilization, and increased costs, particularly among Members with chronic conditions. Meals help individuals achieve their nutrition goals at critical times to help them regain and maintain their health. Results include improved Member health outcomes, lower hospital readmission rates, a well-maintained nutritional health status, and increased Member satisfaction.

1. Meals delivered to the home immediately following discharge from a hospital or nursing home when Members are most vulnerable to readmission.

2. Medically-Tailored Meals: meals provided to the Member at home that meet the unique dietary needs of those with chronic diseases.

3. Medically-Tailored meals are tailored to the medical needs of the Member by a Registered Dietitian (RD) or other certified nutrition professional, reflecting appropriate dietary therapies based on evidence-based nutritional practice guidelines to address medical diagnoses, symptoms, allergies, medication management, and/or side effects to ensure the best possible nutrition-related health outcomes.

4. Medically-supportive food and nutrition services, including medically tailored groceries, healthy food vouchers, and food pharmacies.

5. Behavioral, cooking, and/or nutrition education is included when paired with direct food assistance as enumerated above.

Managed care plans have the discretion to define criteria for the level of services determined to be both medically appropriate and cost-effective for Members (e.g. Medically-Tailored meals, groceries, food vouchers, etc.).

Eligibility (Population Subset)

1. Individuals with chronic conditions, such as but not limited to diabetes, cardiovascular disorders, congestive heart failure, stroke, chronic lung disorders, human immunodeficiency virus (HIV), cancer, gestational diabetes, or other high risk perinatal conditions, and chronic or disabling mental/behavioral health disorders.
2. Individuals being discharged from the hospital or a skilled nursing facility or at high risk of hospitalization or nursing facility placement; or
3. Individuals with extensive care coordination needs.

Restrictions/Limitations

- Up to three meals per day and/or medically-supportive food and nutrition services for up to 12 weeks, or longer if medically necessary.
- Meals that are eligible for or reimbursed by alternate programs are not eligible.
- Meals are not covered to respond solely to food insecurities.

Individuals may not be receiving duplicative support from other State, local, or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Home delivered meal Providers
- Area Agencies on Aging
- Nutritional Education Services to help sustain healthy cooking and eating habits
- Meals on Wheels Providers
- Medically-Supportive Food & Nutrition Providers

Medi-Cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, managed care plans must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

State Plan Service(s) that are likely to be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, and emergency department services.

Sobering Centers

Description/Overview

Sobering centers are alternative destinations for individuals who are found to be publicly intoxicated (due to alcohol and/or other drugs) and would otherwise be transported to the emergency department or jail. Sobering centers provide these individuals, primarily those who are homeless or those with unstable living situations, with a safe, supportive environment to become sober.

Sobering centers provide services such as medical triage, lab testing, a temporary bed, rehydration and food service, treatment for nausea, wound and dressing changes, shower and laundry facilities, substance use education and counseling, navigation and warm hand-offs for additional substance use services or other necessary health care services, and homeless care support services.

- When utilizing this service, direct coordination with the county behavioral health agency is required and warm hand-offs for additional behavioral health services are strongly encouraged.
- The service also includes screening and linkage to ongoing supportive services such as follow-up mental health and substance use disorder treatment andhousing options, as appropriate.
- This service requires partnership with law enforcement, emergency personnel, and outreach teams to identify and divert individuals to Sobering Centers. Sobering centers must be prepared to identify Members with emergent physical health conditions and arrange transport to a hospital or appropriate source of medical care.
- The services provided should utilize best practices for Members who are experiencing homelessness and who have complex health and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma-Informed Care.

Eligibility (Population Subset)

Individuals age 18 and older who are intoxicated but conscious, cooperative, able to walk, nonviolent, free from any medical distress (including life threatening withdrawal symptoms or apparent underlying symptoms), and who would otherwise be transported to the emergency department or a jail or who presented at an emergency department and are appropriate to be diverted to a Sobering Center.

Restrictions/Limitations

This service is covered for a duration of less than 24 hours.

Individuals may not be receiving duplicative support from other State, local, or federally funded programs, which should always be considered first before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services with these unique populations. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Sobering Centers, or other appropriate and allowable substance use disorder facilities. Medi-Cal managed care plans should consult with county behavioral health agencies to ensure these facilities can offer an appropriate standard of care and properly coordinate follow up access to substance use disorder services and other behavioral health services.
- These facilities are unlicensed. Medi-Cal managed care plans must apply minimum standards, subject to review and approval by DHCS, to ensure adequate experience and acceptable quality of care standards are maintained. Medi-Cal managed care plans shall monitor the provision of all the services included above.
- All allowable providers must be approved by the managed care organization to ensure adequate experience and appropriate quality of care standards are maintained.

Medi-Cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, managed care plans must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

State Plan Service(s) that are likely to be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, emergency department services, and emergency transportation services.

Asthma Remediation[20]

Description/Overview

Environmental Asthma Trigger Remediations are physical modifications to a home environment that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function in the home and without which acute asthma episodes could result in the need for emergency services and hospitalization.

Examples of environmental asthma trigger remediations include:

- Allergen-impermeable mattress and pillow dustcovers;
- High-efficiency particulate air (HEPA) filtered vacuums;
- Integrated Pest Management (IPM) services;
- De-humidifiers;
- Air filters;
- Other moisture-controlling interventions;
- Minor mold removal and remediation services;
- Ventilation improvements;
- Asthma-friendly cleaning products and supplies;
- Other interventions identified to be medically appropriate and cost effective.

The services are available in a home that is owned, rented, leased, or occupied by the Member or their caregiver.

When authorizing Asthma Remediation as a Community Support, the managed care plan must receive and document:

1. A current licensed health care provider's order specifying the requested remediation(s) for the Member;
2. A brief written evaluation specific to the Member describing how and why the remediation(s) meets the needs of the individual, required for cases of "Other interventions identified to be medically appropriate and cost-effective.;
3. That a home visit has been conducted to determine the suitability of any requested remediation(s) for the Member.

Asthma Remediation includes providing information to Members about actions to take around the home to mitigate environmental exposures that could trigger asthma symptoms and remediations designed to avoid asthma-related hospitalizations such as:

1. Identification of environmental triggers commonly found in and around the home, including allergens and irritants.

[20] Asthma Remediation should not interfere with EPSDT benefits. All appropriate EPSDT services should be provided and Community Supports should be complementary. See https://www.hud.gov/sites/dfiles/HH/documents/HUD%20Asthma%20Guide%20Document_Final_7_18.pdf; Appendix B)

2. Using dust-proof mattress and pillow covers, high-efficiency particulate air vacuums, asthma-friendly cleaning products, dehumidifiers, and air filters.

3. Health-related minor home repairs such as pest management or patching holes and cracks through which pests can enter.

The Centers for Disease Control, the Environmental Protection Agency, and Housing and Urban Development collaborated to produce an asthma trigger checklist[21] which MCPs may utilize in determining the appropriateness of these interventions. An accompanying training[22] provides additional details about the connections between asthma triggers and lung health.

Eligibility (Population Subset)

Individuals with poorly controlled asthma (as determined by an emergency department visit or hospitalization or two sick or urgent care visits in the past 12 months or a score of 19 or lower on the Asthma Control Test) for whom a licensed health care provider has documented that the service will likely avoid asthma-related hospitalizations, emergency department visits, or other high-cost services.

Restrictions/Limitations

- If another State Plan service such as Durable Medical Equipment, is available and would accomplish the same goals of preventing asthma emergencies or hospitalizations.

- Asthma remediations must be conducted in accordance with applicable State and local building codes.

- Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

- Asthma remediations are payable up to a total lifetime maximum of $7,500. The only exception to the $7,500 total maximum is if the Member's condition has changed so significantly that additional modifications are necessary to ensure the health, welfare, and safety of the Member, or are necessary to enable the Member to function with greater independence in the home and avoid institutionalization or hospitalization.

- Asthma Remediation modifications are limited to those that are of direct medical orremedial benefit to the Member and exclude adaptations or improvements that

[21] https://www.cdc.gov/asthma/pdfs/home_assess_checklist_P.pdf
[22] https://www.epa.gov/sites/production/files/2020-06/home_characteristics_and_asthma_triggers_training_for_home_visitors_0.pptx

are of general utility to the household. Remediations may include finishing (e.g., drywall and painting) to return the home to a habitable condition, but do not include aesthetic embellishments.

- Before commencement of a permanent physical adaptation to the home or installation of equipment in the home, such as installation of an exhaust fan or replacement of moldy drywall, the managed care plan must provide the owner and Member with written documentation that the modifications are permanent, and that the State is not responsible for maintenance or repair of any modification nor for removal of any modification if the Member ceases to reside at the residence. This requirement does not apply to the provision of supplies that are not permanent adaptations or installations, including but not limited to: allergen-impermeable mattress and pillow dust covers; high-efficiency particulate air (HEPA) filtered vacuums; de-humidifiers; portable air filters; and asthma-friendly cleaning products and supplies.

Individuals may not be receiving duplicative support from other State, local, or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

The Medi-Cal managed care plan may: manage these services directly; coordinate with an existing Medi-Cal provider to manage the services; and/or contract with a county agency, community-based organization or other organization, as needed. The services should be provided in conjunction with culturally appropriate asthma self-management education.

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managedcare plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Lung health organizations
- Healthy housing organizations
- Local health departments
- Community-based providers and organizations

Asthma Remediation that is a physical adaptation to a residence must be performed by an individual holding a California Contractor's License.

- Medi-Cal managed care plans must apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. Medi-Cal managed care plans shall monitor the provision of all the services included above.
- All allowable providers must be approved by the managed care organization to

ensure adequate experience and appropriate quality of care standards are maintained.

Medi-Cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, managed care plans must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

State Plan Service(s) that are likely to be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, and emergency department services.

IV. Requesting Approval for New Community Supports

MCPs must apply for and obtain State approval prior to offering any new Community Support, and demonstrate that all of the following requirements will be met through the submission of a Community Supports Model of Care:

- Community Supports are voluntary. MCPs cannot require a Member to use a Community Support instead of a State Plan-covered service.
- The alternative services are medically appropriate and cost-effective.
- The population and criteria for the Community Support is clearly defined, and the Community Support will be offered in an equitable and nondiscriminatory manner to eligible Members.
- The MCP has demonstrated capability to calculate the cost-benefit analysis for each Community Support, including tracking and reporting on Community Supports expenditures in a manner and format established by DHCS.
- MCPs must use the HCPCS rate codes through encounter data that have been approved by DHCS to track the claiming and provision of Community Supports.
- Community Supports may not include expenditures prohibited by CMS, such as room and board.

Once DHCS approves an MCP's submitted Community Supports Model of Care, the Community Support must be added to the MCP's contract and will be posted on the DHCS website as a State Approved Community Support. The cost and utilization of the Community Support will be factored into the medical portion of the MCP's rates.

Members have the right to file a grievance and request an appeal regarding the denial of a State approved Community Support being offered by the MCP. Community Supports are additionally subject to the State Fair Hearings process. DHCS may terminate an MCP's Community Supports offering if it is determined to be harmful to the Member or is not cost-effective. MCPs may terminate a Community Support upon notice to DHCS once annually at the end of the calendar year, except in cases where the Community Support is terminated due to Member health, safety, or welfare concerns. If an MCP terminates a Community Support, they must publicize the service end date and provide at least 30 days' notice to their Members and implement a plan for continuity of care for Members receiving that Community Support.

See the Community Supports Resource Directory for more information and to access the Model of Care.

V. Provider Enrollment, Credentialing, and Vetting Requirements

Community Supports Providers as Medi-Cal Enrolled Providers

MCP Network Providers (including those who will operate as Community Supports Providers) are required to enroll as a Medi-Cal Provider if there is a state-level enrollment pathway for them to do so. However, many Community Supports Providers (e.g., housing agencies, medically-tailored meal Providers) may not have a corresponding state-level enrollment pathway and are not required to enroll in the Medi-Cal program. Instead, these Providers must be vetted by the MCP in order to participate as Community Supports Providers.

Process for Medi-Cal enrollment

For those Community Supports Providers with a state-level Medi-Cal enrollment pathway, the Provider would have to enroll through the DHCS Provider Enrollment Division or the MCP can choose to have a separate enrollment process.

Clarifying the Provider "Credentialing" Requirements of APL 19-004

The credentialing requirements articulated in APL 19-004: Provider Credentialing/Recredentialing and Screening/Enrollment only apply to Providers with a state-level pathway for Medi-Cal enrollment. Therefore, Community Supports Providers without a state-level pathway to Medi-Cal enrollment are not required to meet the credentialing requirements in APL 19-004 in order to become "in-network" ECM and/or Community Supports Providers, but must be vetted by the MCP in order to participate.

MCP Requirements Related to Vetting Community Supports Providers Without a State-level Pathway for Medi-Cal Enrollment

To include an Community Supports Provider in their networks when there is no state-level Medi-Cal enrollment pathway, MCPs are required to vet the qualifications of the Provider or Provider organization to ensure they can meet the standards and capabilities required to be an Community Supports Provider. MCPs must submit Policies and Procedures for how they will vet the qualifications of ECM and Community Supports Providers in their Part 2 submission of the MOC. MCPs must create and implement their own processes to do so. Factors MCPs may want to consider as part of their process includes, but are not limited to:

- Ability to receive referrals from MCPs for the authorized Community Supports;
- Sufficient experience to provide services similar to the specific Community Supports for which they are contracted to provide within the service area;
- Ability to submit claims or invoices for Community Supports using standardized protocols;
- Business licensing that meets industry standards;
- Capability to comply with all reporting and oversight requirements;
- History of fraud, waste, and/or abuse;

- Recent history of criminal activity, including a history of criminal activities that endanger Members and/or their families; and
- History of liability claims against the Provider.

VI. Billing & Payments

Community Supports Billing and Invoicing Guidance

DHCS has developed more comprehensive guidance that describes the minimum set of data elements required to be included in an invoice, available from the Community Supports Resource Directory.

Non-Binding Community Supports Pricing Guidance

The Cal-AIM initiative and, in particular, the introduction of the 14 pre-approved health-related Community Supports, prompts MCPs to work and contract with a new set of "non-traditional" Providers that offer services and supports that historically have not been well integrated into the health care system. These Providers include, but are not limited to, housing service Providers, home modification companies, sobering centers, and organizations that prepare and deliver medically-supportive food and nutrition. While many MCPs and Community Supports Providers have some experience working together, particularly in WPC Pilot counties, CalAIM is designed to encourage and support broader contracting and partnerships throughout the State. In recognition that this requires MCPs and Community Supports Providers to engage in new contracting and payment relationships, DHCS has prepared non-binding Community Supports Pricing Guidance. It offers information on potential rates for each of the 14 pre-approved Community Supports, including mid-point benchmarks and a discussion of key cost drivers that MCPs and Community Supports Providers may want to consider as they establish their own contracting and payment arrangements.

Critically, this pricing guidance is designed to serve as a tool to support discussions regarding rates**; it is in no way binding on MCPs or Community Supports Providers**. MCPs and Community Supports Providers have full flexibility and discretion to agree to Community Supports rates that are different than those outlined in this document, particularly because the rates in the pricing guidance are based on data and assumptions that reflect the statewide average cost of inputs. DHCS reserves the right to make modifications to the pricing guidance on an as needed basis based on experience with the Community Supports initiative and its evolution over time.

The Non-Binding Community Supports Pricing Guidance can be accessed from the Community Supports Resource Directory.

Community Supports HCPCS Codes

The ECM and Community Supports Coding Options guidance lists the HCPCS codes that must be used for Community Supports services. The HCPCS code and modifier combined define the service as Community Supports.

MCPs must use the HCPCS codes listed in the table to report Community Supports services. The HCPCS code and modifier combined define the service as Community Supports.

DHCS expects MCPs to support their Community Supports Providers in reporting and translating their delivered Community Supports to these required HCPCS codes. While MCPs must use the below HCPCS codes and modifiers for reporting applicable Community Supports encounters to DHCS, MCPs may utilize alternative payment approaches with Community Supports providers. For example, an MCP might opt to pay a provider for Housing Transition and Navigation Services as a per member per month (PMPM) payment. That MCP must still report encounters to DHCS as a per diem for every service rendered by that provider, using the HCPCS codes and modifiers below. **If a Community Support is provided through telehealth, the additional modifier GQ must be used. All telehealth services must be provided in accordance with DHCS policy.**[23]

The Finalized ECM & Community Supports (ILOS) Coding Options can be accessed from the Community Supports Resource Directory.

[23] For more information refer to the DHCS Medi-Cal Provider Manuals

VII. Consent, Authorization, & Data Sharing

The vision of Community Supports is to embrace and integrate a diversity of Providers in the delivery of whole-person care, and not just traditional health care providers. DHCS acknowledges the tremendous investment required of both MCPs and Provider organizations to realize this from an information technology infrastructure and data sharing perspective. To that end, listed below are high-level data system requirements for MCPs, along with data sharing requirements for MCPs and Community Supports Providers.

Data System Requirements

MCPs are required to have an IT infrastructure and data analytic capabilities to support Community Supports, including the capabilities to:

- Consume and use claims and encounter data, as well as other data types listed in Community Supports Contract Template Section 7: Identifying Members for Community Supports;
- Assign Members to Community Supports Providers;
- Keep records of Members receiving Community Supports and their consent;
- Securely share data with Community Supports Provider;
- Receive, process, and send encounters and invoices from Community Supports Providers to DHCS in accordance with DHCS standards;
- Receive and process supplemental reports from Community Supports Providers;
- Send Community Supports supplemental reports to DHCS; and
- Open, track, and manage referrals to Community Supports Providers.

Data Sharing Requirements for MCPs

In order to support Community Supports, MCPs shall provide, at a minimum, the following information to all Community Supports Providers:

- Physical, behavioral, administrative, and information indicating Member social determinants of health (SDOH) needs, as specified on previously submitted claims encounters or identified through other data sources (e.g., HMIS)[24] for assigned Members; and
- Reports of performance on quality measures and/or metrics, as requested.

MCPs are required to use defined federal and State standards, specifications, code sets, and terminologies when sharing physical, behavioral, social, and administrative data with Community Supports Providers and with DHCS.

[24] As part of the population health management (PHM) initiative of CalAIM, DHCS has issued guidance encouraging MCPs to incorporate the use of DHCS Priority SDOH Codes; please refer to APL 21-009 for more information.

Data Sharing Requirements for Community Supports Providers

DHCS' vision is that Community Supports Providers will submit encounters to MCPs for transmission to DHCS. Providers that do not have these capabilities will be allowed to submit invoices to MCPs and MCPs will then convert the invoices to encounters for submission to the DHCS.

DHCS is not specifying the payment model between MCPs and Providers for Community Supports, though DHCS encourages plans and Providers to adopt or progress to value based payment (VBP) models for Community Supports.

If the Community Supports Provider is paid by the MCP on a fee-for-service (FFS) basis, they will be expected to generate a claim and send it to the MCP for payment processing. If the Community Supports Provider is unable to send a compliant 837P claim to the MCP, they will be expected to send an invoice with a minimum set of data elements necessary for the MCP to convert that information into a compliant 837P encounter that they will subsequently submit to DHCS according to current DHCS policy.

If a Community Supports Provider is paid by the MCP on a capitated basis, then the Provider will still be expected to generate and submit a compliant encounter to MCPs. In the event that Community Supports Provider is unable to submit a compliant 837P encounter, they will be expected to send a paid invoice with a minimum set of data elements necessary for the MCP to convert that information into a compliant 837P encounter that the plan will subsequently submit to DHCS according to current DHCS policy.

Community Supports Providers and MCPs may need to re-configure their existing systems to meet these requirements.

VIII. Monitoring, Oversight, and Reporting

Oversight of Community Supports Providers

MCP Requirements

MCPs are required to perform oversight of Community Supports Providers, holding them accountable to all Community Supports requirements contained in the ECM and Community Supports Contract Template, the MCP's MOC, and any associated guidance issued by DHCS. MCPs are expected to use Community Supports Provider Standard Terms and Conditions to develop Community Supports contracts with Community Supports Providers, and are expected to incorporate all Community Supports Provider requirements reviewed and approved by DHCS as part of its MOC, including all monitoring and reporting criteria. To streamline the Community Supports implementation:

- MCPs must hold Community Supports Providers responsible for the same reporting requirements as those that the MCP must report to DHCS.
- The MCPs will not impose mandatory reporting requirements that differ from or are additional to those required for encounter and supplemental reporting; and
- MCPs are encouraged to collaborate with other MCPs within the same county on oversight of Community Supports Providers.

Subcontractors

MCPs may subcontract with other entities to administer Community Supports, provided they adhere to the below requirements:

- MCPs will maintain and be responsible for oversight of compliance with all Contract provisions and Covered Services, regardless of the number of layers of subcontracting;
- MCPs will be responsible for developing and maintaining DHCS approved Policies and Procedures to ensure Subcontractors meet required responsibilities and functions;
- MCPs will be responsible for evaluating the prospective Subcontractor's ability to perform services;
- MCPs will remain responsible for ensuring the Subcontractor's Community Supports Provider capacity is sufficient to serve eligible Members;
- MCPs will report to DHCS the names of all Subcontractors by Subcontractor type and service(s) provided, and identify the county or Counties in which Members are served; and
- MCPs will make all Subcontractor agreements available to DHCS upon request. Such agreements must contain minimum required information specified by DHCS, including method and amount of compensation.

MCPs will ensure their agreements with any Subcontractor mirrors the requirements set forth in ECM and Community Supports Contract Template, and the ECM and Community Supports Provider Standard Terms and Conditions, as applicable to Subcontractor. MCPs are encouraged to collaborate with their Subcontractors on the approach to Community Supports to minimize variance in how Community Supports will be implemented and to ensure a streamlined, seamless experience for Community Supports Providers and Members.

Model of Care (MOC) and Approval Process

The ECM and Community Supports MOC is each MCP's framework for providing ECM and Community Supports. Each MCP's MOC will include its overall approach to ECM and Community Supports; its detailed Policies and Procedures with regard to ECM and Community Supports Provider (including non-traditional Providers) contracting and oversight; its ECM and Community Supports Provider network capacity; and the contract language that will define key aspects of its arrangements with its ECM and Community Supports Providers. The MOC also includes specific "Transition and Coordination" content for MCPs operating in Whole Person Care (WPC) and/or Health Home Program (HHP) Counties. MCPs in these Counties must describe how they will ensure smooth transitions for their Members from WPC and HHP into ECM and Community Supports.

DHCS will use each MCP's MOC submission to determine its readiness to meet ECM and Community Supports requirements. MCPs must lay out their MOCs using the DHCS-developed standard template (MOC Template) and submit them to DHCS for review and approval prior to initial ECM and Community Supports implementation in 2022. MCPs must make updates to their MOCs to reflect any Community Supports changes.

MCPs should expect review of the MOC to be an iterative process with DHCS during each review period. DHCS may require resubmission of certain questions or additional material to ensure alignment with DHCS requirements.

Encounter Data Submission Process

DHCS requires MCPs to submit encounter data in accordance with requirements in the MCP contract and All Plan Letter 14-019, or any subsequent updates. MCPs are required to submit encounter data for Community Supports through the existing encounter data reporting mechanisms for all covered services for which they have incurred any financial liability, whether directly or through subcontracts or other arrangements, using ASC X12 837 version 5010 x223 Institutional and Professional transactions or NCPDP 2.2 or 4.2 transactions and the new Community Supports coding requirements, to the Post Adjudicated Claims and Encounters System (PACES) beginning on January 1, 2022.

Scope of Monitoring Activities

DHCS will monitor MCPs implementation of and compliance with ECM and Community Supports requirements across multiple domains including, Membership, Service Provision, Grievances and Appeals, Provider Capacity, and Quality. DHCS will monitor MCP compliance with ECM and Community Supports using existing monitoring processes as well as through submission of time-limited quarterly Implementation Monitoring Report Templates.

IX. Performance Incentive Program

CalAIM's ECM and Community Supports programs will require significant new investments in care management capabilities, Community Supports infrastructure, information technology (IT) and data exchange, and workforce capacity at both the MCP and Provider levels. Incentive payments will be a critical component of CalAIM to promote MCP and Provider participation in, and capacity building for, ECM and Community Supports.

DHCS has designed an incentive payment approach with input from stakeholders with the goal of issuing initial payments to MCPs beginning in January 2022 for the achievement of defined milestones. Infrastructure development, ECM and Community Supports Provider capacity building, and Community Supports take-up are priority areas for Program Year 1 (i.e., Calendar Year 2022). DHCS will incorporate behavioral and physical health integration and health disparities reduction measures within those priority areas. Quality will emerge as a priority area for Program Year 2 (i.e., Calendar Year 2023).

Additional guidance on the Performance Incentive Program, as well more details on available Projects for Assistance in Transition from Homelessness (PATH) Funding, is available on the ECM & Community Supports webpage.

Listed below are the goals and design principles of the program.

Performance Incentive Goals:

- Build appropriate and sustainable ECM and Community Supports capacity
- Drive MCP investment in necessary delivery system infrastructure
- Incentivize MCP take-up of Community Supports
- Bridge current silos across physical and behavioral health delivery
- Reduce health disparities and promote health equity
- Achieve improvements in quality performance

Performance Incentive Design Principles:

1. Develop a clear incentive payment allocation methodology where all plans have an opportunity to participate equitably
2. Set ambitious, yet achievable measure targets
3. Ensure efficient and effective use of all performance incentive dollars
4. Drive significant investments in core priority areas up front
5. Minimize administrative complexity
6. Address variation in existing infrastructure and capacity between Whole Person Care (WPC) / Health Home Program (HHP) Counties and non-WPC/HHP Counties
7. Ensure use of incentive dollars does not overlap with other DHCS incentive programs or with services funded through the rates
8. Measure and report on the impact of incentive funds

X. Community Supports Resource Directory

Community Supports Resource Directory	
Resource	**Description**
ECM and Community Supports (ILOS) Website	Online repository for ECM & Community Supports (ILOS) program documents and technical assistance. Future guidance will be posted here.
Community Supports Fact Sheet	Overview of Community Supports and DHCS' vision for the Community Supports initiative
Frequently Asked Questions Document	Answers to key Community Supports policy questions. Document will updated with new questions/answers on an ad hoc basis
ECM & Community Supports Change Memo	Summary of key policy changes DHCS made to ECM and Community Supports requirements documents based on stakeholder feedback.
DHCS-MCP ECM and Community Supports (ILOS) Contract Template	Community Supports contract requirements for MCPs.
ECM and Community Supports (ILOS) Standard Provider Terms and Conditions	Standardized language that MCPs must include in all contracts with Community Supports Providers.

CalAIM ECM and Community Supports Model of Care Cover Note: Instructions and Timeline **CalAIM ECM and Community Supports (ILOS) Model of Care Template**	Template for MCP to outline proposed protocols for implementation and provision of Community Supports. Each MOC must be reviewed and approved by DHCS prior to Community Supports implementation.
ECM and Community Supports (ILOS) Coding Guidance	Guidance on encounter data submissions and a list of HCPCS Level II Codes for Community Supports services delivered.
Community Supports (ILOS) Evidence Library – Executive Summary	Select highlights and key findings of DHCS' research on the measurable impacts Community Supports may have on health care costs, utilization, and health outcomes
Non-Binding Community Supports Pricing Guidance*	Non-Binding guidance on pricing for Community Supports services.
Community Supports Billing & Invoicing Guidance*	Guidance defining the standard, "minimum necessary" data elements MCPs will collect from Community Supports Providers.
Community Supports Quarterly Implementation Reporting Framework*	Guidance defining DHCS' strategy for monitoring the implementation of Community Supports.

*Check the ECM and Community Supports (ILOS) Website for the latest updates and versions of Community Supports documents.

XI. Glossary of Terms

Medicaid Section 1115 Demonstration Waivers: Section 1115 wavers permit States to use federal Medicaid funds in ways that are not otherwise allowed under federal rules, as long as the U.S. Secretary of Health and Human Services determines that the initiative isan "experimental, pilot, or demonstration project" that is "likely to assist in promoting the objectives of the program." Section 1115 waivers are generally approved for a five-year period.

Section 1915(b) "Freedom of Choice" waivers: States generally use section 1915(b) waivers to require enrollment in managed care delivery systems for certain populations. Many States originally used Section 1115 waiver authority to move enrollees intomanaged care, but the new federal regulations acknowledge that managed care is now the predominant delivery system in Medicaid and CMS has indicated that Section 1115 waivers may not be the most appropriate authority vehicle for managed care.

Section 1915(c) "Home and Community Based Services" waivers: States generally use 1915(c) waivers to develop programs that meet the needs of people who prefer to get long-term care services and supports in their home or community, rather than in an institutional setting.

Behavioral Health: Mental health and substance use disorder services.

Behavioral Health Managed Care Plan: The county prepaid inpatient health plan (PIHP) that would provide specialty mental health services and SUD treatment services under a single contract with DHCS, after full implementation of the behavioral health integration proposal.

CalAIM: California Advancing and Innovating Medi-Cal: DHCS' multi-year initiative to implement overarching policy changes across all Medi-Cal delivery systems with the following objectives:

- Identify and manage member risk and need through Whole Person Care Approaches and addressing Social Determinants of Health;
- Move Medi-Cal to a more consistent and seamless system by reducing complexityand increasing flexibility; and
- Improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems, and payment reform.

Coordinated Care Initiative (CCI): CCI was implemented in 2014 in seven California counties with the goal of coordinating the delivery of medical, behavioral, and long-term

services and supports to Medi-Cal beneficiaries also eligible for Medicare ("dual eligibles"). The CCI is composed of Cal MediConnect and Managed Medi-Cal Long-Term Services and Supports (MLTSS). The Cal MediConnect portion of CCI is currently authorized through December 31, 2022.

County Inmate Pre-Release Application Process: A CalAIM proposal that all counties must implement an inmate pre-release Medi-Cal application process to ensure that county inmates/juveniles who are eligible for Medi-Cal and are in need of ongoing physical or behavioral health treatment receive timely access to services upon release from incarceration. The proposed process would require all county jails and juvenile facilities to implement a process for facilitated referral and linkage from county jail releaseto specialty mental health, Drug Medi-Cal, DMC-ODS and Medi-Cal managed care providers, in cases where the inmate was receiving behavioral health services while incarcerated, to allow for continuation of behavioral health treatment in the community.

County Organized Health System (COHS): A local agency created by a county board of supervisors to contract with the Medi-Cal program. Nearly all Medi-Cal beneficiaries ina COHS county receive their care from the COHS health plan.

Cal MediConnect: A program that coordinates medical, behavioral, and long-termservices and supports (i.e. both Medicare and Medi-Cal benefits) for dual eligibles in seven California CCI counties.

Community Supports (In lieu of services): Services offered by a Medi-Cal health plan that are not included in the State Plan, but are medically appropriate, cost-effective substitutes for State Plan services included within the contract. Applicable in lieu of services must be specifically included in a managed care plan's contract. Services are offered at the plan's option and a Member cannot be required to use them.

Dental Transformation Initiative (DTI): The DTI is a component of the Medi-Cal 2020 demonstration that aims to increase the use of preventive dental services for children, prevent and treat more early childhood caries, and increase continuity of care for children.

Designated Public Hospitals: A California hospital operated by a county, a city and a county, or the University of California.

Designated State Health Programs: Designated State Health Programs (DSHPs) are existing State-funded health programs that have not previously qualified for federal funding, including Medicaid. CMS released a State Medicaid Director Letter informing States that they would phase-out federal funding for DSHPs beginning in 2017, meaning that California's DSHPs will not receive federal funding past December 31, 2020 when the Medi-Cal 2020 demonstration expires.

Drug Medi-Cal: Drug Medi-Cal pays for the SUD treatment services a Medi-Cal beneficiary receives through a Drug Medi-Cal certified program.

Drug Medi-Cal Organized Delivery System (DMC-ODS): DMC-ODS is a continuum of care modeled after the American Society of Addiction Medicine Criteria for substance use disorder treatment services. The program enables more local control and accountability, provides greater administrative oversight, creates utilization controls to improve care and efficient use of resources, implements evidenced based practices in substance abuse treatment, and coordinates with other systems of care. These systems are currently operating in 30 California counties. This program was initially authorized in during the 2010 Bridge to Reform demonstration and was reauthorized in the current Medi-Cal 2020 demonstration.

Enhanced Care Management: A collaborative and interdisciplinary benefit to provide intensive and comprehensive ('whole-person') care management services to high-need Medi-Cal beneficiaries.

Full Integration Plan: A CalAIM proposal to consolidate multiple Medi-Cal delivery systems (Medi-Cal managed care, mental health managed care, DMC-ODS, and dental) under one contract with DHCS. This proposal would only be implemented in select areas with managed care plans and corresponding counties who have mutually volunteered to participate.

Global Payment Program (GPP): Established a statewide pool of funding for the remaining uninsured by combining federal disproportional share hospital and uncompensated care funding, where select Designated Public Hospital systems can achieve their "global budget" by meeting a service threshold that incentivizes movement from high cost, avoidable services to providing higher value, preventive services. GPP is currently set to expire on December 31, 2020 and with approval pending under the Medi-Cal 2020 Demonstration extension to continue for calendar year 2021.

Health Homes Program: Enables participating health plans to provide a range of supports to Med-Cal beneficiaries with complex medical needs and chronic conditions. The HHP includes coordination of the full range of physical health, behavioral health, andcommunity-based long-term services and supports.

Indian Health Care Providers: Means a health care program operated by the Indian Health Service or by an Indian Tribe, Tribal Organization, or Urban Indian Organization per 42 CFR §438.14(a).

Institution for Mental Diseases (IMD): A hospital, nursing facility, or other institution with more than sixteen beds that is primarily engaged in providing diagnosis, treatment, or care to persons with mental diseases (42 U.S.C. §1396d(i)).

Long Term Care: Included skilled nursing facilities, subacute facilities, pediatric subacute facilities, and intermediate care facilities.

Long Term Service and Supports: Services that include medical and non-medical carefor people with a chronic illness or disability. Long-term care services are those provided to an individual who requires a level of care equivalent to that received in a nursing facility.Most long-term care services assist people with Activities of Daily Living, suchas dressing, bathing, and using the bathroom. Long-term care can be provided at home, in the community, or in a facility.

Managed Long Term Services and Supports (MLTSS) Program: The delivery of long-term services and supports through capitated Medi-Cal managed care programs.

Medi-Cal 2020: California's current Section 1115 waiver that expires on December 31, 2020. Medi-Cal 2020 authorized the Whole Person Care program, Global Payment Program, the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) Program, Dental Transformation Initiative, and extended several other California waiver programs including the Drug Medi-Cal Organized Delivery System.

Medi-Cal Managed Care Plan: A health plan that has a contract with DHCS to deliver most physical health care and mild-to-moderate mental health care services to Medicaid beneficiaries through a network of providers at a capitated rate. Managed care plans emphasize primary and preventive care.

Mental Health Managed Care Plan: A health plan that has a contract with DHCS to provide specialty mental health services to Medi-Cal beneficiaries. Mental health managed care plans in California are administered by the counties.

National Committee for Quality Assurance (NCQA): A health care accreditation organization with a focus on improving health care quality.

Population Health Management Program: A cohesive plan of action for addressing member needs across the continuum of care, based on data-driven risk stratification, predictive analytics, and standardized assessment processes. Each Medi-Cal managed care plan will provide DHCS with a strategy for how it will:

- Keep all members healthy by focusing on preventive and wellness services;
- Identify and assess member risks and needs on an ongoing basis;
- Manage member safety and outcomes during transitions, across delivery systems or settings, through effective care coordination; and
- Identify and mitigate the social determinants of health and reduce health disparities or inequities.

Public Hospital Redesign and Incentives in Medi-Cal (PRIME): An incentive programfor Designated Public Hospitals and District and Municipal Public Hospitals designed to improve their delivery systems through a focus on providing high quality, value-based care. PRIME is the successor program to the first-in-the-nation DSRIP (Delivery SystemReform Incentive Payment) program that was authorized in the Bridge to Reform demonstration in 2010. PRIME funding is authorized under the Medi-Cal 2020 demonstration and expired on June 30, 2020.

Quality Incentive Program (QIP): The QIP ties Medi-Cal managed care payments to performance on designated performance metrics in four strategic categories: primary care, specialty care, inpatient care, and resource utilization. The payments are linked to delivery of services under Medi-Cal managed care contracts and increase the amount offunding tied to quality outcomes. California's Designated Public Hospitals receive incentive payments based on achievement of specified improvement targets. Under CalAIM, the District and Municipal Public Hospitals started to participate in the QIP oncePRIME expired.

Regional Rates: A CalAIM proposal to develop regional managed care capitation rates, rather than plan- and county-based rates, in order to simplify the rate-setting process for the Medi-Cal program and allow for more capacity to implement outcomes and value based payment structures.

Safety Net Care Pools (SNCPs): Federal Medicaid funding for safety net providers' uncompensated care costs associated with Medicaid eligible and uninsured individuals. California had SNCPs in the Section 1115 demonstrations that began in 2005 and in 2010. This funding transitioned to be a component of the Global Payment Program in theMedi-Cal 2020 demonstration.

Serious Mental Illness/Seriously Emotional Disturbance Demonstration Opportunity: A federal opportunity for States to receive federal Medicaid funding for short-term residential treatment services in settings otherwise subject to the institution for mental disease (IMD) exclusion. (See SMD #18-011)

Social Determinants of Health: Conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health,functioning, and quality-of-life outcomes and risks (Healthy People 2020).

Targeted Case Management: Targeted Case Management (TCM) is a Medi-Cal program that provides specialized case management services to certain Medi-Cal eligibleindividuals to gain access to needed medical, social, educational, and other services. TheTCM Program is an optional Medi-Cal Program operated with federal and local funds. Eligible populations include:

- Children under age 21;

- Medically fragile individuals;
- Individuals at risk of institutionalization;
- Individuals in jeopardy of negative health or psycho-social outcomes; and
- Individuals with a communicable disease.

Whole Person Care: A pilot program that provides approved counties with funding to coordinate health, behavioral health, and social services for Medi-Cal beneficiaries. The program is authorized under the Medi-Cal 2020 demonstration and expires on December31, 2020, with approval pending to extend through calendar year 2021.

ANCILLARY SERVICES CONTRACT

This Ancillary Services Contract (the "Contract") is entered into by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and **[Provider Name]** ("Provider"), with respect to the following:

RECITALS

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

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

3. DHCS is adding Enhanced Care Management ("ECM") services to the Medi-Cal benefit set, effective January 1, 2022, and transitioning the Whole Person Care ("WPC") and the Health Homes Program ("HHP") to ECM.

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

5. CalOptima has entered into a participation contract with the State of California, acting by and through DHCS, and HHS, acting by and through CMS, to furnish health care services to Medicare/Medi-Cal enrollees who are enrolled in CalOptima's Cal MediConnect program.

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

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

NOW, THEREFORE, the parties agree as follows:

ARTICLE 1
DEFINITIONS

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

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

1.2. "California Children's Services (CCS)" means those services authorized by the CCS Services Program for the diagnosis and treatment of the CCS Services Eligible Conditions of a specific Member.

1.3. "California Children's Services (CCS) Eligible Condition(s)", means a physically handicapping condition, as defined in Title 22 C.C.R. Sections 41515.2 through 41518.9.

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

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

1.5.1. CalOptima Direct Members who are assigned to CalOptima Community Network (CCN) in accordance with CalOptima Policy. Members are assigned to Primary Care Physicians (PCP) as their medical home, and their care is coordinated through their PCP in CCN.

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

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

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

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

1.9. "CCS-Paneled Providers(s)" means any of the following providers when used to treat Members for a CCS condition:

(a) A medical provider that is paneled by the CCS Program, pursuant to Health and Safety Code, Article 5 (commencing with Section 123800 of Chapter 3 of Part 2 of Division 106).

(b) A licensed acute care hospital approved by the CCS Program.

(c) A special care center approved by the CCS Program.

1.10. "CCS Program" means the State of California public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of 21 years who have CCS Eligible Conditions.

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

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

1.13. "Community Supports" means "in-lieu of services", as set forth in 42 CFR § 438.3(e)(2), that are offered in place of services or settings covered under the California Medicaid State Plan ('State Plan") and are medically appropriate, cost-effective alternatives to the State Plan Covered Services. Community Supports are optional for both CalOptima and the Member, must be approved by the DHCS, and are authorized and identified in CalOptima's Medi-Cal Contract with DHCS. Effective no sooner than January 1, 2022, CalOptima shall offer the following fourteen (14) selected DHCS-approved Community Supports, as further defined in CalOptima Policy GG.1355: Community Supports: (i) Housing Transition Navigation Services; (ii) Housing Deposits; (iii) Housing Tenancy and Sustaining Services; (iv) Recuperative Care (Medical Respite); (v) Day Habilitation Programs; (vi) Medically Tailored Meals; (vii) Personal Care and Homemaker Services; (viii) Short-Term Post-Hospitalization Housing Services; (ix) Sobering Centers; (x) Respite Services; (xi) Nursing Facility Transition/Diversion to Assisted Living Facilities Services; (xii) Community Transition /Nursing Facility Transition to a Home Services; (xiii) Environmental Accessibility Adaptations; and (xiv) Asthma Remediation Services.

1.14. For purposes of this Contract, the Community Supports that Provider shall offer to Members are the DHCS-approved Community Supports described in Attachment A of this Contract.

1.15. "Community Supports Provider" means the Provider when providing DHCS-approved Community Supports to Members pursuant to this Contract. Provider shall have the experience and/or training in providing the DHCS-approved Community Supports described in Attachment A of this Contract.

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

1.17. "Compliance Program" means the program (including, without limitation, the compliance manual, code of conduct and CalOptima Policies) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of the members of its Board of Directors, employees, contractors and providers comply with applicable law and ethical standards. The Compliance Program includes CalOptima's Fraud, Waste and Abuse ("FWA") plan.

1.18. "Coordination of Benefits" or "COB" refers to the determination of order of financial responsibility which applies when two or more health benefit plans provide coverage of items and services for an individual.

1.19. "Covered Services" means those services provided under the Fee-for-Service Medi-Cal program, as set forth in Article 4, Chapter 3 (beginning with Section 51301), Subdivision 1, Division 3, Title 22, CCR, and Article 4 (beginning with Section 6840), Subchapter 13, Chapter 4, Division 1 of Title 17, CCR, which (i) are included as Covered Services under the DHCS Contract; and (ii) are

Medically Necessary, as described in Attachment A (which may be revised from time to time at the discretion of CalOptima), 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 effective July 1, 2019, or such later date as the CalOptima Whole Child Model Program becomes effective, Covered Services shall also include CCS Services (as defined in Subdivision 7 of Division 2 of Title 22 of the California Code of Regulations), which shall be covered for Members, notwithstanding whether such benefits are provided under the Fee-for-Service Medi-Cal Program.

1.20. "ECM Provider" means CalOptima Direct or Health Network, as applicable, when providing ECM services to their assigned ECM Members under CalOptima's Medi-Cal Program.

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

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

1.23. "Enhanced Care Management" or "ECM" means a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high need and/or high-cost Members through systematic coordination of services and comprehensive care management that is community-based, high-touch, and person-centered. ECM is a Medi-Cal benefit.

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

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

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

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

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

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

1.30. "Medically Necessary" or "Medical Necessity" means reasonable and necessary services to protect life, to prevent illness or disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury, achieve age appropriate growth and development, and attain, maintain, or

regain functional capacity per Title 22, CCR Section 51303 (a) and 42 CFR 438.210 (a)(5). When determining the Medical Necessity for a Medi-Cal beneficiary under the age of 21, "Medical Necessity" is expanded to include the standards set forth in 42 USC Section 1396d(r), and W & I Code Section 14132(v).

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

1.32. "Medicare Secondary Payer" or "MSP" means the Medicare coordination of benefits requirements as incorporated in MA regulations.

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

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

1.35. "Participating Provider" means an institutional, professional or other Provider of health care services who has entered into a written agreement with CalOptima to provide Covered Services to Members.

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

1.37. "Preclusion List" means the CMS-compiled list of providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.

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

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

1.40. "Whole Child Model Program" or "WCM" means CalOptima's WCM program whereby CCS will be a Medi-Cal managed care plan benefit with the goal being to improve health care coordination for the whole child, rather than handle CCS Eligible Conditions separately.

ARTICLE 2
FUNCTIONS AND DUTIES OF PROVIDER

2.1 Provision of Covered Services.

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

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

2.1.3 In accordance with Section 2.22 of this Contract, Provider and its Subcontractors shall furnish Covered Services to Members under this Contract in the same manner as those services are provided to other patients.

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

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

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

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

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

2.7 Notices and Citations. Provider shall notify CalOptima in writing of any report or other writing of any State or Federal agency and/or Accreditation Organization that regulates Provider that contains a citation, sanction and/or disapproval of Provider's failure to meet any material requirement of State or Federal law or any material standards of an Accreditation Organization.

2.8 Professional Standards. All Provider Services provided or arranged for under this Contract shall be provided or arranged by duly licensed, certified or otherwise authorized professional personnel in manner that (i) meets the cultural and linguistic requirements of this Contract; (ii) within professionally recognized standards of practice at the time of treatment; (iii) in accordance with the provisions of CalOptima's UM and QMI Programs; and (iv) in accordance with the requirements of State and Federal law and all requirements of this Contract.

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

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

2.11 Not applicable to this Contract.

2.12 Provider Agreement to Extend Terms and Rates. Provider agrees to extend to Health Networks the same terms contained in this Contract regarding Provider performance, duties and obligations, and rates for Covered Services provided to CalOptima Members enrolled in Health Networks. Provider agrees to contract with a Health Network(s) upon the request of a Health Network(s).

2.13 CalOptima QMI Program. Provider acknowledges and agrees that CalOptima is accountable for the quality of care furnished to its Members in all settings including services furnished by Provider. Provider agrees, when reasonable and within capability of Provider, that it is subject to the requirements of CalOptima's QMI Program and that it shall participate in QMI Program activities as required by CalOptima. Such activities may include, but are not limited to, the provision of requested data and the participation in assessment and performance audits and projects (including those required by CalOptima's regulators) that support CalOptima's efforts to measure, continuously monitor, and evaluate the quality of items and services furnished to Members. Provider shall participate in CalOptima's QMI Program development and implementation for the purpose of collecting and studying data reflecting clinical status and quality of life outcomes for CalOptima Members. Provider shall cooperate with CalOptima and Government Agencies in any complaint, appeal or other review of Provider Services (e.g., medical necessity) and shall accept as final all decisions regarding disputes over Provider Services by CalOptima or such Government Agencies, as applicable, and as required under the applicable CalOptima Program. Provider shall also allow CalOptima to use performance data for quality and reporting purposes including, but not limited to, quality improvement activities and public reporting to consumers, and performance data reporting to regulators as identified in CalOptima Policies.

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

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

2.15 CalOptima Oversight. Provider understands and agrees that CalOptima is responsible for the monitoring and oversight of all duties of Provider under this Contract, and that CalOptima has the authority and responsibility to: (i) implement, maintain and enforce CalOptima Policies governing Provider's duties under this Contract and/or governing CalOptima's oversight role; (ii) conduct audits, inspections and/or investigations in order to oversee Provider's performance of duties described in this Contract; (iii) require Provider to take corrective action if CalOptima or a Government Agency determines that corrective action is needed with regard to any duty under this

Contract; and/or (iv) revoke the delegation of any duty, if Provider fails to meet CalOptima standards in the performance of that duty. Provider shall cooperate with CalOptima in its oversight efforts and shall take corrective action as CalOptima determines necessary to comply with the laws, accreditation agency standards, and/or CalOptima Policies governing the duties of Provider or the oversight of those duties.

2.16 Transfer of Care. Upon request by a CalOptima Member, Provider shall assist the CalOptima Member in the orderly transfer of such CalOptima Member's medical care. In doing so, Provider shall make available to the new provider of care for the Member, copies of the medical records, patient files, and other pertinent information, including information maintained by any Subcontractor, necessary for efficient medical case management of Member. In no circumstance shall a CalOptima Member be billed for this service.

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

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

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

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

2.20 Equal Opportunity. Provider and its Subcontractors will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental

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

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

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

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

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

In the event of Provider and its Subcontractors' noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced herein, this Contract may be cancelled, terminated, or suspended in whole or in part, and Provider and its Subcontractors may be declared ineligible for further federal and state contracts, in accordance with

procedures authorized in Federal Executive Order No. 11246 as amended, and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity', and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

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

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

2.22 No Discrimination/Harassment (Employees). During the performance of this Contract, Provider and its Subcontractors shall not unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of race, religion, creed, color, national origin, ancestry, physical disability (including Human Immunodeficiency Virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS)), mental disability, medical condition, marital status, age (over 40), gender or the use of family and medical care leave and pregnancy disability leave. Provider and Subcontractors shall ensure that the evaluation and treatment of their employees and applicants for employment are free of such discrimination and harassment. Provider and Subcontractors shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900 et seq.) and the applicable regulations promulgated thereunder, (Title 2, CCR, Section 7285.0 et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990, set forth in Chapter 5 of Division 4 of Title 2 of the CCR are incorporated into this Contract by reference and made a part hereof as if set forth in full. Provider and its Subcontractors shall give written notice of their

obligations under this clause to labor organizations with which they have a collective bargaining or other agreement.

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

For the purpose of this Contract, if based on any of the foregoing criteria, the following constitute prohibited discrimination: (a) denying any Member any Covered Services or availability of a Provider, (b) providing to a Member any Covered Service which is different or is provided in a different name or at a different time from that provided to other similarly situated Members under this Contract, except where medically indicated, (c) subjecting a Member to segregation or separate treatment in any manner related to the receipt of any Covered Service, (d) restricting a Member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service, (e) treating a Member differently than others similarly situated in determining compliance with admission, enrollment, quota, eligibility, or other requirements or conditions that individuals must meet in order to be provided any Covered Service, or in assigning the times or places for the provision of such services. Provider and its Subcontractors agree to render Covered Services to Members in the same manner, in accordance with the same standards, and within the same time availability as offered to non-CalOptima patients. Provider and its Subcontractors shall take affirmative action to ensure that all Members are provided Covered Services without discrimination, except where medically necessary. For the purposes of this section, physical handicap includes the carrying of a gene which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genetic handicap shall include, but not be limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia. Provider and its Subcontractors shall act upon all complaints alleging discrimination against Members in accordance with CalOptima's Policies.

2.24 Reporting Obligations. In addition to any other reporting obligations under this Contract, Provider shall submit such reports and data relating to services covered under this Contract as are required by CalOptima, including, without limitations, to comply with the requests from Government Agencies to CalOptima. CalOptima shall reimburse Provider for reasonable costs for producing and delivering such reports and data.

2.25 Subcontract Requirements. If permitted by the terms of this Contract, Provider may subcontract for certain functions covered by this Contract, subject to the requirements of this Contract. Subcontracts shall not terminate the legal liability of Provider under this Contract. Provider must ensure that all Subcontracts are in writing and include any and all provisions required by this Contract or applicable Government Programs to be incorporated into Subcontracts. Provider shall

make all Subcontracts available to CalOptima or its regulators upon request. Provider is required to inform CalOptima of the name and business addresses of all Subcontractors. Additionally, Provider shall require that all Subcontracts relating to the provision of Covered Services include, without limitation, the following provisions:

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

2.25.2 An agreement to maintain such books and records (a) in accordance with the general standards applicable to such books and records and any record requirements in this Contract and CalOptima Policies; (b) at the Subcontractor's place of business or at such other mutually agreeable location in California.

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

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

2.25.5 An agreement to comply with all provisions of this Contract and applicable law with respect to providing and paying for Emergency Services.

2.25.6 An agreement that Subcontractors shall notify Provider of any investigations into Subcontractors' professional conduct, or any suspension of or comment on a Subcontractor's professional licensure, whether temporary or permanent.

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

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

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

2.27 Participation Status. Provider shall have Policies and Procedures to verify the Participation Status of Provider's Agents. In addition, Provider attests and agrees as follows:

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

2.27.2 Provider shall immediately disclose to CalOptima, including, but not limited to, any pending investigation involving, or any determination of, suspension, exclusion or debarment of Provider or Provider's Agents occurring and/or discovered during the term of this Contract.

2.27.3 Provider shall take immediate action to remove any employee of Provider that does not meet Participation Status requirements from furnishing items or services related to this Contract (whether medical or administrative) to CalOptima Members which may include but is not limited to adverse decisions and licensure issues.

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

2.27.5 CalOptima shall not make payment for a healthcare item or service furnished by an individual or entity that does not meet Participation Status requirements or is included on the Preclusion List. Provider shall provide written notice to the Member who received the services and the excluded provider or provider listed on the Preclusion List that payment will not be made, in accordance with CMS requirements.

2.28 Credentialing and Recredentialing. Prior to providing any Covered Services under, and throughout the duration of, this Contract, Provider, and all Subcontractors, shall be credentialed and periodically recredentialed by CalOptima in the manner and to the extent required by CalOptima Policy.

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

2.30 Smoke Free Workplace. Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible party. By signing this Contract, Provider certifies that it will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The prohibitions herein are effective December 26, 1994. Provider further agrees that it will insert this certification into any subcontracts entered into that provide for children's services as described in the Act.

2.31 CLIA Laboratories. Provider shall only use laboratories with a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. Those laboratories with certificates of waiver shall provide only the types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

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

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

2.34 Advanced Directives. Provider shall maintain written Policies and Procedures related to Advanced Directives in compliance with State and Federal laws and regulations. Provider shall document patient records with respect to the existence of an Advanced Directive in accordance with applicable law. Provider shall not discriminate against any Member on the basis of that Member's Advanced Directive status. Nothing in this Contract shall be interpreted to require a Member to execute an Advance Directive or agree to orders regarding the provision of life-sustaining treatment as a condition of receipt of services.

2.35 Not applicable to this Contract.

2.36 Not applicable to this Contract.

2.37 Whole Child Model Program Compliance. If Provider is a CCS-authorized provider, then in the provision of CCS Services to CalOptima Members, the Provider shall follow CCS Program guidelines, including CCS Program regulations, and where CCS clinical guidelines do not exist, Provider will use evidence-based guidelines or treatment protocols that are medically appropriate to the Member's CCS Eligible Condition.

2.38 CCS Provider Compliance.

2.38.1 Only CCS-Paneled Providers may treat a Member's CCS Eligible Condition.

2.38.2 If Provider is a CCS-Paneled Provider, Provider agrees to provide services for the Whole Child Model Program in accordance with this Contract and CalOptima Policies.

2.38.2.1 Effective when the CalOptima Whole Child Model Program becomes effective, Provider shall provide all Medically Necessary services previously covered by the CCS Program as Covered Services under this Contract for Members who are eligible for the CCS Program, and for Members who are determined medically eligible for CCS by the local CCS Program.

2.38.2.2 To ensure consistency in the provision of CCS Covered Services, Provider shall use all current and applicable CCS Program guidelines, including CCS Program regulations. When applicable CCS clinical guidelines do not exist, Provider shall use evidence-based guidelines or treatment protocols that are medically appropriate given the Members' CCS Eligible Condition.

2.39 Provider Terminations. In the event that a Participating Provider is terminated or leaves Provider, Provider shall ensure that there is no disruption in services provided to Members who are receiving treatment for a chronic or ongoing medical condition or LTSS, Provider shall ensure that there is no disruption in services provided to the CalOptima Member.

2.40 Government Claims Act. Provider shall ensure that Provider and its agents and Subcontractors comply with the applicable provisions of the Government Claims Act (California Government Code section 900 et seq.), including, but not limited to Government Code sections 910 and 915, for any disputes arising under this Contract, and in accordance with CalOptima Policy AA.1217.

2.41 Certification of Document and Data Submissions. All data, information, and documentation provided by Provider to CalOptima pursuant to this Contract and/or CalOptima Policies, which are specified in 42 CFR 438.604 and/or as otherwise required by CalOptima and/or CalOptima's Regulators, shall be accompanied by a certification statement on the Provider's letterhead sign by the Provider's Chief Executive Officer or Chief Financial Officer (or an individual who reports directly to and has delegated authority to sign for such Officer) attesting that based on the best information, knowledge, and belief, the data, documentation, and information is accurate, complete, and truthful.

2.42 Community Supports.

2.42.1 Community Supports Provider Requirements.

2.42.1.1 If a State-level enrollment pathway exists for the Community Supports Provider, the Community Supports Provider shall enroll in the Medi-Cal program pursuant to relevant APLs, including APL 19-004: Provider Credentialing/Recredentialing and Screening/Enrollment. If APL 19-004 does not apply to the Community Supports Provider, the Community Supports Provider will comply with CalOptima's process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

2.42.1.2 The Community Supports Provider shall have the required experience and/or training in the provision of the Community Supports being offered.

2.42.1.3 The Community Supports Provider shall have the capacity to provide the Community Supports in a culturally and linguistically competent manner, as demonstrated by a successful history of providing such services, training, or other factors identified by CalOptima, in its sole discretion.

2.42.1.4 Subject to all applicable requirements set forth in this Contract (including but not limited to, subcontracting requirements) and CalOptima's prior written approval, if the Community Supports Provider subcontracts with other entities to administer its Community Supports obligations under this Contract, the Community Supports Provider shall ensure the agreements with each Subcontractor bind that Subcontractor to applicable terms and conditions set forth in this Section 2.42 and Attachment A of this Contract and CalOptima Policies. Notwithstanding any subcontracting arrangements, Community Supports Provider shall remain responsible and accountable for any subcontracted Community Supports functions.

2.42.2 Delivery of Community Supports. Community Supports Provider shall deliver contracted Community Supports in accordance with the DHCS service definitions and requirements, CalOptima Policies, including but not limited to, CalOptima Policy GG.1355: Community Supports, and this Contract.

2.42.2.1 Community Supports Provider shall maintain staffing that allows for timely, high-quality service delivery of the Community Supports that it is required to provide under this Contract.

2.42.2.2 Community Supports Provider shall:

a. Accept and act upon Member referrals from CalOptima or Health Network for authorized Community Supports, unless the Community Supports Provider is at pre-determined capacity;

b. Conduct outreach to the referred Member for authorized Community Supports as soon as possible, including by making best efforts to conduct initial outreach within twenty four (24) hours of assignment, if applicable;

c. Be responsive to incoming calls or other outreach from Members, including by maintaining a phone line that is staffed or able to record voicemail twenty four (24) hours a day, seven (7) days a week;

d. Coordinate with other providers in the Member's care team, including ECM Providers, other Community Supports providers, CalOptima, and Health Networks;

e. Comply with cultural competency and linguistic requirements required by this Contract, CalOptima Policies, and federal, State and local laws;

f. Comply with non-discrimination requirements set forth in this Contract and State and federal laws.

2.42.3 When federal law requires authorization for data sharing, Community Supports Provider shall obtain and/or document such authorization from each assigned Member, including sharing of protected health information ("PHI"), and shall confirm it has obtained such authorization to CalOptima. Member authorization for Community Supports-related data sharing is not required for the Community Supports Provider to initiate delivery of Community Supports unless such authorization is required by federal law. Community Supports Provider will be reimbursed only for Community Supports services that are authorized by CalOptima or Health Network. In the event of a Member requesting Community Supports services that are not yet authorized by CalOptima or a Health Network, Community Supports Provider shall send prior authorization request(s) to CalOptima for a CalOptima Direct Member or the Member's assigned Health Network, as applicable.

2.42.4 If a Community Supports is discontinued for any reason, Community Supports Provider shall support transition planning for the Member into other programs or services that meet their needs.

2.42.5 Community Supports Provider is encouraged to identify additional Community Supports the Member may benefit from and send any additional request(s) for Community Supports to CalOptima or Health Network for authorization.

2.42.6 Payment of Community Supports. Community Supports Provider shall record, generate, and send a claim or invoice to CalOptima for Community Supports rendered. If

Community Supports Provider submits claims, Community Supports Provider Shall submit claims to CalOptima using specifications based Medi-Cal national standards and code sets defined by DHCS.

2.42.6.1 In the event Community Supports Provider is unable to submit claims to CalOptima for Community Supports-related services using specifications based on national standards or DHCS-defined standard specifications and code sets, Community Supports Provider shall submit invoices with minimum necessary data elements defined by DHCS, which includes (i) information about the Member, (ii) the Community Supports services rendered, and (iii) Community Supports Providers' information to support appropriate reimbursement by CalOptima, that will allow CalOptima to convert Community Supports invoice information into DHCS-defined standard specifications and code sets for submission to DHCS.

2.42.6.2 Community Supports Provider shall not receive payment from CalOptima for the provision of any Community Supports services not authorized by CalOptima or Health Network.

2.42.6.3 CalOptima will provide expedited payments for urgent Community Supports (e.g., Recuperative Care services for a Member who no longer requires hospitalization, but still needs to heal from an injury or illness, including behavioral health conditions, and whose condition would be exacerbated by an unstable living environment), pursuant to its contract with DHCS and any other related DHCS guidance.

2.42.7 Community Supports Provider must have a system in place to accept payment from CalOptima for Community Supports rendered. CalOptima shall pay ninety percent (90%) of all clean claims and invoices within thirty (30) days of receipt and ninety nine percent (99%) of clean claims and invoices within ninety (90) days of receipt.

2.42.8 Data Sharing to Support Community Supports. As part of the referral process, CalOptima will ensure Community Supports Provider has access to:

2.42.8.1 Demographic and administrative information confirming the referred Member's eligibility for the requested service;

2.42.8.2 Appropriate administrative, clinical, and social service information the Community Supports Provider might need in order to effectively provide the requested service; and

2.42.8.3 Billing information necessary to support the Community Supports Provider's ability to submit invoices to CalOptima.

2.42.8.4 Quality and Oversight. Community Supports Provider acknowledges that CalOptima will conduct oversight of its delivery of Community Supports to ensure the quality of services rendered and ongoing compliance with all legal and contractual obligations both CalOptima and the Community Supports Provider have, including but not limited to, required reporting, audits, and corrective actions, among other oversight activities.

ARTICLE 3
FUNCTIONS AND DUTIES OF CALOPTIMA

3.1 Payment. CalOptima shall pay Provider for Covered Services provided to CalOptima Members. Provider agrees to accept the compensation set forth in Attachment C as payment in full from CalOptima for such Covered Services. Upon submission of a Clean Claim, CalOptima shall pay Provider pursuant to CalOptima Policies and Attachment C. Notwithstanding the foregoing, Provider may also collect other amounts (e.g., copayments, deductibles, OHC and/or third party liability payments) where expressly authorized to do so under the CalOptima Program(s) and applicable law. Provider agrees that Members will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts and that the provider will (A) accept the plan payment as payment in full, or (B) bill the appropriate State source as required at 42 CFR §422.504(g)(1)(iii).

3.2 Service Authorization. CalOptima shall provide a written authorization process for Covered Services pursuant to CalOptima Policies.

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

ARTICLE 4
PAYMENT PROCEDURES

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

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

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

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

4.5 COB. Provider shall coordinate benefits with other programs or entitlements recognizing where OHC is primary coverage in accordance with CalOptima Program requirements. Provider acknowledges that Medi-Cal is the payor of last resort.

4.6 (This section left intentionally blank)

4.7 Member Financial Protections. Provider and its Subcontractors shall comply with Member financial protections as follows:

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

4.7.2 In no event, including, but not limited to, non-payment by CalOptima, CalOptima's or Provider's insolvency, or breach of this contract by CalOptima, shall Provider, or any of its Subcontractors, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against the State of California or any Member or person acting on behalf of a Member for Covered Services pursuant to this Contract. Notwithstanding the foregoing, Provider may collect SOC, co-payments, and deductibles if, and to the extent, required under a specific CalOptima Program and applicable law.

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

4.7.4 Upon receiving notice of Provider invoicing or balance billing a Member for the difference between the Provider's billed charges and the reimbursement paid by CalOptima for any Covered Services, CalOptima may sanction the Provider or take other action as provided in this Contract.

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

4.8 Overpayments and CalOptima Right to Recover. Provider has an obligation to report any overpayment identified by Provider, and to repay such overpayment to CalOptima within sixty (60) days of such identification by Provider, or of receipt of notice of an overpayment identified by CalOptima. Provider acknowledges and agrees that, in the event that CalOptima determines that an amount has been overpaid or paid in duplicate, or that funds were paid which were not due under this Contract to Provider, CalOptima shall have the right to recover such amounts from Provider by recoupment or offset from current or future amounts due from CalOptima to Provider, after giving Provider notice and an opportunity to return/pay such amounts. This right to recoupment or offset shall extend to any amounts due from Provider to CalOptima, including, but not limited to, amounts due because of:

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

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

4.8.3 Unpaid Conlan reimbursements owed by provider to a Member.

4.8.4 Payments made for services provided by a Provider that has entered into a private contract with a Medicare beneficiary for Covered Services.

ARTICLE 5
INSURANCE AND INDEMNIFICATION

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

5.2 Provider Professional Liability. Provider, at its sole cost and expense, shall ensure that it and Subcontractors providing professional services under this Contract shall maintain professional liability insurance coverage with minimum per incident and annual aggregate amounts which are at least equal to the community minimum amounts in Orange County, California, for the specialty or type of service which Provider provides, with a minimum of $1,000,000 per incident/$3,000,000 aggregate per year.

5.2.1 If the provision of Covered Services under this Contract requires direct face-to-face contact with a Member whereby the Member is alone with Provider's staff or Subcontractors, and the opportunity for harm to Member could arise, Provider and/or its Subcontractors, as applicable, shall maintain Sexual Misconduct Insurance (Abuse & Molestation Coverage) with the minimum per incident and annual aggregate limit of $1,000,000.

5.3 Provider Commercial General Liability ("CGL")/Automobile Liability. Provider at its sole cost and expense shall maintain such policies of commercial general liability and automobile liability insurance and other insurance as shall be necessary to insure it and its business addresses, customers (including Members), employees, agents, and representatives against any claim or claims for damages arising by reason of a) personal injuries or death occasioned in connection with the furnishing of any Covered Services hereunder, b) the use of any property of the Provider, and c) activities performed in connection with the Contract, with minimum coverage of $1,000,000 per incident/$3,000,000 aggregate per year.

5.4 Workers Compensation Insurance. Provider at its sole cost and expense shall maintain workers compensation insurance within the limits established and required by the State of California and employers liability insurance with minimum limits of liability of $1,000,000 per occurrence/$1,000,000 aggregate per year.

5.5 Insurer Ratings. All above insurance shall be provided by an insurer:

5.5.1 rated by Best's with a rating of B or better; and

5.5.2 "admitted" to do business in California or an insurer approved to do business in California by the California Department of Insurance and listed on the Surplus Lines Association of California List of Eligible Surplus Lines Insurers (LESLI) or licensed by the California Department of Corporations as an Unincorporated Interindemnity Trust Arrangement as authorized by the California Insurance Code 12180.7.

5.6 Captive Risk Retention Group/Self Insured. Where any of the insurances mentioned above are provided by a Captive Risk Retention Group or are self-insured, such above provisions may be waived at the sole discretion of CalOptima, but only after CalOptima reviews the Captive Risk Retention Group's or self-insured's audited financial statements and approves the waiver.

5.7 Cancellation or Material Change. The Provider shall not of its own initiative cause such insurances as addressed in this Article to be canceled or materially changed during the term of this Contract.

5.8 Certificates of Insurance. Prior to execution of this Contract, Provider shall provide Certificates of Insurance to CalOptima showing the required insurance coverage and further providing that CalOptima is named as an additional insured on the Comprehensive General Liability Insurance and Automobile Liability Insurance with respect to the performance hereunder and coverage is primary and non-contributory as to any other insurance with respect to performance hereunder.

ARTICLE 6
RECORDS, AUDITS AND REPORTS

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

6.2 Medical Records. Provider and its Subcontractors shall establish and maintain for each Member who has obtained Covered Services, medical records which are organized in a manner which contain such demographic and clinical information as is necessary to provide and ensure accurate and timely documentation as to the medical problems and Covered Services provided to the Member. Such medical records shall be consistent with State and Federal laws and CalOptima Program requirements and shall include a historical record of diagnostic and therapeutic services recommended or provided by, or under the direction of, the Provider. Such medical records shall be in such a form as to allow trained health professionals, other than the Provider, to readily determine the nature and extent of the Member's medical problem and the services provided, and to permit peer review of the care furnished to the Member.

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

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

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

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

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

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

6.6 Data Submission. Provider shall submit to CalOptima complete, accurate, reasonable, and timely provider data, encounter date, and other data and reports (a) needed by CalOptima in order for CalOptima to meet its reporting requirements to DHCS, and/or (b) required by CalOptima and CalOptima's Regulators as provided in this Contract and in CalOptima's Policies.

ARTICLE 7
TERM AND TERMINATION

7.1 Term. The term of this Contract shall become effective on the Effective Date through June 30, 2023. This Contract shall then automatically extend for additional one-year terms (July 1st through June 30th) upon formal approval by the CalOptima Board of Directors, unless earlier terminated by either party as provided for in this Contract.

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

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

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

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

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

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

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

7.8 Obligations Upon Termination. Upon termination of this Contract, it is understood and agreed that Provider shall continue to provide authorized Covered Services to Members who retain eligibility and who are under the care of Provider at the time of such termination, until the services being rendered to Members are completed, unless CalOptima, in its sole discretion, makes reasonable and medically appropriate provisions for the assumption of such services. Payment for services under this paragraph shall be at the contracted rates. Prior to the termination or expiration of this Contract, and upon request by CalOptima or one of its regulatory agencies to assist in the orderly transfer of Members' medical care, Provider shall make available to CalOptima and/or such regulatory agency, copies of any pertinent information, including information maintained by Provider and any Subcontractor necessary for efficient case management of Members. Costs of reproduction shall be borne by CalOptima or the government agency, as applicable. For purposes of this section only, "under the care of Provider" shall mean that a Member has an authorization from CalOptima to receive services from the Provider issued prior to the Termination, all of the services authorized under that authorization have not yet been completed, and the time period covered by the authorization has not yet expired.

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

ARTICLE 8
GRIEVANCES AND APPEALS

8.1 Provider Grievances. CalOptima has established a fast and cost-effective complaint system for provider complaints, grievances and appeals. Provider shall have access to this system for any issues arising under this Contract, as provided in CalOptima Policies related to the applicable CalOptima Program(s). Provider complaints, grievances, appeals, or other disputes regarding any issues arising under this Contract shall be resolved through such system.

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

ARTICLE 9
GENERAL PROVISIONS

9.1 Assignment and Assumption. Provider acknowledges and agrees that a primary goal of CalOptima is to ensure the provision of quality healthcare services to CalOptima Members and that CalOptima and Provider have entered into this Contract for the benefit of CalOptima Members. Accordingly, CalOptima retains the rights set forth in this Section. Except as specifically permitted hereunder, this Contract is not assignable by the Provider, either in whole or in part, without the prior written consent of CalOptima, provided that CalOptima's consent may be withheld in its sole and absolute discretion. For purposes of this Section and this Contract, assignment includes, without limitation, (a) the change of more than twenty-five percent (25%) of the ownership or equity interest in

Provider (whether in a single transaction or in a series of transactions), (b) the change of more than twenty-five percent (25%) of the directors or trustees of Provider, (c) the merger, reorganization, or consolidation of Provider with another entity with respect to which Provider is not the surviving entity, and/or (d) a change in the management of Provider from management by persons appointed, elected or otherwise selected by the governing body of Provider (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

9.2 Documents Constituting Contract. This Contract and its attachments, schedules, addenda and exhibits and all CalOptima Policies applicable to Covered Services and CalOptima Members (and any amendments thereto) shall constitute the entire agreement between the parties. It is the express intention of Provider and CalOptima that any and all prior or contemporaneous agreements, promises, negotiations or representations, either oral or written, relating to the subject matter and period governed by this Contract which are not expressly set forth herein shall be of no further force, effect or legal consequence after the effective date hereunder.

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

9.4 Governing Law and Venue. This Contract shall be governed by and construed in accordance with all laws of the State of California and Federal laws and regulations applicable to the CalOptima Programs and all contractual obligations of CalOptima. Provider shall bring any and all legal proceedings against CalOptima under this Contract in California State courts located in Orange County, California, unless mandated by law to be brought in federal court, in which case such legal proceedings shall be brought in the Central District Court of California.

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

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

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

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

provided hereunder shall be delivered, exchanged or otherwise provided in a manner which does not constitute a waiver of immunity or privilege under applicable law.

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

If to CalOptima:

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

If to Provider:

_____
Name

_____
Title

_____
Address

_____

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

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

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

9.13 Authority to Execute. The persons executing this Contract on behalf of the parties warrant that they are duly authorized to execute this Contract, and that by executing this Contract, the parties are formally bound.

9.14 Severability. In the event any provision of this Contract is rendered invalid or unenforceable by Act of Congress, by statute of the State of California, by any regulation duly promulgated by the United States or the State of California in accordance with law or is declared null and void by any court of competent jurisdiction, the remainder of the provisions hereof shall remain in full force and effect.

ARTICLE 10
EXECUTION

10.1 Subject to the State of California and United States providing funding for the term of this Contract and for the purposes with respect to which it is entered into, and execution of the Government Contracts and the approval of the Contract by the Government Agencies, this Contract shall become effective as of _____the Effective Date.

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

Provider	**CalOptima**
_____	_____
Signature	Signature
_____	_____
Print Name	Print Name
_____	Chief Operating Officer
Title	Title
_____	_____
Date	Date

ATTACHMENT A
COVERED SERVICES
ARTICLE 1
CALOPTIMA PROGRAMS

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

X Medi-Cal Program

X Medicare Advantage Program (One Care)

X Cal MediConnect Program/OneCare Connect (Members dually eligible for Medicare and Medi-Cal)

ARTICLE 2
SERVICES

2.1 Scope of Covered Services. "Covered Services", as referred to in this Contract, means the services described in each of the schedules to this Attachment A.

ATTACHMENT A
Recuperative Care (Medical Respite) Schedule

1. Description/Overview

A. Recuperative Care, also referred to as medical respite care and as defined in this Section 1, is short-term residential care for Members who no longer require hospitalization but still need to heal from an injury or illness (including behavioral health conditions) and whose condition would be exacerbated by an unstable living environment ("**Recuperative Care**"). An extended stay in a recovery care setting allows Members to continue their recovery and receive post-discharge treatment while obtaining access to primary care, behavioral health services, case management and other supportive social services, such as transportation, food, and housing.

B. At a minimum, the service will include interim housing with a bed and meals and ongoing monitoring of the Member's ongoing medical or behavioral health condition (e.g., monitoring of vital signs, assessments, wound care, medication monitoring). Based on Member needs, the service may also include:

i. Limited or short-term assistance with Instrumental Activities of Daily Living ("IADLs")/or Activities of Daily Living ADLs

ii. Coordination of transportation to post-discharge appointments

iii. Connection to any other ongoing services a Member may require including mental health and substance use disorder services

iv. Support in accessing benefits and housing

v. Gaining stability with case management relationships and programs

C. Recuperative Care is primarily used for those Members who are experiencing homelessness or those with unstable living situations who are too ill or frail to recover from an illness (physical or behavioral health) or injury in their usual living environment; but who are not otherwise ill enough to be in a hospital.

D. The services provided to a Member while in Recuperative Care shall not replace or be duplicative of the services provided to Members utilizing the ECM program. Recuperative care may be utilized in conjunction with other housing Community Supports. Whenever possible, other housing Community Supports shall be provided to members on-site in the Recuperative Care facility. When enrolled in ECM, Community Supports shall be managed in coordination with ECM providers.

E. The services provided shall utilize best practices for Members who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions, including housing first, harm reduction, progressive engagement, motivational interviewing, and trauma informed care.

2. Eligibility

A. Members who are at risk of hospitalization or are post-hospitalization, and

B. Members who live alone with no formal supports; or

C. Members who face housing insecurity or have housing that would jeopardize their health and safety without modification. For this population, the service could be coordinated with home modifications (which are covered as a separate Community Supports) and serve as a temporary placement until the Member can safely return home.

3. Restrictions and Limitations

A. Recuperative Care is an allowable Community Supports service if it is (1) necessary to achieve or maintain medical stability and prevent hospital admission or re-admission, which may require behavioral health interventions, (2) is not more than 90 days in continuous duration, and (3) does not include funding for building modification or building rehabilitation.

B. Members may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

4. Licensing/Allowable Community Supports Providers

A. This list is provided to show examples of the types of providers CalOptima may choose to contract with, but it is not an exhaustive list of providers that may offer the services for Provider.

i. Interim housing facilities with additional on-site support

ii. Shelter beds with additional on-site support

iii. Converted homes with additional on-site support

iv. County directly operated or contracted Recuperative Care facilities

B. Facilities Are unlicensed. CalOptima shall apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. CalOptima can adopt or adapt local or national standards for Recuperative Care or interim housing. CalOptima shall monitor the provision of all the services included above.

C. Community Supports Providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS All Plan Letters (APLs), including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, CalOptima must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

ATTACHMENT A
Housing Deposits Schedule

1. Description/Overview

A. Housing Deposits, as defined in this Section 1, assist with identifying, coordinating, securing, or funding one-time services and modifications necessary to enable a person to establish a basic household that do not constitute payment for room and board, such as:

i. Security deposits required to obtain a lease on an apartment or home.

ii. Set-up fees/deposits for utilities or service access and utility arrearages.

iii. First month coverage of utilities, including but not limited to telephone, gas, electricity, heating, and water.

iv. First month's and last month's rent as required by landlord for occupancy.

v. Services necessary for the Member's health and safety, such as pest eradication and one-time cleaning prior to occupancy.

vi. Goods such as an air conditioner or heater, and other medically necessary adaptive aids and services, designed to preserve a Members' health and safety in the home, such as hospital beds, Hoyer lifts, air filters, and specialized cleaning or pest control supplies etc., that are necessary to ensure access and safety for the Member upon move-in to the home.

B. Housing Deposits provided shall be based on individualized assessment of needs and documented in the individualized housing support plan. Members may require and access a subset of the services listed above.

C. Housing Deposits provided shall utilize best practices for Members who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions, including housing first, harm reduction, progressive engagement, motivational interviewing, and trauma informed care.

D. Housing Deposits do not include the provision of room and board or payment of ongoing rental costs beyond the first and last month's coverage as noted above.

2. Eligibility

A. Any Member who received Housing Transition/Navigation Services Community Supports in counties that offer Housing Transition/Navigation Services;

B. Members who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless coordinated entry system or similar system designed to use information to identify highly vulnerable Members with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services as a result of a substance use disorder and/or is exiting incarceration; or

C. Members who meet the Housing and Urban Development ("**HUD**") definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving ECM, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals.

3. Restrictions and Limitations

A. Housing Deposits are available once in a Member's lifetime. Housing Deposits can only be approved one additional time with documentation as to what conditions have changed to demonstrate why providing Housing Deposits would be more successful on the second attempt. CalOptima is expected to make a good faith effort to review information available to it to determine whether a Member has previously received services.

B. These services must be identified as reasonable and necessary in the Member's individualized housing support plan and are available only when the Member is unable to meet such expense.

C. Members must also receive Housing Transition/Navigation services (at a minimum, the associated tenant screening, housing assessment and individualized housing support plan) in conjunction with this service.

D. Members may not be receiving duplicative support from other State, local or federally funded programs, which shall always be considered first, before using Medi-Cal funding.

4. Licensing/Allowable Community Supports Providers

A. Community Supports Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner. This list is provided to show examples of the types of Community Supports Providers CalOptima may choose to contract with, but it is not an exhaustive list of providers that may offer the services.

B. The entity that is coordinating a Member's Housing Transition Navigation Services, or the CalOptima case manager, care coordinator, or housing navigator, may coordinate these services and pay for them directly (e.g., to the landlord, utility company, pest control company, etc.) or subcontract the services.

C. Community Supports Providers must have demonstrated or verifiable experience and expertise with providing these unique services.

D. Community Supports Providers that have a state-level enrollment pathway must enroll in the Medi-Cal program pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment (APL 19-004). If there is no state-level enrollment pathway, CalOptima must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on

behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

ATTACHMENT A
Housing Transition Navigation Services Schedule

1. Description/Overview

A. Housing Transition Navigation services, as defined in this Section 1, assist Members with obtaining housing and include:

i. Conducting a tenant screening and housing assessment that identifies the Member's preferences and barriers related to successful tenancy. The assessment may include collecting information on the Member's housing needs and on potential Housing Transition barriers, as well as identification of housing retention barriers.

ii. Developing an individualized housing support plan based upon the housing assessment that addresses identified barriers, includes short- and long-term measurable goals for each issue, establishes the Member's approach to meeting the goal, and identifies when other Providers or services, both reimbursed and not reimbursed by Medi-Cal, may be required to meet the goal.

iii. Searching for housing and presenting options.

iv. Assisting in securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).

v. Assisting with benefits advocacy, including assistance with obtaining identification and documentation for Supplemental Security Income ("SSI") eligibility and supporting the SSI application process. Such service can be subcontracted out to retain needed specialized skillset.

vi. Identifying and securing available resources to assist with subsidizing rent (such as U.S. Department of Housing and Urban Development's Housing Choice Voucher Program ("Section 8")) or state and local assistance programs and matching available rental subsidy resources to Members.

vii. Identifying and securing resources to cover expenses, such as security deposit, moving costs, adaptive aids, environmental modifications, moving costs, and other one-time expenses. Actual payment of these Housing Deposits and move-in expenses is a separate Community Supports under the Housing Deposits Schedule of this Agreement, if applicable.

viii. Assisting with requests for reasonable accommodation, if necessary, as related to expenses incurred by the housing navigator supporting the Member moving into the home.

ix. Educating and engaging with landlords.

x. Ensuring that the living environment is safe and ready for move-in.

xi. Communicating and advocating on behalf of the Member with landlords.

xii. Assisting with arranging for and supporting the details of the move.

xiii. Establishing procedures and contacts to retain housing, including developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized. The services associated with the crisis plan are a separate Community Supports under Housing Tenancy and Sustaining Services.

xiv. Identifying, coordinating, securing, or funding non-emergency, non-medical transportation to assist Members' mobility to ensure reasonable accommodations and access to housing options prior to transition and on move-in day.

xv. Identifying and coordinating environmental modifications to install necessary accommodations for accessibility (*see* Community Supports under Environmental Accessibility Adaptations).

B. The Housing Transition Navigation services provided should be based on individualized assessment of needs and documented in the individualized housing support plan. Members may only require and access only a subset of the services listed above.

C. The Housing Transition Navigation services provided shall utilize best practices for Members who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions. Examples of best practices include housing first harm reduction, progressive engagement, motivational interviewing, and trauma informed care.

D. The Housing Transition Navigation services may involve additional coordination with other entities to ensure the Member has access to supports needed for successful tenancy. These entities may include County Health, Public Health, Substance Use, Mental Health and Social Services Departments; County and City Housing Authorities; Continuums of Care and Coordinated Entry System; Sheriff's Department and Probation Officers, as applicable and to the extent possible; local legal service programs, community-based organizations housing Providers, local housing agencies, and housing development agencies. For Members who will need rental subsidy support to secure permanent housing, the services will require close coordination with local Coordinated Entry Systems, homeless services authorities, public housing authorities, and other operators of local rental subsidies. Some housing assistance (including recovery residences and emergency assistance or rental subsidies for Full Service Partnership Members) is also funded by county behavioral health agencies, and CalOptima and their contracted Community Supports Providers should expect to coordinate access to these housing resources through county behavioral health when appropriate.

E. The Housing Transition Navigation services should adopt, as a standard, the demonstrated need to ensure seamless service to Members experiencing homelessness entering the Housing Transition Navigation Services to Community Supports.

F. The Housing Transition Navigation services do not include the provision of room and board or payment of rental costs. Coordination with local entities is crucial to ensure that available options for room and board or rental payments are also coordinated with housing services and supports.

2. Eligibility

A. Members who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable Members with disabilities and/or one or more serious chronic conditions and/or serious mental illness or institutionalization or requiring residential services as a result of a substance use disorder and/or exiting incarceration; or

B. Members who meet the Housing and Urban Development ("**HUD**") definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving ECM, or who have one or more serious chronic conditions and/or serious mental illness and/or are at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facilities, substance use disorder residential treatment facilities, recovery residences, institution for mental diseases and state hospitals; or

C. Members who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:

i. A Member or family who:

a. Has an annual income below 30 percent of median family income for the area, as determined by HUD;

b. Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in the "Homeless" definition in this section; and

c. Meets one of the following conditions:

(i) Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;

(ii) Is living in the home of another because of economic hardship;

(iii) Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance;

(iv) Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income Members;

(v) Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room,

as defined by the U.S. Census Bureau;

(vi) Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or

(vii) Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;

ii. A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or

iii. A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him.

D. Members who are determined to be at risk of experiencing homelessness are eligible to receive Housing Transition Navigation services if they have significant barriers to housing stability and meet at least one of the following:

i. Have one or more serious chronic conditions;

ii. Have a serious mental illness;

iii. Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder or have a serious emotional disturbance (children and adolescents);

iv. Are receiving Enhanced Care Management ("ECM"); or

v. Are a transition-age youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have serious mental illness and/or are children or adolescents with serious emotional disturbance and/or who have been victims of trafficking or domestic violence.

3. Restrictions and Limitations

A. Housing Transition/Navigation services must be identified as reasonable and necessary in the Member's individualized housing support plan. The service duration can be as long as necessary.

B. Members may not be receiving duplicative support from other State, local tax or federally funded programs, which should always be considered first, before using Medi-Cal funding.

4. Licensing/Allowable Community Supports Providers

A. Community Supports Providers providing Housing Transition Navigation services must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner. This list is provided to show examples of the types of Community Supports Providers that CalOptima may choose to contract with, but it is not an exhaustive list of Community Supports Providers who may offer the services.

B. These Community Supports Providers must have demonstrated experience with providing housing-related services and supports and may include Providers such as:

i. Vocational services agencies;

ii. Providers of services for Members experiencing homelessness;

iii. Life skills training and education providers;

iv. County agencies;

v. Public hospital systems;

vi. Mental health or substance use disorder treatment providers, including county behavioral health agencies;

vii. Social services agencies;

viii. Affordable housing providers;

ix. Supportive housing providers; and

x. Federally qualified health centers and rural health clinics.

Community Supports Providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, CalOptima must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider. Members who meet the eligibility requirements for Housing Transition/Navigation services shall also be assessed for ECM and Housing and Tenancy Support Services (if provided in their county). When enrolled in ECM, Community Supports Services should be managed in coordination with ECM Providers. When Members receive more than one of these services, CalOptima should ensure services are coordinated by an ECM Provider whenever possible to minimize the number of care/case management transitions experienced by Members and to improve overall care coordination and management. One exception to this is for benefits advocacy, which may require providers with a specialized skill set.

C. If the CalOptima case manager, care coordinator or housing navigator is providing the service, that individual must have demonstrated experience working with Members experiencing homelessness or with the provision of housing-related services and supports to vulnerable populations.

ATTACHMENT A
Housing Tenancy and Sustaining Services Schedule

1. Description/Overview

A. Housing Tenancy and Sustaining services, as defined in this Section 1, provide tenancy and sustaining services, with a goal of maintaining safe and stable tenancy once housing is secured. Services include:

i. Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment, hoarding, substance use, and other lease violations.

ii. Education and training on the roles, rights and responsibilities of the tenant and landlord.

iii. Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy.

iv. Coordination with the landlord and case management provider to address identified issues that could impact housing stability.

v. Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action including developing a repayment plan or identifying funding in situations in which the Member owes back rent or payment for damage to the unit.

vi. Advocacy and linkage with community resources to prevent eviction when housing is or may potentially become jeopardized.

vii. Assisting with benefits advocacy, including assistance with obtaining identification and documentation for SSI eligibility and supporting the SSI application process. Such service can be subcontracted out to retain needed specialized skill set.

viii. Assistance with the annual housing recertification process.

ix. Coordinating with the tenant to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers.

x. Continuing assistance with lease compliance, including ongoing support with activities related to household management.

xi. Health and safety visits, including unit habitability inspections. This does not include housing quality inspections.

xii. Other prevention and early intervention services identified in the crisis plan that are activated when housing is jeopardized (e.g., assisting with reasonable accommodation requests that were not initially required upon move-in).

xiii. Providing independent living and life skills including assistance with and training on budgeting, including financial literacy and connection to community resources.

B. The services provided shall be based on individualized assessment of needs and documented in the individualized housing support plan. Members may only require and access a subset of the services listed above.

C. The services provided shall utilize best practices for Members who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions including housing first, harm reduction, progressive engagement, motivational interviewing, and trauma informed care.

D. The services may involve coordination with other entities to ensure the Member has access to supports needed to maintain successful tenancy. Final program guidelines shall adopt, as a standard, the demonstrated need to ensure seamless service to Members experiencing homelessness entering the Housing Tenancy and Sustaining Services Community Supports.

E. Services do not include the provision of room and board or payment of rental costs.

2. Eligibility

A. Any Member who received Housing Transition/Navigation Services Community Supports;

B. Members who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable Members with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services as a result of a substance use disorder and/or is exiting incarceration; or

C. Members who meet the Housing and Urban Development ("**HUD**") definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving ECM, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, institutions for mental disease and state hospitals; or

D. Members who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:

i. A Member or family who:

a. Has an annual income below 30 percent of median family income for the area, as determined by HUD;

b. Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to

prevent them from moving to an emergency shelter or another place described in paragraph C of the "Homeless" definition in this section; and

c. Meets one of the following conditions:

(i) Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;

(ii) Is living in the home of another because of economic hardship;

(iii) Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance;

d. Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income Members;

e. Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;

f. Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or

g. Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;

ii. A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or

iii. A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him.

iv. Members who are determined to be at risk of experiencing homelessness are eligible to receive Housing Tenancy and Sustaining Services if they have significant barriers to housing stability and meet at least one of the following:

a. Have one or more serious chronic conditions;

b. Have a serious mental illness;

c. Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder or have a serious emotional disturbance (children and adolescents);

d. Are receiving ECM; or

e. Are a transition-age youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking or domestic violence.

3. Restrictions and Limitations

A. These Housing Tenancy and Sustaining services are available from the initiation of services through the time when the Member's housing support plan determines they are no longer needed. They are only available for a single duration in the Member's lifetime. Housing Tenancy and Sustaining Services can only be approved one additional time with documentation as to what conditions have changed to demonstrate why providing Housing Tenancy and Sustaining Services would be more successful on the second attempt. CalOptima is expected to make a good faith effort to review information available to it to determine if Member has previously received services. The service duration can be as long as necessary.

B. These Housing Tenancy and Sustaining services must be identified as reasonable and necessary in the Member's individualized housing support plan and are available only when the enrollee is unable to successfully maintain longer-term housing without such assistance.

C. Many Members will have also received Housing Transition/Navigation services (at a minimum, the associated tenant screening, housing assessment and individualized housing support plan) in conjunction with this service, but accessing such services is not a prerequisite for eligibility.

D. Members may not be receiving duplicative support from other State, local or federally funded programs, which shall always be considered first, before using Medi-Cal funding.

4. Licensing/Allowable Community Supports Providers

A. Community Supports Providers providing Housing Tenancy and Sustaining services must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner. This list is provided to show examples of the types of Community Supports Providers that CalOptima may choose to contract with, but it is not an exhaustive list of providers who may offer the services. Providers must have demonstrated or verifiable experience or expertise with providing housing-related services and supports and may include providers such as:

i. Vocational services agencies

ii. Providers of services for Members experiencing homelessness

iii. Life skills training and education providers

iv. County agencies

v. Public hospital systems

vi. Mental health or substance use disorder treatment providers, including county behavioral health agencies

vii. Supportive housing providers

viii. Federally qualified health centers and rural health clinics

B. Community Supports. Providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs, including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, CalOptima must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

C. If the CalOptima case manager, care coordinator or housing navigator is providing the service, that individual must have demonstrated experiencing working with Members experiencing homelessness or with the provision of housing-related services and supports to vulnerable populations. CalOptima should coordinate with county homelessness entities to provide these services.

D. Members who meet the eligibility requirements for Housing and Tenancy Support Services shall also be assessed for ECM and may have received Housing Transition/Navigation services. When enrolled in ECM, Community Supports shall be managed in coordination with ECM providers. When Members receive more than one of these services, CalOptima shall ensure it is coordinated by an ECM provider whenever possible to minimize the number of care/case management transitions experienced by Members and to improve overall care coordination and management.

ATTACHMENT A
Day Habilitation Programs Schedule

1. Description/Overview.

A. Day Habilitation Programs, as defined in this Section 1, are provided in a Member's home or an out-of-home, non- facility setting. Day Habilitation Programs are designed to assist the Member in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in the person's natural environment. Day Habilitation Programs are often considered as peer mentoring when provided by an unlicensed caregiver with the necessary training and supervision. For Members experiencing homelessness who are receiving ECM or other Community Supports Services, Day Habilitation Programs can provide a physical location for Members to meet with and engage with these Community Supports Providers. When possible, these services should be provided by the same entity to minimize the number of care/case management transitions experienced by Members and to improve overall care coordination and management.

B. As used in this Schedule, the General Assistance or General Relief ("GA/GR") Program is designed to provide relief and support to indigent adults who are not supported by their own means, other public funds, or assistance programs.

C. Day habilitation program services include, but are not limited to, training on:

i. The use of public transportation;

ii. Personal skills development in conflict resolution;

iii. Community participation;

iv. Developing and maintaining interpersonal relationships;

v. Daily living skills (cooking, cleaning, shopping, money management); and,

vi. Awareness of community resources such as police, fire, or local services, to support independence in the community.

D. Day Habilitation Programs may include assistance with, but not limited to, the following:

i. Selecting and moving into a home (refer to the Housing Transition/Navigation Services Community Supports);

ii. Locating and choosing suitable housemates;

iii. Locating household furnishings;

iv. Settling disputes with landlords (refer to the Housing Tenancy and Sustaining Services Community Supports);

v. Managing personal financial affairs;

vi. Recruiting, screening, hiring, training, supervising, and dismissing personal attendants;

vii. Dealing with and responding appropriately to governmental agencies and personnel;

viii. Asserting civil and statutory rights through self-advocacy;

ix. Building and maintaining interpersonal relationships, including a circle of support;

x. Coordination with CalOptima to link Member to any in Community Supports and or ECM services for which the Member may be eligible;

xi. Referral to non-Community Supports housing resources if the Member does not meet Housing Transition and Navigation Services Community Supports eligibility criteria;

xii. Assistance with income and benefits advocacy, including GA/GR and SSI if the Member is not receiving these services through Community Supports or ECM; and

xiii. Coordination with CalOptima to link the Member to health care, mental health services, and substance use disorder services based on the individual needs of the the Member, for Members who are not receiving this linkage through Community Supports or ECM.

E. The services provided should utilize best practices for Members who are experiencing homelessness or formerly experienced homelessness including housing first, harm reduction, progressive engagement, motivational interviewing, and trauma informed care. Day Habilitation Program services are available for as long as necessary and can be provided continuously or through intermittent meetings, in an individual or group setting.

2. Eligibility

Members who are experiencing homelessness, Members who exited homelessness and entered housing in the last twenty-four (24) months, and Members at risk of homelessness or institutionalization whose housing stability could be improved through participation in a Day Habilitation Program.

3. Restrictions and Limitations

Members may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

4. Licensing and Allowable Community Supports Providers

Community Supports Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of Providers who may provide Day Habilitation Programs, but it is not an exhaustive list of Community Supports Providers who may offer these programs.

A. Mental health or substance use disorder treatment providers, including county behavioral health agencies

B. Licensed psychologists

C. Licensed certified social workers

D. Registered nurses

E. Home health agencies

F. Professional fiduciary

G. Vocational skills agencies

Community Supports Providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs, including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, CalOptima must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

ATTACHMENT A
Medically Tailored Meals Schedule

1. Description/Overview

   A. Malnutrition and poor nutrition can lead to devastating health outcomes, higher utilization, and increased costs, particularly among Members with chronic conditions. Meals help Members achieve their nutrition goals at critical times to help them regain and maintain their health. Results include improved Member health outcomes, lower hospital readmission rates, a well-maintained nutritional health status and increased Member satisfaction.

2. Medically Tailored Meals, as defined in this Section 1, are:

   A. Meals delivered to the home immediately following discharge from a hospital or nursing home when Members are most vulnerable to readmission.

   B. Meals provided to the Member at home that meet the unique dietary needs of those with chronic diseases.

   C. Meals are tailored to the medical needs of the Member by a registered dietitian or other certified nutrition professional, reflecting appropriate dietary therapies based on evidence-based nutritional practice guidelines to address medical diagnoses, symptoms, allergies, medication management, and side effects to ensure the best possible nutrition-related health outcomes.

   D. Medically-supportive food and nutrition services, including medically tailored groceries, healthy food vouchers, and food pharmacies.

   E. Behavioral, cooking, and/or nutrition education is included when paired with direct food assistance as enumerated above.

   CalOptima has the discretion to define criteria for the level of services determined to be both medically appropriate and cost-effective for Members (e.g., Medically Tailored Meals, groceries, food vouchers, etc.).

3. Eligibility

   A. Members with chronic conditions, such as but not limited to diabetes, cardiovascular disorders, congestive heart failure, stroke, chronic lung disorders, human immunodeficiency virus (HIV), cancer, gestational diabetes, or other high risk perinatal conditions, and chronic or disabling mental/behavioral health disorders.

   B. Members being discharged from the hospital or a skilled nursing facility or at high risk of hospitalization or nursing facility placement; or

   C. Members with extensive care coordination needs.

4. Restrictions and Limitations

   A. Medically Tailored Meals cover up to three medically tailored meals per day and or medically-supportive food and nutrition services for up to twelve (12) weeks, or longer if medically necessary.

(i) Meals that are eligible for or reimbursed by alternate programs are not eligible.

(ii) Meals are not covered to respond solely to food insecurities.

Members may not be receiving duplicative support from other State, local or federally funded programs, which shall always be considered first, before using Medi-Cal funding.

5. Licensing and Allowable Community Supports Providers

A. Community Supports Providers must have experience and expertise with providing Medically Tailored Meals. This list is provided as an example of the types of Community Supports Providers who may provide Medically Tailored Meals, but it is not an exhaustive list of providers who may offer these services.

(i) Home delivered meal providers

(ii) Area Agencies on Aging

(iii) Nutritional Education Services to help sustain healthy cooking and eating habits

(iv) Meals on Wheels providers

(v) Medically supportive food and nutrition providers

B. Community Supports Providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs, including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, CalOptima must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

ATTACHMENT A
Personal Care and Homemaker Services Schedule

1. Description/Overview

A. Personal Care and Homemaker Services, as defined in this Section 1, are provided for Members who need assistance with activities of daily living ("**ADL**") such as bathing, dressing, toileting, ambulation or feeding. Personal Care and Homemaker Services can also include assistance with instrumental activities of daily living ("**IADL**") such as meal preparation, grocery shopping and money management.

B. Personal Care and Homemaker Services provided through the In-Home Support Services ("**IHSS**") program include house cleaning, meal preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, bathing, grooming and paramedical services), accompaniment to medical appointments and protective supervision for the mentally impaired.

C. Personal Care and Homemaker Services include help with tasks such as cleaning and shopping, laundry, and grocery shopping. Personal Care Services and Homemaker Services aid Members who otherwise could not remain in their homes.

D. Community Services can be utilized:

i. Above and beyond any approved county IHSS hours, when:

a. Additional hours are required and if IHSS benefits are exhausted; and

b. As authorized during any IHSS waiting period (Member must be already referred to IHSS); this approval time period includes services prior to and up through the IHSS application date.

ii. For Members not eligible to receive IHSS, to help avoid a short-term stay in a skilled nursing facility (not to exceed 60 days).

Similar services available through IHSS shall always be utilized first. These Personal Care and Homemaker Services shall only be utilized if appropriate and if additional hours/supports are not authorized by IHSS.

2. Eligibility

A. Members at risk for hospitalization, or institutionalization in a nursing facility; or

B. Members with functional deficits and no other adequate support system; or

C. Members approved for IHSS. Eligibility criteria can be found at: http://www.cdss.ca.gov/In-Home-Supportive-Services.

3. Restrictions and Limitations.

Personal Care and Homemaker Services cannot be utilized in lieu of referring to the IHSS program. Member must be referred to the IHSS program when they meet referral criteria.

If a Member receiving Personal Care and Homemaker Services has any change in their current condition, they must be referred to IHSS for reassessment and determination of additional hours.

Members may continue to receive Personal Care and Homemaker Services in lieu of IHSS services during this reassessment waiting period.

Members may not be receiving duplicative support from other State, local or federally funded programs, which shall always be considered first, before using Medi-Cal funding.

4. Licensing/Allowable Community Supports Providers

Community Supports Providers must have experience and expertise with providing Personal Care and Homemaker Services. This list is provided as an example of the types of Community Supports Providers that may provide Personal Care and Homemaker Services, but it is not an exhaustive list of providers who may offer the services.

A. Home health agencies

B. County agencies

C. Personal care agencies

D. AAA (Area Agency on Aging)

Community Supports Providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs, including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, CalOptima must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

ATTACHMENT A
Short-Term Post-Hospitalization Housing Schedule

1. Description/Overview

A. Short-Term Post-Hospitalization Housing, as defined in this Section 1, provides Members who do not have a residence and who have high medical or behavioral health needs with the opportunity to continue their medical/psychiatric/substance use disorder recovery immediately after exiting an inpatient hospital (either acute or psychiatric or chemical dependency and recovery hospital), residential substance use disorder treatment or recovery facility, residential mental health treatment facility, correctional facility, nursing facility, or recuperative care and avoid further utilization of state plan services. Up to 90 days of recuperative care is available under specified circumstances as a separate Community Supports Program.

B. Short-Term Post-Hospitalization Housing provides Members with ongoing supports necessary for recuperation and recovery such as gaining (or regaining) the ability to perform activities of daily living, receiving necessary medical/psychiatric/substance use disorder care, case management and beginning to access other housing supports such as Housing Transition Navigation. Housing Transition/Navigation Services are a separate Community Supports Program.

C. This setting may include an individual or shared interim housing setting, where residents receive the services described above.

D. Beneficiaries must be offered Housing Transition Navigation supports during the period of Short-Term Post-Hospitalization housing to prepare them for transition from this setting. These services shall include a housing assessment and the development of individualized housing support plan to identify preferences and barriers related to successful housing tenancy after Short-Term Post-Hospitalization Housing. The development of a housing assessment and individualized support plan are covered as a separate Community Supports Program under Housing Transition/Navigation Services.

E. Short-Term Post-Hospitalization Housing provided should utilize best practices for Members who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions, including housing first, harm reduction, progressive engagement, motivational interviewing, and trauma informed care.

2. Eligibility

A. Members exiting recuperative care.

B. Members exiting an inpatient hospital stay (either acute or psychiatric or chemical dependency and recovery hospital), residential substance use disorder treatment or recovery facility, residential mental health treatment facility, correctional facility, or nursing facility and who meet any of the following criteria:

i. Members who meet the Housing and Urban Development ("**HUD**") definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving ECM, or who have one or more

serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, institution for mental disease and state hospitals.

In addition to meeting one of these criteria at a minimum, individuals must have medical/behavioral health needs such that experiencing homelessness upon discharge from the hospital, substance use or mental health treatment facility, correctional facility, nursing facility, or recuperative care would likely result in hospitalization, re- hospitalization, or institutional readmission.

3. Restrictions and Limitations

A. Short-Term Post-Hospitalization Services are available once in a Member's lifetime and are limited and are not to exceed a duration of six (6) months per episode (but may be authorized for a shorter period based on Member needs). CalOptima is expected to make a good faith effort to review information available to them to determine if Member has previously received services.

B. The service is only available if the Member is unable to meet such an expense.

C. Members may not be receiving duplicative support from other State, local or federally funded programs, which shall always be considered first, before using Medi-Cal funding.

4. Licensing/Allowable Community Supports Providers

A. Community Supports Providers must have experience and expertise with providing Short-Term Post-Hospitalization Services. The below list is provided as an example of the types of Community Supports Providers that may provide Short-Term Post-Hospitalization Services but is not an exhaustive list of providers who may offer the services.

i. Interim housing facilities with additional on-site support

ii. Shelter beds with additional on-site support

iii. Converted homes with additional on-site support

iv. County directly operated or contracted recuperative care facilities

v. Supportive housing providers

vi. County agencies

vii. Public hospital systems

viii. Social service agencies

ix. Providers of services for Members experiencing homelessness

B. Facilities may be unlicensed. CalOptima must apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. CalOptima can adopt or adapt local or national standards for Short-Term Post-Hospitalization Housing

services. CalOptima shall monitor the provision of all the services included above. Community Supports Providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs, including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, CalOptima must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

ATTACHMENT A
Sobering Centers Schedule

1. Description/Overview

   A. Sobering Centers, as defined in this Section 1, are alternative destinations for Members who are found to be publicly intoxicated (due to alcohol and/or other drugs) and would otherwise be transported to the emergency department or jail. Sobering Centers provide these Members, primarily those who are homeless or those with unstable living situations, with a safe, supportive environment in which to become sober.

   B. Sobering Centers provide services such as medical triage, lab testing, a temporary bed, rehydration and food service, treatment for nausea, wound and dressing changes, shower and laundry facilities, substance use education and counseling, navigation and warm hand-offs for additional substance use services or other necessary health care services, and homeless care support services.

      i. When utilizing Sobering Centers, direct coordination with the Orange County behavioral health agency is required and warm hand-offs for additional behavioral health services are strongly encouraged.

      ii. Sobering Centers also include screening and linkage to ongoing supportive services such as follow-up mental health and substance use disorder treatment and housing options, as appropriate.

      iii. Sobering Centers require partnership with law enforcement, emergency personnel, and outreach teams to identify and divert Members to Sobering Centers. Sobering Centers must be prepared to identify Members with emergent physical health conditions and arrange transport to a hospital or appropriate source of medical care.

      iv. The Sobering Centers services provided shall utilize best practices for Members who are experiencing homelessness and who have complex health and/or behavioral health conditions, including housing first, harm reduction, progressive engagement, motivational interviewing, and trauma informed care.

2. Eligibility

   A. Members aged 18 and older who are intoxicated but conscious, cooperative, able to walk, nonviolent, and free from any medical distress (including life threatening withdrawal symptoms or apparent underlying symptoms) and who would otherwise be transported to the emergency department or a jail or who presented at an emergency department and are appropriate to be diverted to a Sobering Center.

3. Restrictions and Limitations

   A. Sobering Centers are covered for a duration of less than 24 hours.

   B. Members may not be receiving duplicative support from other State, local or federally funded programs, which shall always be considered first, before using Medi-Cal funding.

4. Licensing and Allowable Providers

A. Community Supports Providers must have experience and expertise with providing Sobering Center services. This list is provided to show examples of the types of Community Supports Providers that may provide Sobering Centers, but it is not an exhaustive list of providers who may offer the services.

i. Sobering Centers, or other appropriate and allowable substance use disorder facilities. CalOptima shall consult with the Orange County behavioral health agency to ensure these facilities can offer an appropriate standard of care and properly coordinate follow up access to substance use disorder services and other behavioral health services.

ii. These facilities are unlicensed. CalOptima must apply minimum standards, subject to review and approval by DHCS, to ensure adequate experience and acceptable quality of care standards are maintained. CalOptima shall monitor the provision of all the services included above.

iii. All allowable Community Supports Providers must be approved by the managed care organization to ensure adequate experience and appropriate quality of care standards are maintained.

B. Community Supports Providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs, including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, CalOptima must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

ATTACHMENT A
Respite Services Schedule

1. Description/Overview

A. Respite Services, as defined in this Section 1, are provided to caregivers of Members who require intermittent temporary supervision. The services are provided on a short-term basis because of the absence or need for relief of those persons who normally care for and/or supervise them and are nonmedical in nature. These services are distinct from medical respite/recuperative care and provide rest for the caregiver only.

B. Respite Services can include any of the following:

i. Services provided by the hour on an episodic basis because of the absence of or need for relief for those persons normally providing the care to individuals.

ii. Services provided by the day/overnight on a short-term basis because of the absence of or need for relief for those persons normally providing the care to individuals.

iii. Services that attend to the Member's basic self-help needs and other activities of daily living, including interaction, socialization, and continuation of usual daily routines that would ordinarily be performed by those persons who normally care for and/or supervise them.

C. Home Respite Services are provided to the Member in his or her own home or another location being used as the home.

D. Facility Respite Services are provided in an approved, out-of-home location.

E. Respite should be made available when it is useful and necessary to maintain a person in their own home and to preempt caregiver burnout to avoid institutional services for which CalOptima is responsible.

2. Eligibility

A. Eligible Members include those who live in the community and are compromised in their Activities of Daily Living ("**ADLs**") and are therefore dependent upon a qualified caregiver who provides most of their support, and who require caregiver relief to avoid institutional placement.

B. Other subsets may include children who previously were covered for Respite Services under the Pediatrics Palliative Care Waiver, foster care program beneficiaries, Members enrolled in California Children's Services or Genetically Handicapped Persons Program ("**GHPP**"), and Members with complex care needs.

3. Restrictions/Limitations

A. In the home setting, these services, in combination with any direct care services the Member is receiving, can provide up to 24 hours per day of care.

B. The service limit is up to 336 hours per calendar year. The service is inclusive of all in-home and in-facility services. Exceptions to the limit of 336 hours per calendar year can be made, with CalOptima authorization, when the caregiver experiences an episode, including medical treatment and hospitalization, that leaves a Member without their caregiver. Respite support provided during these episodes can be excluded from the 336-hour annual limit.

C. This service is only provided to avoid placements for which CalOptima would be responsible.

D. Members may not be receiving duplicative support from other state, local, or federally funded programs, which should always be considered first, before using Medi-Cal funding.

4. Licensing/Allowable Providers

A. Community Supports Providers must have experience and expertise with providing these unique services. This list is provided to show examples of the types of Community Supports Providers CalOptima may choose to contract with, but it is not an exhaustive list of Community Supports Providers that may offer the services.

i. Home health or respite agencies to provide services in:

a. Private residence

b. Residential facility approved by the State, such as congregate living health facilities

c. Providers contracted by county behavioral health

ii. Other community settings that are not a private residence, such as:

a. Adult family home/family teaching home

b. Certified family homes for children

c. County agencies

d. Residential care facility for the elderly

e. Child day care facility; child day care center; family childcare home

f. Respite facility; residential facility: small family home (children only)

g. Respite facility; residential facility: foster family agency-certified family homes (Children Only)

h. Respite facility; residential facility: adult residential facilities

i. Respite facility; residential facility: group home (children only)

j. Respite facility; residential facility: family home agency; adult family home/family teaching home

k. Respite facility; residential facility: adult residential facility for persons with special health care needs

l. Respite facility; residential facility: foster family homes (children only)

m. Short-term residential therapeutic program providers or other care providers that are serving youth with complex needs

iii. Community Supports Providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs, including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, managed care plans must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

ATTACHMENT A
Nursing Facility Transition/Diversion Schedule Services Schedule

1. Description/Overview

A. Nursing Facility Transition/Diversion Services, as defined in this Section 1, help Members live in the community and/or avoid institutionalization when possible.

B. The goal is to both facilitate nursing facility transition back into a home-like, community setting and/or prevent skilled nursing admissions for Members with an imminent need for nursing facility level of care ("LOC"). Members have the choice of residing in an assisted living setting as an alternative to long-term placement in a nursing facility when they meet eligibility requirements.

C. The assisted living Provider is responsible for meeting the needs of the Member, including helping with Activities of Daily Living ("ADLs") and Instrumental ADLs ("IADLs") and providing meals, transportation, and medication administration, as needed.

D. Nursing Facility Transition/Diversion Services are for individuals who are transitioning from a licensed health care facility to a living arrangement in a Residential Care Facility for the Elderly ("RCFE") or an Adult Residential Facility ("ARF"). They include wraparound services such as assistance with ADLs and IADLs as needed, companion services, medication oversight, and therapeutic social and recreational programming, provided in a home-like environment. It also includes 24- hour direct care staff on-site to meet scheduled unpredictable needs in a way that promotes maximum dignity and independence and to provide supervision, safety, and security. Allowable expenses are those necessary to enable a person to establish a community facility residence (except room and board), including but not limited to:

i. Assessing the Member's housing needs and presenting options. Refer to Housing Transition/Navigation Services Community Support for additional details.

ii. Assessing the service needs of the Member to determine whether the Member needs enhanced on-site services at the RCFE/ARF so the Member can be safely and stably housed in an RCFE/ARF.

iii. Assisting in securing a facility residence, including the completion of facility applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).

iv. Communicating with facility administration and coordinating the move.

v. Establishing procedures and contacts to retain facility housing.

vi. Coordinating with CalOptima to ensure that the needs of Members who need enhanced services to be safely and stably housed in RCFE/ARF settings have Community Supports services and/or ECM services that provide the necessary enhanced services.

a. CalOptima may also fund RCFE/ARF operators directly to provide these enhanced services.

2. Eligibility

A. For Nursing Facility Transition Services:

i. Has resided 60+ days in a nursing facility;

ii. Is willing to live in an assisted living setting as an alternative to a nursing facility; and

iii. Is able to reside safely in an assisted living facility with appropriate and cost- effective supports.

B. For Nursing Facility Diversion Services:

iv. Is interested in remaining in the community;

v. Is willing and able to reside safely in an assisted living facility with appropriate and cost-effective supports and services; and

vi. Must be currently receiving medically necessary nursing facility LOC or meet the minimum criteria to receive nursing facility LOC services and, in lieu of going into a facility, is choosing to remain in the community and continue to receive medically necessary nursing facility LOC services at an assisted living facility.

3. Restrictions/Limitations

A. Members are directly responsible for paying their own living expenses.

B. Members may not be receiving duplicative support from other state, local, or federally funded programs, which should always be considered first, before using Medi-Cal funding.

4. Licensing/Allowable Community Supports Providers

A. Community Supports Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner. The below list is provided to show examples of the types of Community Supports Providers that may provide Nursing Facility Transition/Diversion Services but is not an exhaustive list of Community Supports Providers that may offer the services.

i. Case management agencies

ii. Home Health Agencies

iii. Medi-Cal managed care plans

iv. ARF/RCFE operators

B. Community Supports Providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs, including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-

level enrollment pathway, managed care plans must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

C. RCFEs/ARFs are licensed and regulated by the California Department of Social Services, Community Care Licensing Division.

ATTACHMENT A
Community Transition Services/Nursing Facility Transition to a Home Schedule

1. Description/Overview

A. Community Transition /Nursing Facility Transition to a Home Services, as described in this Section 1, help Members live in the community and avoid further institutionalization.

B. Community Transition/Nursing Facility Transition to a Home Services cover non-recurring setup expenses for Members who are transitioning from a licensed facility to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a Member to establish a basic household that do not constitute room and board and include:

i. Assessing the Member's housing needs and presenting options. Refer to the Housing Transition/Navigation Services and/or Housing Tenancy/Sustaining Services Community Supports for additional details.

ii. Assisting in searching for and securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).

iii. Communicating with the landlord (if applicable) and coordinating the move.

iv. Establishing procedures and contacts to retain housing.

v. Identifying, coordinating, securing, or funding non-emergency, nonmedical transportation to assist Members' mobility to ensure reasonable accommodations and access to housing options prior to transition and on move-in day.

vi. Identifying the need for and coordinating funding for environmental modifications to install necessary accommodations for accessibility. Refer to the Housing Transition/Navigation Services and/or Housing Tenancy/Sustaining Services for additional details.

vii. Identifying the need for and coordinating funding for services and modifications necessary to enable a Member to establish a basic household refers to funding that does not constitute room and board, such as security deposits required to obtain a lease on an apartment or home; setup fees for utilities or service access; first-month coverage of utilities, including telephone, electricity, heating, and water; funds for services necessary for the Member's health and safety, such as pest eradication and one-time cleaning prior to occupancy; funds for home modifications, such as an air conditioner or heater; and funds for other medically necessary services, such as hospital beds and Hoyer lifts, etc. to ensure access and reasonable accommodations. Refer to the Environmental Accessibility Adaptations and/or Asthma Remediation Community Supports for additional details.

2. Eligibility

A. Is currently receiving medically necessary nursing facility level of care ("LOC") services and, in lieu of remaining in the nursing facility or Medical Respite setting, is choosing to transition home and continue to receive medically necessary nursing facility LOC services;

B. Has lived 60+ days in a nursing home and/or medical respite setting;

C. Is interested in moving back to the community; and

D. Is able to reside safely in the community with appropriate and cost-effective supports and services.

3. Restrictions/Limitations

A. Community Transition/Nursing Facility Transition to a Home Services do not include monthly rental or mortgage expense, food, regular utility charges, and/or household appliances or items that are intended for purely diversionary/recreational purposes.

B. Community Transition/Nursing Facility Transition to a Home Services are payable up to a total lifetime maximum amount of $7,500.00. The only exception to the $7,500.00 total maximum is if the Member is compelled to move from a Provider-operated living arrangement to a living arrangement in a private residence through circumstances beyond his or her control.

C. Community Transition/Nursing Facility Transition to a Home Services must be necessary to ensure the health, welfare, and safety of the Member, and without which the Member would be unable to move to the private residence and would then require continued or re-institutionalization.

Members may not be receiving duplicative support from other state, local, or federally funded programs, which should always be considered first, before using Medi-Cal funding.

4. Licensing/Allowable Providers

A. Community Supports Providers must have experience and expertise with providing these unique services. The list is provided to show examples of the types of Community Supports Providers that may provide Community Transition/Nursing Facility Transition, but it is not an exhaustive list of Providers that may offer the services.

i. Case management agencies

ii. Home health agencies

iii. Medi-Cal managed care plans

iv. County mental health providers

v. 1915c home and community-based alternatives/assisted living waiver providers

vi. California community transitions/money follows the person providers

Community Supports Providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs, including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, CalOptima must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

ATTACHMENT A
Environmental Accessibility Adaptations (Home Modifications) Schedule

1. Description/Overview

A. Environmental Accessibility Adaptations ("**EAAs**") are physical adaptations to a home that are necessary to ensure the health, welfare, and safety of the Member or to enable the Member to function with greater independence in the home, without which the Member would require institutionalization.

B. Examples of environmental accessibility adaptions include:

i. Ramps and grab bars to assist Members in accessing the home;

ii. Doorway widening for Members who require a wheelchair;

iii. Stair lifts;

iv. Making a bathroom and shower wheelchair accessible (e.g., constructing a roll-in shower);

v. Installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies of the Member; and

vi. Installation and testing of a Personal Emergency Response System ("**PERS**") for Members who are alone for significant parts of the day without a caregiver and who otherwise require routine supervision (including monthly service costs, as needed).

C. EAAs are available in a home that is owned, rented, leased, or occupied by the Member. For a home that is not owned by the Member, the Member must provide written consent from the owner for physical adaptations to the home or for equipment that is physically installed in the home (e.g., grab bars, chair lifts, etc.).

D. When authorizing EAAs as a Community Supports Service, CalOptima must receive and document an order from the Member's current primary care physician or other health professional specifying the requested equipment or service, as well as documentation from the Provider of the equipment or service describing how the equipment or service meets the medical needs of the Member, including any supporting documentation describing the efficacy of the equipment, where appropriate. Brochures will suffice in showing the purpose and efficacy of the equipment; however, a brief written evaluation specific to the Member describing how and why the equipment or service meets the needs of the Member will still be necessary.

E. CalOptima must also receive and document:

i. A physical or occupational therapy evaluation and report to evaluate the medical necessity of the requested equipment or service unless CalOptima

determines it is appropriate to approve without an evaluation. This should typically come from an entity with no connection to the Provider of the requested equipment or service. The physical or occupational therapy evaluation and report should contain at least the following:

a. An evaluation of the Member and the current equipment needs specific to the Member, describing how/why the current equipment does not meet the needs of the Member;

b. An evaluation of the requested equipment or service that includes a description of how/why it is necessary for the Member and reduces the risk of institutionalization. This should also include information on the ability of the Member and/or the primary caregiver to learn about and appropriately use any requested item; and

c. A description of similar equipment used either currently or in the past that has demonstrated to be inadequate for the Member and a description of the inadequacy.

ii. If possible, a minimum of two bids from appropriate Community Supports Providers of the requested service, which itemize the services, cost, labor, and applicable warranties; and

iii. Proof that a home visit has been conducted to determine the suitability of any requested equipment or service.

F. The assessment and authorization for EAAs must take place within a 90-day time frame beginning with the request for the EAAs, unless more time is required to receive documentation of homeowner consent, or the individual receiving the service requests a longer time frame.

2. Eligibility

A. Members at risk for institutionalization in a nursing facility.

3. Restrictions/Limitations

A. If another state plan service, such as durable medical equipment, is available and would accomplish the same goals of independence and avoiding institutional placement, that service should be used.

B. EAAs must be conducted in accordance with applicable state and local building codes.

C. EAAs are payable up to a total lifetime maximum of $7,500. The only exceptions to the $7,500 total maximum are if the Member's place of residence changes or if the Member's condition has changed so significantly that additional modifications are necessary to ensure the health, welfare, and safety of the Member or to enable

the Member to function with greater independence in the home and avoid institutionalization or hospitalization.

D. EAAs may include finishing (e.g., drywall and painting) to return the home to a habitable condition, but they do not include aesthetic embellishments.

E. Modifications are limited to those that are of direct medical or remedial benefit to the Member and exclude adaptations or improvements that are of general utility to the household. Adaptations that add to the total square footage of the home are excluded except when necessary to complete an adaptation (e.g., to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

F. Before commencement of a physical adaptation to the home or equipment that is physically installed in the home (e.g., grab bars, chair lifts, etc.), CalOptima must provide the owner and Member with written documentation stating that the modifications are permanent and that the State of California is not responsible for maintenance or repair of any modification or for removal of any modification if the Member ceases to reside at the residence.

Members may not be receiving duplicative support from other state, local, or federally funded programs, which should always be considered first, before using Medi-Cal funding.

4. Licensing/Allowable Providers

A. CalOptima may manage these services directly or may coordinate with Community Supports Providers to manage the services.

B. Community Supports Providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs, including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, CalOptima must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

C. Community Supports Providers must have experience and expertise with providing these unique services. This list is provided to show examples of the types of Community Supports Providers that may provide EAAs, but it is not an exhaustive list of Community Supports Providers that may offer the services.

i. Area agencies on aging

ii. Local health departments

iii. Community-based providers and organizations

D. All EAAs that are physical adaptations to a residence must be performed by an individual holding a California Contractor's License with the exception of a PERS installation, which may be performed in accordance with the system's installation requirements.

ATTACHMENT A
Asthma Remediation

1. Description/Overview

A. Asthma Remediation Services, as described in this Section 1, are environmental asthma trigger remediations that physically modify a home environment as necessary to ensure the health, welfare, and safety of the Member or to enable the Member to function in the home and without which acute asthma episodes could result in the need for emergency services and hospitalization.

B. Examples of environmental asthma trigger remediations include:

i. Allergen-impermeable mattress and pillow dustcovers

ii. High-efficiency particulate air ("**HEPA**") filtered vacuums

iii. Integrated pest management services

iv. Dehumidifiers

v. Air filters

vi. Other moisture-controlling interventions

vii. Minor mold removal and remediation services

viii. Ventilation improvements

ix. Asthma-friendly cleaning products and supplies

x. Other interventions identified to be medically appropriate and cost-effective

C. Asthma Remediation Services are available in a home that is owned, rented, leased, or occupied by the Member or their caregiver.

D. When authorizing Asthma Remediation Services as a Community Supports Service, CalOptima must receive and document:

i. A current licensed health care provider's order specifying the requested remediation(s) for the Member;

ii. A brief written evaluation specific to the Member describing how and why the remediation(s) meets the needs of the individual, required for cases of "Other interventions identified to be medically appropriate and cost-effective"; and

iii. Proof that a home visit has been conducted to determine the suitability of any requested remediation(s) for the Member.

E. Asthma Remediation Services include providing information to Members about actions to take around the home to mitigate environmental exposures that could trigger asthma symptoms and remediations designed to avoid asthma-related hospitalizations, such as:

i. Identification of environmental triggers commonly found in and around the home, including allergens and irritants.

ii. Using dust-proof mattress and pillow covers, HEPA vacuums, asthma-friendly cleaning products, dehumidifiers, and air filters.

iii. Health-related minor home repairs such as pest management or patching holes and cracks through which pests can enter.

F. The Centers for Disease Control and Prevention, the Environmental Protection Agency, and Housing and Urban Development collaborated to produce an asthma trigger checklist, which MCPs may utilize in determining the appropriateness of these interventions. An accompanying training provides additional details about the connections between asthma triggers and lung health.

2. Eligibility

Members with poorly controlled asthma (as determined by an emergency department visit or hospitalization or two sick or urgent care visits in the past 12 months or a score of 19 or lower on the Asthma Control Test) for whom a licensed health care provider has documented that the service will likely help avoid asthma-related hospitalizations, emergency department visits, or other high-cost services.

3. Restrictions/Limitations

A. If another state plan service, such as durable medical equipment, is available and would accomplish the same goals of preventing asthma emergencies or hospitalizations, that service should be used.

B. Asthma Remediation Services must be conducted in accordance with applicable state and local building codes.

C. Members may not be receiving duplicative support from other state, local, or federally funded programs, which should always be considered first, before using Medi-Cal funding.

D. Asthma Remediation Services are payable up to a total lifetime maximum of $7,500. The only exception to the $7,500 total maximum is if the Member's condition has changed so significantly that additional modifications are necessary to ensure the health, welfare, and safety of the Member, or are necessary to enable the Member to function with greater independence in the home and avoid institutionalization or hospitalization.

E. Asthma Remediation Services modifications are limited to those that are of direct medical or remedial benefit to the Member and exclude adaptations or improvements that are of general utility to the household. Remediations may include finishing (e.g., drywall and painting) to return the home to a habitable condition, but they do not include aesthetic embellishments.

F. Before commencement of a permanent physical adaptation to the home or installation of equipment in the home, such as installation of an exhaust fan or replacement of moldy drywall, CalOptima must provide the owner and Member with written documentation that the modifications are permanent, and that the State of California is not responsible for

maintenance or repair of any modification or for removal of any modification if the Member ceases to reside at the residence. This requirement does not apply to the provision of supplies that are not permanent adaptations or installations, including but not limited to allergen-impermeable mattress and pillow dust covers, HEPA filtered vacuums, dehumidifiers, portable air filters, and asthma-friendly cleaning products and supplies.

Members may not be receiving duplicative support from other state, local, or federally funded programs, which should always be considered first, before using Medi-Cal funding.

4. Licensing/Allowable Providers

A. CalOptima may manage these services directly; coordinate with an existing Medi-Cal provider to manage the services; and/or contract with a county agency, community-based organization, or other organization, as needed. Asthma Remediation Services should be provided in conjunction with culturally appropriate asthma self-management education.

B. Community Supports Providers must have experience and expertise with providing these Asthma Remediation Services. This list is provided to show examples of the types of Community Supports Providers that may provide Asthma Remediation Services, but it is not an exhaustive list of Community Supports Providers that may offer the services.

i. Lung health organizations

ii. Healthy housing organizations

iii. Local health departments

iv. Community-based providers and organizations

C. Asthma Remediation that is a physical adaptation to a residence must be performed by an individual holding a California Contractor's License.

i. CalOptima must apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. CalOptima shall monitor the provision of all the services included above.

ii. All allowable Community Supports Providers must be approved by the managed care organization to ensure adequate experience and appropriate quality of care standards are maintained.

D. Community Supports Providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs, including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, CalOptima must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

ATTACHMENT B
PROCEDURES FOR REQUESTING INTERPRETATION SERVICES

ARTICLE 1
CALOPTIMA DIRECT MEMBERS

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

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

1.2.1 Member name and ID, date of birth and telephone number;

1.2.2 Name and phone number of the caretaker, if applicable;

1.2.3 Language or sign language needed;

1.2.4 Date and time of the appointment;

1.2.5 Address and telephone number of the facility where the appointment is to take place;

1.2.6 Estimated amount of time the interpretation service will be needed; and

1.2.7 Type of appointment: assessment, fitting/delivery or other.

1.3 Provider's Responsibilities.

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

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

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

ARTICLE 2
HEALTH NETWORK MEMBERS

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

ATTACHMENT C

COMPENSATION

CalOptima shall reimburse Provider, and Provider shall accept as payment in full from CalOptima, the following amounts:

I. Program Reimbursement(s)

CalOptima shall reimburse for Covered Services as follows:

Recuperative Care (Medical Respite)

Rate	$
Unit of Service	Per Diem
Billing Code(s): including modifiers	See DHCS guidance for specific billing codes and modifiers

Housing Deposits

Service Rate	Up to a Maximum of $
Unit of Service	The amount of the Housing Deposit advanced, up to the Maximum allowed
Billing Code(s): including modifiers	See DHCS guidance for specific billing codes and modifiers

Housing Transition Navigation Service Rate

Bundled Payments (per Enrollee per Month (PEPM))	$
Unit of Service	PEPM
Billing Code(s): including modifiers	See DHCS guidance for specific billing codes and modifiers

Housing Tenancy and Sustaining Service Rate

Bundled Payments (per Enrollee per Month (PEPM))	$
Unit of Service	PEPM
Billing Code(s): including modifiers	See DHCS guidance for specific billing codes and modifiers

Day Habilitation Programs Service Rate

Service Rate		
Unit of Service	Per Diem	hourly

Medically Tailored Meals/Medically Support Food Service Rate

Service Rate	$	$	$
Unit of Service	Per Delivered Meal	Per Weekly Grocery Box Delivered	Per Nutritional Assessment
HCPCS Billing Code	S5170 (Modifier U6)	S9977 (Modifier U6)	S9470 (Modifier U6)

Personal Care and Homemaker Services Rate

Service Rate	$
Unit of Service	Hourly – Agency Model
HCPCS Billing Code	S5130, T1019

Short Term Post Hospitalization Housing Service Rate

Service Rate	$
Unit of Service	Per Diem
HCPCS Billing Code	H0044 (Modifier U3)

Sobering Centers Service Rate

Service Rate	$
Unit of Service	Per Diem
HCPCS Billing Code	H0014 (Modifier U6)

Respite Services Rate

Service Rate	
Unit of Service	Hourly
HCPCS Billing Code	H0045, S5151, S9125

Nursing Facility Transition/Diversion to Assisted Living Facilities

Service Rate	$	$
Unit of Service	PMPM	Per Hour
HCPCS Billing Code	T2038 (Modifier U4)	N/A

Community Transition Services/ Nursing Facility Transition to a Home Service Rate

Service Rate	
Unit of Service	PMPM
HCPCS Billing Code	T2038 (Modifier U5)

Environmental Accessibility Adaptions (Home Modifications) Service Rate

Service Rate	$
Unit of Service	Cap
HCPCS Billing Code	S5165 (Modifier U6)

Asthma Remediation Service Rate

Service Rate	$
Unit of Service	Cap
HCPCS Billing Code	S5165 (Modifier U6)

ATTACHMENT D

DISCLOSURE FORM

_____

Name of Provider

The undersigned hereby certifies that the following information regarding

_____ (the "Provider") is true and correct as of the date set forth below:

Officer(s)/Director(s)/General Partner(s):

_____

_____

Co-Owner(s):

_____

_____

Stockholder(s) owning more than five percent (5%) of the Provider's stock:

_____

Major creditor(s) holding more than five percent (5%) of the Provider's debt:

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

Dated: _____ Signature: _____

Name: _____

(Please type or print)

Title: _____

(Please type or print)

ADDENDUM 1
MEDI-CAL PROGRAM

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

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

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

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

2. Access to Books and Records. Provider agrees to make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of the Contract, available for the purpose of an audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State's Right to Monitor, as set forth in the DHCS Contract, Exhibit E, Attachment 2, Provision 20: (a) by CalOptima, the Government Agencies, CalOptima's Regulators, DOJ, Bureau of Medi-Cal Fraud, Comptroller General and any other entity statutorily entitled to have oversight responsibilities of the COHS program, (b) at all reasonable times at Provider's place of business or at such other mutually agreeable location in California, and (c) in a form maintained in accordance with the general standards applicable to such book or record keeping for a term of at least ten (10) years from the final date of the Contract between CalOptima and DHCS, or from the date of completion of any audit, whichever is later, in which the records or data were created or applied, and for which the financial record was completed, and including, if applicable, all Medi-Cal 35 file paid claims data and encounter data for a period of at least ten (10) years from the date of expiration or termination. Provider shall provide access to all security areas and shall provide reasonable facilities, cooperation and assistance to State representatives in the performance of their duties. If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit Provider at any time. Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Provider from participation in the Medi-Cal program; seek recovery of payments made to the Subcontractor; impose other sanctions provided under the State Plan, and

direct CalOptima to terminate this Contract for provision of services to CalOptima Medi-Cal Members due to fraud.

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

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

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

4. Third Party Tort Liability/Estate Recovery. Provider shall make no claim for the recovery of the value of Covered Services rendered to a Member when such recovery would result from an action involving tort liability of a third party, recovery from the estate of deceased Member, or casualty liability insurance awards and uninsured motorist coverage. Provider shall identify and notify CalOptima, within five (5) calendar days of discovery, which shall in turn notify DHCS, of any action by the CalOptima Member involving the Tort Workers' Compensation liability of a third party or estate recovery that could result in recovery by the CalOptima Member of funds to which DHCS has lien rights under Article 3.5 (commencing with Section 14124.70), Part 3, Division 9, Welfare and Institutions Code.

5. Records Related to Recovery for Litigation.

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

5.2 In addition to the payments provided for elsewhere in this Contract, CalOptima agrees to pay Provider for complying with Paragraph 5.1, above, as follows:

5.2.1 CalOptima shall reimburse Provider amounts paid by Provider to third parties for services necessary to comply with Paragraph 5.1. Any third-party assisting Provider with compliance with Paragraph 5.1 shall comply with all applicable confidentiality requirements. Amounts paid by Provider to any third party for

assisting Provider in complying with Paragraph 5.1, shall not exceed normal and customary charges for similar services and such charges and supporting documentation shall be subject to review by CalOptima.

5.2.2 If Provider uses existing personnel and resources to comply with Paragraph 5.1, CalOptima shall reimburse Provider as specified below. Provider shall maintain and provide to CalOptima time reports supporting the time spent by each employee as a condition of reimbursement. Reimbursement claims and supporting documentation shall be subject to review by CalOptima.

5.2.2.1 Compensation and payroll taxes and benefits, on a prorated basis, for the employees' time devoted directly to compiling information pursuant to Paragraph 5.1.

5.2.2.2 Costs for copies of all documentation submitted to CalOptima pursuant to Paragraph 5.1, subject to a maximum reimbursement of ten (10) cents per copied page.

5.2.2.3 Provider shall submit to CalOptima all information needed by CalOptima to determine reimbursement to Provider under this provision, including, but not limited to, copies of invoices from third parties and payroll records.

6. Medical Records. All medical records shall meet the requirements of Section 1300.80(b)(4) of Title 28 of the California Code of Regulations, and Section 1936a(w) of Title 42 of the United States Code. Such records shall be available to health care providers at each encounter, in accordance with Section 1300.67.1(c) of Title 28 of the California Code of Regulations. Provider shall ensure that an individual is delegated the responsibility of securing and maintaining medical records at each Participating Provider or Subcontractor site.

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

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

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

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

11. Confidentiality of Medi-Cal Members. Provider and its employees, agents, or Subcontractors shall protect from unauthorized disclosure the names and other identifying information concerning

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

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

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

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

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

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

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

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

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

12.1.2 Have not within a three-year period preceding this Contract have been convicted

of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

12.1.3 Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in Subprovision 12.1.2 herein; and

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

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

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

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

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

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

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

14. Lobbying Restrictions and Disclosure Certification.

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

14.2 Certification and Disclosure Requirements

14.2.1 Each person (or recipient) who requests or receives a contract, subcontract, grant, or subgrant, which is subject to Section 1352 of the 31, U.S.C., and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in Attachment 1 to this Addendum 1, consisting of one page, entitled "Certification Regarding Lobbying") that the recipient has not made, and will not make, any payment prohibited by Paragraph 14.3 of this provision.

14.2.2 Each recipient shall file a disclosure (in the form set forth in Attachment 2 to this Addendum 1, entitled "Standard Form-LLL 'disclosure of Lobbying Activities'") if such recipient has made or has agreed to make any payment using nonappropriated funds (to include profits from any covered federal action) in connection with a contract or grant or any extension or amendment of that contract or grant, which would be prohibited under Paragraph 14.3 of this provision if paid for with appropriated funds.

14.2.3 Each recipient shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by such person under Paragraph 14.2.2 herein. An event that materially affects the accuracy of the information reported includes:

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

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

14.2.3.3 A change in the officer(s), employee(s), or member(s) contacted for the purpose of influencing or attempting to influence a covered federal action.

14.2.4 Each person (or recipient) who requests or receives from a person referred to in Paragraph 14.2.1 of this provision a contract, subcontract, grant or subgrant exceeding $100,000 at any tier under a contract or grant shall file a certification, and a disclosure form, if required, to the next tier above.

14.2.5 All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in Paragraph 14.2.1 of this provision. That person shall forward all disclosure forms to DHCS program contract manager.

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

15. Additional Subcontracting Requirements.

15.1 Provider shall ensure that all Subcontracts are in writing and require that the Provider and its Subcontractors:

15.1.1 Make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to this Contract, available at all reasonable times for audit, inspection, examination, or copying by CalOptima, DHCS, CalOptima's Regulators, and/or DOJ, or their designees.

15.1.2 Retain such books and all records and documents for a term minimum of at least ten (10) years from the final date of the DHCS Contract period or from the date of completion of any audit, whichever is later.

15.2 Provider shall require all Subcontracts that relate to the provision of Medi-Cal Covered Services to Members pursuant to the Contract include the following:

15.2.1 Services to be provided by the Subcontractor, term of the Subcontract (beginning and ending dates), methods of extension, renegotiation, termination, and full disclosure of the method and amount of compensation or other consideration to be received by the Subcontractor.

15.2.2 Subcontract or its amendments are subject to DHCS approval as provided in the DHCS Contract, and the Subcontract shall be governed by and construed in accordance with all laws and applicable regulations governing the DHCS Contract.

15.2.3 An agreement that the assignment or delegation of the Subcontract will be void unless prior written approval is obtained pursuant to Section 21 of this Addendum 1.

15.2.4 An agreement to submit provider data, encounter data, and reports related to the Subcontract in accordance with Sections 2.23 of the Contract, and to gather, preserve, and provide any records in the Subcontractor's possession in accordance with Section 5 of this Addendum 1.

15.2.5 An agreement to make all premises, facilities, equipment, books, records, contracts, computer, and other electronic systems of the Subcontractor pertaining to the goods and services furnished by Subcontractor under the Subcontract, available for purpose of an audit, inspection, evaluation, examination, or copying, in accordance with Section 6.1 of the Contract and Sections 2 and 16 of this Addendum 1.

15.2.6 An agreement to maintain and make available to DHCS, CalOptima, and/or Provider, upon request, all sub-subcontracts related to the Subcontract, and to ensure all sub-contractors are in writing and require the sub-subcontractors to comply with the requirements set forth in Section 15.1 of this Addendum 1.

15.2.7 An agreement to comply with CalOptima's Compliance Program (including, without limitations, CalOptima Policies), all applicable requirements or the DHCS Medi-Cal Managed Care Program, and all monitoring provisions and requests set forth in Section 16 of this Addendum 1.

15.2.8 An agreement to assist Provider and/or CalOptima in the transfer of care of a Member in the event of termination of the DHCS Contract or the Contract for

any reason, in accordance with Section 19 of this Addendum 1, and in the event of termination of the Subcontract for any reason.

15.2.9 An agreement to hold harmless the State, Members, and CalOptima in the event the Provider cannot or will not pay for services performed by the Subcontractor pursuant to the Subcontract, and to prohibit Subcontractors from balance billing a Member as set forth in Section 4.7 of the Contract.

15.2.10 An agreement to notify DHCS in the manner provided in Section 7.9 of the Contract in the event the Subcontract is amended or terminated.

15.2.11 An agreement to the provision of interpreter services to Members at all provider sites as set forth in Section 2.17 of the Contract, to comply with the language assistance standards developed pursuant to Health and Safety Code section 1367.04, and to the requirements for cultural and linguistic sensitivity as set forth in Section 2.16 or the Contract.

15.2.12 Subcontractors shall have access to CalOptima's dispute resolution mechanism in accordance with Section 8.1 of the Contract.

15.2.13 An agreement to participate and cooperate in quality improvement system as set forth in Section 2.12 of the Contract, and to the revocation of the delegation of activities or obligations under the Subcontract or other specified remedies in instances where DHCS, CalOptima and/or Provider determines that the Subcontractor has not performed satisfactorily.

15.2.14 If and to the extent Subcontractor is responsible for the coordination of care of Members, an agreement to comply with Section 25 of this Addendum 1 and Section 6.5.3 of the Contract.

15.2.15 An agreement by the Provider to notify the Subcontractor of prospective requirements and the Subcontractor's agreement to comply with the new requirements, in accordance with Section 7.5. of the Contract.

15.2.16 An agreement for the establishment and maintenance of and access to medical and administrative records as set forth in Sections 6.2 and 6.3 of the Contract and Sections 1, 3 and 6 of this Addendum 1.

15.2.17 An agreement that Subcontractors shall notify Provider of any investigations into Subcontractor's professional conduct, or any suspension of or comment on a Subcontractor's professional licensure, whether temporary or permanent.

15.2.18 An agreement requiring Subcontractor to sign a Declaration of Confidentiality pursuant to Section 6.5.3 or the Contract, which shall be signed and filed with DHCS prior to the Subcontractor being allowed access to computer files or any other data or files, including identification of Members.

16. State's Right to Monitor. Provider shall comply with all monitoring provisions of this Contract and the DHCS Contract between CalOptima and DHCS, and any monitoring requests by CalOptima and DHCS. Without limiting the foregoing, CalOptima and authorized State and Federal agencies will have the right to monitor, inspect or otherwise evaluate all aspects of the Provider's operation

for compliance with the provisions of this Contract and applicable Federal and State laws and regulations. Such monitoring, inspection or evaluation activities will include, but are not limited to, inspection and auditing of Provider, Subcontractor, and provider facilities, management systems and procedures, and books and records as the Director of DHCS deems appropriate, at anytime, pursuant to 42 CFR Section 438.3(h). The monitoring activities will be either announced or unannounced. To assure compliance with the Contract and for any other reasonable purpose, the State and its authorized representatives and designees will have the right to premises access, with or without notice to the Provider. The monitoring activities will be either announced or announced. Staff designated by authorized State agencies will have access to all security areas and the Provider will provide, and will require any and all of its subcontractors to provide, reasonable facilities, cooperation and assistance to State representative(s) in the performance of their duties. Access will be undertaken in such a manner as to not unduly delay the work of the Provider and/or the subcontractor(s).

17. Provider shall comply with language assistance standards developed pursuant to Health & Safety Code Section 1367.04.

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

19. Prior to the termination or expiration of this Contract, including termination due to termination or expiration of CalOptima's DHCS Contract, and upon request by DHCS or CalOptima to assist in the orderly transfer of Members' medical care and all necessary data and history records to DHCS or a successor DHCS Contractor, the Provider shall make available to DHCS and/or CalOptima copies of medical records, patient files, and any other pertinent information, including information maintained by any Subcontractor necessary for efficient case management of Members, and the preservation, to the extent possible, of Member-Provider relationships. Costs of reproduction shall be borne by DHCS and CalOptima, as applicable.

20. This Contract shall be governed by and construed in accordance with all laws and applicable regulations governing the DHCS Contract between CalOptima and DHCS.

21. Provider agrees that the assignment or delegation of this Contract or Subcontract, either in whole or in part, will be void unless prior written approval is obtained from DHCS and CalOptima, as applicable, provided that approval may be withheld in their sole and absolute discretion. For purposes of this Section, and with respect to this Contract and any Subcontracts, as applicable, an assignment constitutes any of the following: (i) the change of more than twenty-five percent (25%) of the ownership or equity interest in Provider or Subcontractor (whether in a single transaction or in a series of transactions); (ii) the change or more than twenty-five percent (25%) of the directors of trustees of Provider of Subcontractor; (iii) the merger, reorganization, or consolidation of Provider or Subcontractor, with another entity with respect to which Provider or Subcontractor is not the surviving entity; and/or (iv) a change in the management of Provider or Subcontractor from management by persons appointed, elected or otherwise selected by the governing body of Provider or Subcontractor (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

22. Provider further agrees to timely gather, preserve, and provide to DHCS any records in the Provider's or its Subcontractor's possession, in accordance with the State Contract, Exhibit E, Attachment 2, "Records Related to Recovery for Litigation Provision".

23. Provider agrees to assist CalOptima in the transfer of care in the event of any Subcontract termination for any reason.

24. Notwithstanding anything in this Contract to the contrary, Provider shall be entitled to the protections of the Health Care Providers' Bill of Rights, California Health and Safety Code section 1375.7, in the administration of this Contract relative to the Medi-Cal program.

25. If and to the extent that the Provider is responsible for the coordination of care for Members, CalOptima shall share with Provider, in accordance with the appropriate Declaration of Confidentiality signed by Provider and filed with DHCS, any utilization data that DHCS has provided to CalOptima, and Provider shall receive the utilization data provided by CalOptima and use it as the Provider is able for the purpose of Members care coordination.

ADDENDUM 2
MEDICARE ADVANTAGE PROGRAM
(ONECARE)

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

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

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

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

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

   3.2 Reports on Delegated Activities. Provider agrees to provide CalOptima with periodic reports on delegated activities performed by Provider as provided in the delegation criteria. The report shall be in a form and contain such information as shall be agreed upon between

the parties. Provider agrees to take those corrective actions identified by CalOptima through the audit review process.

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

3.4 Review of Credentials. Provider shall ensure that the credentials of medical professionals affiliated with the Provider are reviewed by it. Provider agrees that CalOptima will review and approve Provider's credentialing process on ongoing basis.

4. COB Requirements.

4.1 MSP Obligations. Provider agrees to comply with Medicare Secondary Payer ("MSP") requirements. Provider shall coordinate with CalOptima for proper determination of COB and to bill and collect from other payers and third-party liens such charges for which the other payer is responsible. Provider agrees to establish procedures to effectively identify, at the time of service and as part of their claims payment procedures, individuals and services for which there may be a financially responsible party other than MA Program. Provider will bill and collect from other payers such amounts for Covered Services for which the other payer is responsible.

4.2 Provider Authority to Bill Third Party Payers. Provider may bill other individuals or entities for Covered Services for which Medicare is not the primary payer, as specified herein. If a Medicare Member receives Covered Services from Provider that are also covered under state or federal workers' compensation, any no-fault insurance, or any liability insurance policy or plan, including a self-insured plan, Provider may bill any of the following— (1) the insurance carrier, the employer, or any other entity that is liable for payment for the services under section 1862(b) of the Act and 42 C.F.R. part 411 or (2) the Medicare enrollee, to the extent that he or she has been paid by the carrier, employer, or entity for covered medical expenses.

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

6. Submission and Prompt Payment of Claims. Provider agrees to submit claims to CalOptima in such format as CalOptima may require (but at minimum the CMS forms 1500, UB 04 or other form as appropriate) within ninety (90) days after the services are rendered. CalOptima reserves the right to deny claims that are not submitted within ninety (90) days of the date of service, except where Provider bills a third party payor as primary. Provider agrees to refrain from duplicate billing any

claims submitted to CalOptima, unless expressly approved by CalOptima in order to process coordination of benefit claims. CalOptima shall provide payment to Provider within forty-five (45) business days of CalOptima's receipt of a clean and uncontested claim from Provider, or, CalOptima will contest or deny Provider's claim within forty-five (45) business days following CalOptima's receipt thereof.

ADDENDUM 3
CAL MEDICONNECT PROGRAM REQUIREMENTS

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

1. Provider shall provide services or perform other activity pursuant to this Contract in accordance with (i) applicable DHCS and CMS laws, regulations, instructions, including, but not limited to 42 CFR Sections 422.504, 423.505, 438.3(k), and 438.414, (ii) contractual obligations with CalOptima, and (iii) CalOptima's contractual obligations to CMS and DHCS.

2. Provider shall (i) safeguard Member privacy and confidentiality of Member health records (ii) comply with all federal and state laws and regulations regarding confidentiality and disclosure of medical records, or other health and enrollment information, (iii) ensure that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas, (iv) maintain the records and information in an accurate and timely manner, (v) ensure timely access by Members to the records and information that pertain to them, and (vi) comply with all DHCS and CMS confidentiality requirements.

3. The performance of the Provider and its Downstream Entities is monitored by CalOptima on an ongoing basis and CalOptima may impose corrective action as necessary. Provider shall comply with all CalOptima and DHCS monitoring of performance and any monitoring requests by CalOptima and DHCS.

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

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

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

7. Provider shall not close or limit their practice or acceptance of CalOptima Members as patients unless the same limitations apply to all commercially insured Members as well.

8. Provider shall not be prohibited from communicating or advocating on behalf of a Member who is a prospective, current, or former patient of Provider. Provider may freely communicate the provisions, terms or requirements of CalOptima's health benefit plans as they relate to the needs of such Member; or communicate with respect to the method by which such Provider is compensated by the Contractor for services provided to the Member. CalOptima will not refuse to contract or pay Provider for the provision of covered services under the CalOptima Cal MediConnect Program solely because Provider has in good faith communicated or advocated on behalf of a Member as set forth above.

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

10. Downstream Entity Contracts.

A. If any services under this Contract are to be provided by a Downstream Entity on behalf of Provider, Provider shall ensure that such subcontracts are in compliance with 42 CFR Sections 422.504, 423.505, 438.3(k), and 438.414. Such subcontracts shall include all language required by DHCS and CMS as provided in this Contract, including but not limited to, the following:

i. An agreement that any services or other activity performed under the subcontract shall comply with Section 1 of this Addendum 4 and Section 2.20 of the Contract.

ii. An agreement to (i) Member financial protections in accordance with Section 4.7 of the Contract, including prohibiting Downstream Entities from holding a Member liable for payment of any fees that are the obligation of the Provider, and (ii) safeguard Member privacy and confidentiality of Member health records.

iii. An agreement to comply with the inspection, evaluation, and/or auditing requirements of Section 11 of this Addendum 4 and the reporting requirements of Section 5 of this Addendum 4.

iv. An agreement to (i) the revocation of the delegation activities and related reporting requirements or other specified remedies in accordance with Section 12 of this Addendum 4 and 2.14 of the Contract, and (ii) monitoring and corrective action in accordance with Section 3 of this Addendum 4.

v. If the subcontract is for credentialing of medical providers, an agreement to the requirements of Section 13 of this Addendum 4.

vi. An agreement to provide a written statement to provider of the reason(s) for termination for cause as set forth in Section 14 of this Addendum 4.

vii. Language that specifies the Downstream Entities and related entities must comply with the federal and state laws, regulations and CMS instructions.

viii. Notify DHCS in the even the agreement with the subcontract is amended or terminated. Notice is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached.

B. In addition to Section 10.A of this Addendum 4, Provider shall further ensure any subcontracts with its Downstream Entities for medical providers include the following:

i. Term of the subcontract (beginning and ending dates), methods of extension, renegotiation, termination, and full disclosure of the method and amount of compensation or other consideration to be received from the Provider.

ii. An agreement that the contracted medical providers are paid under the terms of the Subcontract, including but not limited to, a mutually agreeable prompt payment provision.

iii. An agreement that services are provided in a culturally competent manner to all Members, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds, in accordance with Section 6 of this Addendum 4.

iv. An agreement to comply with (i) the confidentiality requirements of Member records and information in accordance with Section 2 of this Addendum 4.

v. An agreement that (i) providers shall not close or otherwise limit their acceptance of Members as patients unless the same limitations apply to all commercially insured Members, and (ii) Members shall not be held liable for Medicare Part A and B cost sharing in accordance with Section 4.7.1 of the Contract and Section 19 of this Addendum.

vi. An agreement regarding (i) provider communication or advocacy on behalf of Members as set forth in Section 8 of this Addendum 4, and (ii) specified circumstances where indemnification is not required by provider as set forth in Section 16 of this Addendum 4.

vii. An agreement that the medical provider assist the Provider and/or CalOptima in the transfer of care of a Member in accordance with Section 15 of this Addendum.

viii. An agreement (i) that the assignment or delegation of the subcontract will be void unless prior written approval is obtained pursuant to Section 17 of this Addendum 4, and (ii) to notify DHCS in the manner set forth in Section 7.9 of the Contract in the event the subcontract is amended or terminated.

ix. An agreement to (i) gather, preserve, and provide records as set forth in Section 18 of Addendum 4, and (ii) provider's right to submit a grievance in accordance with Section 8.1 of the Contract for issues arising under the subcontract related to the provision of services to CalOptima Members under the Cal MediConnect Program, as provided in CalOptima Policies relative to the Cal MediConnect Program, and excluding any contract disputes between Provider and medical provider, particularly regarding, but not limited to, payment for services under the subcontract.

x. An agreement to (i) participate and cooperate in quality improvement system as set forth in Section 2.12 of the Contract, and (ii) the provision of interpreter services for Members at all provider sites in accordance with Section 2.17 of the Contract.

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

12. Provider and its Downstream Entities agree to the revocation of the delegation of activities or obligations and related reporting requirements or other remedies set forth in Section 2.12 of the Contract in instances where CMS, DHCS, and/or CalOptima determines that the Provider and/or its Downstream Entities have not performed satisfactorily.

13. Review of Credentials. Provider shall ensure that the credentials of medical professionals affiliated with the Provider are reviewed by it. Provider agrees that CalOptima will review, approve, and audit Provider's credentialing process on ongoing basis.

14. Provider Terminations. In the event a provider is terminated for cause by Professional, Provider shall provide the provider with written notice of the reason or reasons for the action and as required by applicable Federal and State laws. In the event Provider terminates a provider for deficiencies in the quality of care provided, Provider shall give notice of the action to the appropriate licensing and disciplinary agencies.

15. In addition to Section 2.15 of the Contract, Provider agrees to assist CalOptima in the transfer of care of a Member. Provider shall further assist CalOptima in the transfer of care of a Member in the event of Subcontract termination for any reason.

16. Provider is not required to indemnify CalOptima for any expenses and liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs and any associated charges, incurred in connection with any claim or action brought against CalOptima based on CalOptima's management decisions, utilization review provisions, or other policies, guidelines, or actions relative to CalOptima Cal MediConnect Program.

17. Assignment or Delegation. Provider agrees that the assignment or delegation of this Contract or subcontract, either in whole or in part, will be void unless prior written approval is obtained from DHCS and CalOptima, as applicable, provided that approval may be withheld in their sole and absolute discretion. For purposes of this Section, and with respect to this Contract and any subcontracts, as applicable, an assignment constitutes any of the following: (i) the change of more than twenty-five percent (25%) of the ownership or equity interest in Provider or Downstream Entity (whether in a single transaction or in a series of transactions); (ii) the change of more than twenty-five percent (25%) of the directors of trustees of Provider or Downstream Entity; (iii) the

merger, reorganization, or consolidation of Provider or Downstream Entity, with another entity with respect to which Provider or Downstream Entity is not the surviving entity; and/or (iv) a change in the management of Provider or Downstream Entity from management by persons appointed, elected or otherwise selected by the governing body of Provider or Downstream Entity (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

18. Provider agrees to timely gather, preserve, and provide to DHCS or CalOptima, as applicable, any records in the Provider's or its Subcontractor's possession.

19. In addition to Section 4.7.1 of the Contract, Provider acknowledges and agrees that Medicare Parts A and B services shall be provided at zero-cost sharing to Members.

Addendums -Attachment 1
STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES

CERTIFICATION REGARDING LOBBYING

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

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

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

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontractors, subgrants, and contracts under grants and cooperative agreements) of $100,000 or more, and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

_____	_____
Name of Contractor	Printed Name of Person Signing for Contractor
_____	_____
Contract / Grant Number	Signature of Person Signing for Contractor
_____	_____
Date	Title

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

Department of Health Care Services

Medi-Cal Managed Care Division

MS 4415, 1501 Capitol Avenue, Suite 71.4001 P.O.
Box 997413

Sacramento, CA 95899-7413

Addendums-Attachment 2

CERTIFICATION REGARDING LOBBYING

Approved by OMB

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

0348-0046

1. Type of Federal Action:	2. Status of Federal Action:	3. Report Type:
contract grant cooperative agreement	bid/offer/application initial award post-award	initial filing material change For Material Change Only:

4. Name and Address of Reporting Entity: Prime Subawardee Congressional District, If known:	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District, If known:
6. Federal Department/Agency:	Federal Program Name/Description: CDFA Number, if applicable:
8. Federal Action Number, if known:	9. Award Amount, if known:
10. a. Name and Address of Lobbying Entity (If individual, last name, first name, MI): (attach Continuation Sheets(s)	b. Name and Address of Lobbying Entity (If individual, last name, first name, MI): SF-LLL-A, If necessary)
Amount of Payment (check all that apply): $ actual planned Form of Payment (check all that apply): a. cash Value	13. Type of Payment (check all that apply): a. retainer b. one-time fee c. commission d. contingent fee

14. Brief Description of Services Performed or to be Performed and Dates(s) of Service, including Officer(s), Employee(s), or Member(s) Contracted for Payment indicated in item 11:

15. Continuation Sheet(s) SF-LLL-A Attached: Yes No

16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the Congress semiannually and will be available for public	Signature: Print Name: Title: Telephone No.: Date:

Federal Use Only	Authorized for Local Reproduction Standard Form-LLL

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

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

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

Identify the status of the covered federal action.

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

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

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

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

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

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

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

10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.

10. (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).

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

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

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

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

Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

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

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

AMENDMENT 11

TO THE

COORDINATION AND PROVISION OF PUBLIC HEALTH CARE SERVICES CONTRACT

THIS AMENDMENT 11 is entered into by and between and between the Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and the County of Orange, a political subdivision of the State of California, through its division the Orange County Health Care Agency ("County"), and shall become effective on the first day of the first month following execution of this Amendment 11 by both parties ("Effective Date"), with respect to the following facts:

RECITALS

A. CalOptima and County entered into a Coordination and Provision of Public Health Care Services Contract ("Contract") effective June 1, 2013 to set forth the manner in which their respective services shall be coordinated, and County shall be reimbursed by CalOptima, as required by CalOptima's contract with the State of California, Department of Health Care Services ("DHCS").

B. On January 8, 2021, DHCS released a revised California Advancing and Innovating Medi-Cal ("CalAIM") proposal that takes a whole-person care approach to improving health outcomes for Medi-Cal Members by incorporating both clinical and nonclinical services. Implementation of CalAIM initiatives by managed care plans began January 1, 2022. Enhanced Care Management and Community Supports are two key CalAIM initiatives. Amendment 10 of this Contract added Enhanced Care Management for Members experiencing Serious Mental Illness ("SMI") and/or Substance Use Disorder ("SUD") inclusive of other related population of focus criteria under CalOptima's CalAIM program.

C. Community Supports under CalAIM are medically appropriate cost-effective alternatives that are provided as a substitute for services covered under Medi-Cal and are delivered by a different provider or in a different setting than those described in the State plan. Community Supports are optional for CalOptima Members.

D. County wishes to provide the following Community Support services related to CalAIM under the Contract: Housing Deposits; Housing Transition Navigation Services; Housing Tenancy and Sustaining Services; Recuperative Care (Medical Respite); Medically Tailored Meals; Day Habilitation Programs; Short-Term Post-Hospitalization Housing; Nursing Facility Transition/Diversion Services; and Community Transition Services/Nursing Facility Transition to a Home.

E. CalOptima and County desire to amend this Contract on the terms and conditions set forth herein.

NOW, THEREFORE, the parties agree as follows:

1. The following shall be inserted as Recitals D and E of the Contract and the existing Recitals D, E, F. and G of the Contract shall be re-lettered accordingly as Recitals F, G, H and I:

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

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

2. Section 1.58 shall be added to the Contract as follows:

"1.58 "Cal MediConnect" is a program to furnish health care services to Members who are dually eligible for Medicare and Medi-Cal and enrolled in CalOptima's Cal MediConnect program. Cal MediConnect is also referred to in this Contract as "OneCare Connect."

3. Section 5.7 shall be deleted in its entirety and replaced with the following new Section 5.7:

"5.7 Member Financial Protections. County and its Subcontractors shall comply with Member financial protections as follows:

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

5.7.2 In no event, including, but not limited to, non-payment by CalOptima, CalOptima's or County's insolvency, or breach of this contract by CalOptima, shall County Associates, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against the State of California or any Member or person acting on behalf of a Member for Covered Services pursuant to this Contract. Notwithstanding the foregoing, County Associates may collect Share of Cost (SOC), co-payments, and deductibles if, and to the extent, required under a specific CalOptima Program and applicable law.

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

5.7.4 Upon receiving notice of County Associate's invoicing or balance billing a Member for the difference between the County's billed charges and the reimbursement paid by CalOptima for any Covered Services, CalOptima may sanction the County or take other action as provided in this Contract.

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

5.7.6 County shall hold harmless both the State and Members in the event that CalOptima cannot or will not pay for services performed by the County pursuant to the Contract.

5.7.7 County agrees to hold Members harmless and not liable for Medicare Part A and B cost sharing when the State and/or DHCS is responsible for paying such amounts. County may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the Member under Title XIX if the Member were not enrolled in OneCare Connect. County will:

1) Accept CalOptima payment as payment in full, or

2) Bill the appropriate State source."

4. Section 6.2.1 shall be added to the Contract as follows:

"6.2.1 If the provision of Covered Services under this Contract requires direct, face-to-face contact with Members whereby the Member is alone with County's staff or Subcontractors, County or its Subcontractors, as applicable, shall maintain Sexual Misconduct Insurance (Abuse & Molestation Coverage) with the minimum per incident and annual aggregate limit of one million dollars ($1,000,000)."

5. Part XV "CalAIM Community Supports Services", as set forth in the attachment hereto entitled "Attachment A, Part XV, CalAIM Community Supports Services", is added to Attachment A of the Contract.

6. Section I.E "CalAIM Community Supports Services" is added to Attachment B – Amendment 10 "Compensation" as follows:

"**E. CalAIM Community Supports Services**

1. REIMBURSEMENT -- County shall be reimbursed for its services according to the rates and effective dates listed below:

Housing Deposits – Effective as of the Effective Date of this Amendment 11.

Service Rate	Up to a maximum of $
Unit of Service	The amount of the Housing Deposit advanced, up to the maximum allowed
Billing Code(s); including modifiers	See DHCS guidance for specific billing codes and modifiers

Housing Transition Navigation Service Rate- Effective as of the Effective Date of this Amendment 11.

Bundled Payments (per Enrollee per Month (PEPM))	$
Unit of Service	PEPM
Billing Code(s); including modifiers	See DHCS guidance for specific billing codes and modifiers

Housing Tenancy and Sustaining Service Rate- Effective as of the Effective Date of this Amendment 11.

Bundled Payments (per Enrollee per Month (PEPM))	$
Unit of Service	PEPM

Billing Code(s); including modifiers	See DHCS guidance for specific billing codes and modifiers

Recuperative Care (Medical Respite) Service Rate- Effective as of the Effective Date of this Amendment 11.

Service Rate	$
Unit of Service	Per Diem
Billing Code(s); including modifiers	See DHCS guidance for specific billing codes and modifiers

Medically Tailored Meals Service Rate- Effective 7/01/2022

Service Rate	$
Unit of Service	Per Meal
Billing Code(s); including modifiers	See DHCS guidance for specific billing codes and modifiers

Day Habilitation Programs Service Rate- Effective 7/01/2022

Service Rate	$
Unit of Service	PEPM
Billing Code(s); including modifiers	See DHCS guidance for specific billing codes and modifiers

Short-Term Post-Hospitalization Housing Service Rate- Effective 7/01/2022

Service Rate	$
Unit of Service	Per Diem
Billing Code(s); including modifiers	See DHCS guidance for specific billing codes and modifiers

Nursing Facility Transition/Diversion Services Service Rate- Effective 1/01/2023

Service Rate	$
Unit of Service	PMPM
Billing Code(s); including modifiers	See DHCS guidance for specific billing codes and modifiers

Community Transition Services/Nursing Facility Transition to a Home Service Rate- Effective 1/01/2023

Service Rate	$
Unit of Service	PEPM
Billing Code(s); including modifiers	See DHCS guidance for specific billing codes and modifiers

2. BILLING -- County shall submit Community Supports Services claims to CalOptima's Claims Department in accordance with DHCS billing guidelines specific to Community Supports. Billing and payment provisions in Sections II.E and II.F of Attachment A – Part XV "CalAIM Community Supports Services" of this Contract also apply."

7. "CalAIM Community Supports Services" Category is added to Section II "Services Eligible for Reimbursement" of Attachment B – Amendment 10 as follows:

Category	County	CalOptima/Health Networks
CalAIM Community Supports Services	**Medi-Cal, Medicare Advantage (OneCare), and Cal MediConnect (OneCare Connect)**: County will bill CalOptima for the select CalAIM Program services listed below, for CalOptima Members. Effective as of the Effective Date of this Amendment 11. 1. Housing Deposits 2. Housing Transition Navigation Services 3. Housing Tenancy and Sustaining Services 4. Recuperative Care (Medical Respite) Effective 7/01/2022 5. Medically Tailored Meals 6. Day Habilitation Programs 7. Short-Term Post-Hospitalization Housing Effective 1/01/2023 8. Nursing Facility Transition/Diversion Services 9. Community Transition Services/Nursing Facility Transition to a Home	**Medi-Cal, Medicare Advantage (OneCare), and Cal MediConnect (OneCare Connect)**: CalOptima will pay County for claims submitted for the select CalAIM Program services listed below provided to CalOptima Members. Effective as of the Effective Date of this Amendment 11. 1. Housing Deposits 2. Housing Transition Navigation Services 3. Housing Tenancy and Sustaining Services 4. Recuperative Care (Medical Respite) Effective 7/01/2022 5. Medically Tailored Meals 6. Day Habilitation Programs 7. Short-Term Post-Hospitalization Housing Effective 1/01/2023 8. Nursing Facility Transition/Diversion Services 9. Community Transition Services/Nursing Facility Transition to a Home

8. Addendum 2, "MEDICARE ADVANTAGE PROGRAM (ONECARE)", is added to the Contract, attached to this Amendment 11, and incorporated into the Contract by this reference.

9. Addendum 3, "CAL MEDICONNECT PROGRAM REQUIREMENTS", is added to the Contract, attached to this Amendment 11, and incorporated into the Contract by this reference.

10. CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment 11, all other conditions contained in the Contract as previously amended shall continue in full force and effect. This Amendment 11 is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS WHEREOF, CalOptima and County have executed this Amendment 11.

FOR COUNTY:	FOR CALOPTIMA:
Signature	Signature
Clayton Chau, MD, PhD Print Name	Yunkyung Kim Print Name
Director, Health Care Agency Title	Chief Operating Officer Title
Date	Date

Approved as to form:
County Counsel
County of Orange, California

By: _____

Date: _____

Attachment A, Part XV

CalAIM Community Supports Services

I. SCOPE OF WORK--- County shall provide Community Supports Covered Services under the CalOptima Medi-Cal Program and to CalOptima eligible Medi-Cal, Medicare Advantage (OneCare), and Cal MediConnect (OneCare Connect) Members. "Covered Services", as referred to in this Attachment A, Part XV, means Housing Deposits; Housing Transition/Navigation Services; and Housing Tenancy and Sustaining Services, as further described below.

A. Housing Deposits

1. Description/Overview

A. Housing Deposits assist with identifying, coordinating, securing, or funding one-time services and modifications necessary to enable a Member to establish a basic household that do not constitute payment for room and board, such as:

i. Security deposits required to obtain a lease on an apartment or home.

ii. Set-up fees/deposits for utilities or service access and utility arrearages.

iii. First month coverage of utilities, including but not limited to telephone, gas, electricity, heating, and water.

iv. First month's and last month's rent as required by landlord for occupancy.

v. Services necessary for the Member's health and safety, such as pest eradication and one-time cleaning prior to occupancy.

vi. Goods such as an air conditioner or heater, and other medically-necessary adaptive aids and services, designed to preserve a Members' health and safety in the home such as hospital beds, Hoyer lifts, air filters, specialized cleaning or pest control supplies etc., that are necessary to ensure access and safety for the Member upon move-in to the home.

B. The Housing Deposits services provided by County Associates shall be based on individualized assessment of needs by County Associates and documented in the individualized housing support plan. Members may require and access a subset of the services listed above.

C. The Housing Deposits services provided by County Associates shall utilize best practices for Members who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions, including housing first, harm reduction, progressive engagement, motivational interviewing, and trauma informed care.

D. Housing Deposits services do not include the provision of room and board or payment of ongoing rental costs beyond the first and last month's coverage as noted above.

2. Eligibility (Population Subset)

A. Any Member who received Housing Transition/Navigation Services Community Supports.

B. Members who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable Members with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services as a result of a substance use disorder and/or is exiting incarceration; or

C. Members who meet the Housing and Urban Development ("HUD") definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management ("ECM"), or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this Housing Deposits service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals.

3. Restrictions and Limitations

A. Housing Deposits are available once in a Member's lifetime. Housing Deposits can only be approved one additional time with documentation as to what conditions have changed to demonstrate why providing Housing Deposits would be more successful on the second attempt. County is expected to make a good faith effort to review information available to it to determine if Member has previously received services.

B. These services must be identified by County Associates as reasonable and necessary in the Member's individualized housing support plan and are available only when the Member is unable to meet such expense.

C. Members must also receive Housing Transition /Navigation services (at a minimum, the associated tenant screening, housing assessment and individualized housing support plan, as discussed in Subsection I.B of this Attachment A, Part XV below) in conjunction with this service.

D. Members may not be receiving duplicative support from other State, local or federally funded programs, which shall always be considered first, before using Medi-Cal funding.

4 Licensing/Allowable County Associates (as that term is defined in Section III)

A. County Associates must have experience and expertise with providing Housing Deposit services in a culturally and linguistically appropriate manner.

B. County Associates, case managers, care coordinators or housing navigators may coordinate these services and pay for them directly (e.g., to the landlord, utility company, pest control company, etc.) or subcontract the services. County shall not seek reimbursement from CalOptima for Housing Deposit amounts paid directly by CalOptima.

C. County Associates must have demonstrated or verifiable experience and expertise with providing Housing Deposit services.

D. County Associates have a state-level enrollment pathway and are enrolled in the Medi-Cal program pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment (APL 19-004). If there is no state-level enrollment pathway, CalOptima has a process for vetting County Associates, which may extend to individuals employed by or delivering services on behalf of County, to ensure County Associates can meet the capabilities and standards required to be a CSP.

B. Housing Transition/Navigation Services

1. Description/Overview

A. Housing Transition/Navigation services assist Members with obtaining housing and include:

i. Conducting a tenant screening and housing assessment that identifies the Member's preferences and barriers related to successful tenancy. The assessment may include collecting information on the Member's housing needs, potential housing transition barriers, and identification of housing retention barriers.

ii. Developing an individualized housing support plan based upon the housing assessment that addresses identified barriers, includes short- and long-term measurable goals for each issue, establishes the Member's approach to meeting the goal, and identifies when other providers or services, both reimbursed and not reimbursed by Medi-Cal, may be required to meet the goal.

iii. Searching for housing and presenting options.

iv. Assisting in securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).

v. Assisting with benefits advocacy, including assistance with obtaining identification and documentation for SSI eligibility and supporting the SSI application process. Such service can be subcontracted out by County to retain needed specialized skillset.

vi. Identifying and securing available resources to assist with subsidizing rent (such as Section 8, state and local assistance programs etc.) and matching available rental subsidy resources to Members.

vii. Identifying and securing resources to cover expenses, such as security deposits, moving costs, adaptive aids, environmental modifications, moving costs, and other one-time expenses. Actual payment of these housing deposits and move-in expenses is a separate Community Supports under Section I.A, Housing Deposits, of this Attachment A, Part XV.

viii. Assisting with requests for reasonable accommodation, if necessary, as related to expenses incurred by the housing navigator supporting the Member moving into the home.

ix. Educating and engaging with landlords.

x. Ensuring that the living environment is safe and ready for move-in.

xi. Communicating and advocating on behalf of the Member with landlords.

xii. Assisting with arranging for and supporting the details of the move.

xiii. Identifying, coordinating, securing, or funding non-emergency, non-medical transportation to assist Members' mobility to ensure reasonable accommodations and access to housing options prior to transition and on move in day.

xiv. Identifying and coordinating, environmental modifications to install necessary accommodations for accessibility.

B. The Housing Transition/Navigation services provided by County Associates shall be based on individualized assessment of needs by County Associates and documented in the individualized housing support plan. Members may only require and access a subset of the services listed above.

C. The Housing Transition/Navigation services provided by County Associates shall utilize best practices for Members who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions. Examples of best practices include housing first harm reduction, progressive engagement, motivational interviewing, and trauma informed care.

D. The Housing Transition/Navigation services provided by County Associates may involve additional coordination with other entities to ensure the Member has access to supports needed for successful tenancy. These entities may include County Health, Public Health, Substance Use, Mental Health and Social Services Departments; County and City Housing Authorities; Continuums of Care and Coordinated Entry System; Sheriff's Department and Probation Officers, as applicable and to the extent possible; local legal service programs, community-based organizations housing providers, local housing agencies and housing development agencies. For Members who will need rental subsidy support to secure permanent housing, the services will require close coordination with local Coordinated Entry Systems, homeless services authorities, public housing authorities, and other operators of local rental subsidies. Some housing assistance (including recovery residences and emergency assistance or rental subsidies for Full-Service Partnership Members) is also funded by county behavioral health agencies, and CalOptima and their contracted Community Supports Providers shall expect to coordinate access to these housing resources through County behavioral health when appropriate.

E. The services provided by County Associates may involve coordination with other entities to ensure the Member has access to supports needed to enter successfully into Housing Transition Navigation services and tenancy. Final program guidelines shall adopt, as a standard, the demonstrated need to ensure seamless service to Members experiencing homelessness entering the Housing Transition Navigation services Community Supports.

F. Housing Transition/Navigation services do not include the provision of room and board or payment of rental costs. County Associate's provision of, or coordination with, local entities is crucial to ensure that available options for room and board or rental payments are also coordinated with housing services and supports.

2. Eligibility (Population Subset)

A. Members who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable Members with disabilities and/or one or more

serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services as a result of a substance use disorder and/or is exiting incarceration; or

B. Members who meet the HUD definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving ECM, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals; or

C. Members who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:

i. A Member or family who:

a. Has an annual income below 30 percent of median family income for the area, as determined by HUD;

b. Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in the "Homeless" definition in this Section 1.2.3; and

c. Meets one of the following conditions:

(i) Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;

(ii) Is living in the home of another because of economic hardship;

(iii) Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance;

(iv) Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income Members;

(v) Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;

(vi) Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or

(vii) Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;

(viii) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or

(ix) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him.

D. Members who are determined to be at risk of experiencing homelessness are eligible to receive Housing Transition/Navigation services if they have significant barriers to housing stability and meet at least one of the following:

i. Have one or more serious chronic conditions;

ii. Have a SMI;

iii. Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder; or

iv. Have a Serious Emotional Disturbance (children and adolescents);

v. Are receiving ECM; or

vi. Are a transition-age youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a SMI and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking or domestic violence.

3. Restrictions and Limitations

A. Housing Transition/Navigation services must be identified by County Associates as reasonable and necessary in the Member's individualized housing support plan. The service duration can be as long as necessary.

B. Members may not be receiving duplicative support from other State, local tax or federally funded programs, which shall always be considered first, before using Medi-Cal funding.

4. Licensing/Allowable County Associates

A. County Associates must have experience and expertise with providing Housing Transition Navigation services in a culturally and linguistically appropriate manner. This list is provided as an example of the types of services County Associates may offer, but it is not an exhaustive list of services. County Associates must demonstrate experience

with providing and coordinating housing-related services and supports and may include County Associates such as:

i. Vocational services agencies;

ii. Providers of services for Members experiencing homelessness;

iii. Life skills training and education providers;

iv. County agencies;

v. Public hospital systems;

vi. Mental health or substance use disorder treatment providers, including county behavioral health agencies;

vii. Social services agencies;

viii. Affordable housing providers;

ix. Supportive housing providers; and

x. Federally qualified health centers and rural health clinics.

B. County Associates have a state-level enrollment pathway and are enrolled in the Medi-Cal program, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, CalOptima must have a process for vetting County Associates, which may extend to individuals employed by or delivering services on behalf of County, to ensure it can meet the capabilities and standards required to be a CSP.

C. Members who meet the eligibility requirements for Housing Transition Navigation services shall also be assessed for ECM and Housing and Tenancy Support Services. When enrolled in ECM, Community Supports shall be managed in coordination with County's ECM providers. When Members receive more than one of these services, County shall coordinate with CalOptima or CalOptima's health network to ensure service coordination, to minimize the number of care/case management transitions experienced by Members, and to improve overall care coordination and management.

D. County Associates, case manager, care coordinator or housing navigator providing the service, must have demonstrated experience working with Members experiencing homelessness or with the provision of housing-related services and supports to vulnerable populations.

C. Housing Tenancy and Sustaining Services

1. Description/Overview

A. Housing Tenancy and Sustaining services provide tenancy and sustaining services, with a goal of maintaining safe and stable tenancy once housing is secured. Services include:

i. Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment, hoarding, substance use, and other lease violations.

ii. Education and training on the role, rights and responsibilities of the tenant and landlord.

iii. Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy.

iv. Coordination with the landlord and case management provider to address identified issues that could impact housing stability.

v. Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action, including developing a repayment plan or identifying funding in situations in which the Member owes back rent or payment for damage to the unit.

vi. Advocacy and linkage with community resources to prevent eviction when housing is or may potentially become jeopardized.

vii. Assisting with benefits advocacy, including assistance with obtaining identification and documentation for SSI eligibility and supporting the SSI application process. Such service can be subcontracted out to retain needed specialized skillset.

viii. Assistance with the annual housing recertification process.

ix. Coordinating with the tenant to review, update, and modify the tenant's housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers.

x. Continuing assistance with lease compliance, including ongoing support with activities related to household management.

xi. Health and safety visits, including unit habitability inspections. This does not include housing quality inspections.

xii. Other prevention and early intervention services identified in the crisis plan that are activated when housing is jeopardized (e.g., assisting with reasonable accommodation requests that were not initially required upon move-in).

xiii. Providing independent living and life skills including assistance with and training on budgeting, including financial literacy and connection to community resources.

xiv. Members who meet the eligibility requirements for Housing Transition Navigation services shall also be assessed for ECM and Housing and Tenancy Support Services. When enrolled in ECM, Community Supports shall be managed in coordination with County's ECM providers. When Members receive more than one of these services, County shall coordinate with CalOptima or CalOptima's health network to ensure service coordination, to minimize the number of care/case management transitions experienced by Members, and to improve overall care coordination and management.

B. The services provided by County Associates shall be based on individualized assessment of Member needs by County Associates and documented in the individualized housing support plan. Members may only require and access a subset of the services listed above.

C. The services provided by County Associates shall utilize best practices for Members who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

D. The services provided by County Associates may involve coordination with other entities to ensure the Member has access to supports needed to maintain successful tenancy. Final program guidelines shall adopt, as a standard, the demonstrated need to ensure seamless service to Members experiencing homelessness entering the Housing Tenancy and Sustaining Services Community Supports.

E. Services do not include the provision of room and board or payment of rental costs.

2. Eligibility (Population Subset)

A. Any Member who received Housing Transition/Navigation Services Community Supports.

B. Any Member who received Housing Deposits Services Community Supports.

C. Members who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable Members with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services as a result of a substance use disorder and/or is exiting incarceration; or

D. Members who meet the HUD definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving ECM, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals; or

E. Members who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:

i. Member or family who:

a. Has an annual income below 30 percent of median family income for the area, as determined by HUD;

b. Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in section 2.2.3 of the "Homeless" definition in this section; and

c. Meets one of the following conditions:

(i) Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;

(ii) Is living in the home of another because of economic hardship;

(iii) Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance;

d. Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income Members;

e. Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;

f. Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or

g. Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;

ii. A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or

iii. A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him; or

iv. Members who are determined to be at risk of experiencing homelessness are eligible to receive Housing Tenancy and Sustaining services if they have significant barriers to housing stability and meet at least one of the following:

a. Have one or more serious chronic conditions;

b. Have a SMI;

c. Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder, or

d. Have a Serious Emotional Disturbance (children and adolescents);

e. Are receiving ECM; or

f. Are a transition-age youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking or domestic violence.

3. Restrictions and Limitations

A. These Housing Tenancy and Sustaining services provided by County Associates are available from the initiation of services through the time when the Member's housing support plan determines they are no longer needed. They are only available for a single duration in the Member's lifetime. Housing Tenancy and Sustaining services provided by County Associates can only be approved one additional time by CalOptima or CalOptima's health networks with documentation as to what conditions have changed to demonstrate why providing Housing Tenancy and Sustaining services would be more successful on the second attempt. County Associates are expected to make a good faith effort to review information available to it to determine if Member has previously received services. The service duration can be as long as necessary.

B. These services must be identified by County Associates as reasonable and necessary in the Member's individualized housing support plan and are available only when the enrollee is unable to successfully maintain longer-term housing without such assistance.

C. Many Members will have also received Housing Transition/Navigation services (at a minimum, the associated tenant screening, housing assessment and individualized housing support plan) in conjunction with this Housing Tenancy and Sustaining service, but accessing such Housing Transition/Navigation services is not a prerequisite for eligibility.

D. Members may not be receiving duplicative support from other State, local or federally funded programs, which shall always be considered first, before using Medi-Cal funding.

4. Licensing/Allowable County Associates

A. County Associates must have experience and expertise with providing Housing Tenancy and Sustaining services in a culturally and linguistically appropriate manner. This list is provided as an example of the types of services County Associates may offer, but it is not an exhaustive list of services. County Associates must demonstrate experience with providing and coordinating housing-related services and supports and may include County Associates such as:

i. Vocational services agencies

ii. Providers of services for Members experiencing homelessness

iii. Life skills training and education providers

iv. County agencies

v. Public hospital systems

vi. Mental health or substance use disorder treatment providers, including county behavioral health agencies

vii. Supportive housing providers

viii. Federally qualified health centers and rural health clinics

B. County Associates that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs, including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, CalOptima must have a process for vetting the CSP, which may extend to individuals employed by or delivering services on behalf of the CSP, to ensure it can meet the capabilities and standards required to be a CSP.

C. County Associates, case manager, care coordinator or housing navigator providing the service must have demonstrated experience working with Members experiencing homelessness or with the provision of housing-related services and supports to vulnerable populations

D. Members who meet the eligibility requirements for Housing Tenancy and Sustaining services shall also be assessed for ECM and may have received Housing Transition Navigation services. When enrolled in ECM, Community Supports shall be managed in coordination with County associates' ECM providers. When Members receive more than one of these services, County shall coordinate with CalOptima or CalOptima's health network to ensure service coordination, to minimize the number of care/case management transitions experienced by Members, and to improve overall care coordination and management.

D. Recuperative Care (Medical Respite) Services

1. Description/Overview

A. Recuperative Care, also referred to as medical respite care and as defined in this Section D.1, is short-term residential care for Members who no longer require hospitalization but still need to heal from an injury or illness (including behavioral health conditions) and whose condition would be exacerbated by an unstable living environment ("**Recuperative Care**"). An extended stay in a recovery care setting allows Members to continue their recovery and receive post-discharge treatment while obtaining access to primary care, behavioral health services, case management and other supportive social services, such as transportation, food, and housing.

B. At a minimum, the service will include interim housing with a bed and meals and ongoing monitoring of the Member's ongoing medical or behavioral health condition (e.g., monitoring of vital signs, assessments, wound care, medication monitoring). Based on Member needs, the service may also include:

i. Limited or short-term assistance with Instrumental Activities of Daily Living ("IADLs")/or Activities of Daily Living ADLs

ii. Coordination of transportation to post-discharge appointments

iii. Connection to any other ongoing services a Member may require including mental health and substance use disorder services

iv. Support in accessing benefits and housing

v. Gaining stability with case management relationships and programs

C. Recuperative Care is primarily used for those Members who are experiencing homelessness or those with unstable living situations who are too ill or frail to recover from an illness (physical or behavioral health) or injury in their usual living environment; but who are not otherwise ill enough to be in a hospital.

D. The services provided to a Member while in Recuperative Care shall not replace or be duplicative of the services provided to Members utilizing the ECM program. Recuperative care may be utilized in conjunction with other housing Community Supports. Whenever possible, other housing Community Supports shall be provided to members on-site in the Recuperative Care facility. When enrolled in ECM, Community Supports shall be managed in coordination with ECM providers.

E. The services provided shall utilize best practices for Members who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions, including housing first, harm reduction, progressive engagement, motivational interviewing, and trauma informed care.

2. Eligibility

A. Members who are at risk of hospitalization or are post-hospitalization, and

B. Members who live alone with no formal supports; or

C. Members who face housing insecurity or have housing that would jeopardize their health and safety without modification. For this population, the service could be coordinated with home modifications (which are covered as a separate Community Supports) and serve as a temporary placement until the Member can safely return home.

3. Restrictions and Limitations

A. Recuperative Care is an allowable Community Supports service if it is (1) necessary to achieve or maintain medical stability and prevent hospital admission or re-admission, which may require behavioral health interventions, (2) is not more than 90 days in continuous duration, and (3) does not include funding for building modification or building rehabilitation.

B. Members may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

4. Licensing/Allowable Community Supports Providers

A. This list is provided to show examples of the types of providers County may choose to contract with, but it is not an exhaustive list of providers that may offer the services for County.

i. Interim housing facilities with additional on-site support

ii. Shelter beds with additional on-site support

iii. Converted homes with additional on-site support

iv. County directly operated or contracted Recuperative Care facilities

B. Facilities Are unlicensed. CalOptima shall apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. CalOptima can adopt or adapt local or national standards for Recuperative Care or interim housing. CalOptima shall monitor the provision of all the services included above.

C. County Associates that have a state-level enrollment pathway and are enrolled in the Medi-Cal program, pursuant to relevant DHCS All Plan Letters (APLs), including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, CalOptima has a process for vetting the County Associates, which may extend to individuals employed by or delivering services on behalf of County, to ensure County Associates can meet the capabilities and standards required to be a CSP.

E. Medically Tailored Meals Services

1. Description/Overview

A. Malnutrition and poor nutrition can lead to devastating health outcomes, higher utilization, and increased costs, particularly among Members with chronic conditions. Meals help Members achieve their nutrition goals at critical times to help them regain and maintain their health. Results include improved Member health outcomes, lower hospital readmission rates, a well-maintained nutritional health status and increased Member satisfaction.

2. Medically Tailored Meals, as defined in this Section E, are:

A. Meals delivered to the home immediately following discharge from a hospital or nursing home when Members are most vulnerable to readmission.

B. Meals provided to the Member at home that meet the unique dietary needs of those with chronic diseases.

C. Meals are tailored to the medical needs of the Member by a registered dietitian or other certified nutrition professional, reflecting appropriate dietary therapies based on evidence-based nutritional practice guidelines to address medical diagnoses, symptoms, allergies, medication management, and side effects to ensure the best possible nutrition-related health outcomes.

D. Medically-supportive food and nutrition services, including medically tailored groceries, healthy food vouchers, and food pharmacies.

E. Behavioral, cooking, and/or nutrition education is included when paired with direct food assistance as enumerated above.

CalOptima has the discretion to define criteria for the level of services determined to be both medically appropriate and cost-effective for Members (e.g., Medically Tailored Meals, groceries, food vouchers, etc.).

3. Eligibility

A. Members with chronic conditions, such as but not limited to diabetes, cardiovascular disorders, congestive heart failure, stroke, chronic lung disorders, human immunodeficiency virus (HIV), cancer, gestational diabetes, or other high risk perinatal conditions, and chronic or disabling mental/behavioral health disorders.

B. Members being discharged from the hospital or a skilled nursing facility or at high risk of hospitalization or nursing facility placement; or

C. Members with extensive care coordination needs.

4. Restrictions and Limitations

A. Medically Tailored Meals cover up to three medically tailored meals per day and or medically-supportive food and nutrition services for up to twelve (12) weeks, or longer if medically necessary.

(i) Meals that are eligible for or reimbursed by alternate programs are not eligible.

(ii) Meals are not covered to respond solely to food insecurities.

Members may not be receiving duplicative support from other State, local or federally funded programs, which shall always be considered first, before using Medi-Cal funding.

5. Licensing and Allowable Community Supports Providers

A. County Associates must have experience and expertise with providing Medically Tailored Meals. This list is provided as an example of the types of services County Associates may offer, but it is not an exhaustive list of services.

(i) Home delivered meal providers

(ii) Area Agencies on Aging

(iii) Nutritional Education Services to help sustain healthy cooking and eating habits

(iv) Meals on Wheels providers

(v) Medically supportive food and nutrition providers

B. County Associates that have a state-level enrollment pathway and are enrolled in the Medi-Cal program, pursuant to relevant DHCS APLs, including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, CalOptima has a process for vetting County Associates, which may extend to individuals employed by or delivering services on behalf of County, to ensure County Associates can meet the capabilities and standards required to be a CSP.

F. Day Habilitation Programs Services

1. Description/Overview.

A. Day Habilitation Programs, as defined in this Section 1, are provided in a Member's home or an out-of-home, non- facility setting. Day Habilitation Programs are designed to assist

the Member in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in the person's natural environment. Day Habilitation Programs are often considered as peer mentoring when provided by an unlicensed caregiver with the necessary training and supervision. For Members experiencing homelessness who are receiving ECM or other Community Supports Services, Day Habilitation Programs can provide a physical location for Members to meet with and engage with these Community Supports Providers. When possible, these services should be provided by the same entity to minimize the number of care/case management transitions experienced by Members and to improve overall care coordination and management.

B. As used in this Schedule, the General Assistance or General Relief ("GA/GR") Program is designed to provide relief and support to indigent adults who are not supported by their own means, other public funds, or assistance programs.

C. Day habilitation program services include, but are not limited to, training on:

i. The use of public transportation;

ii. Personal skills development in conflict resolution;

iii. Community participation;

iv. Developing and maintaining interpersonal relationships;

v. Daily living skills (cooking, cleaning, shopping, money management); and,

vi. Awareness of community resources such as police, fire, or local services, to support independence in the community.

D. Day Habilitation Programs may include assistance with, but not limited to, the following:

i. Selecting and moving into a home (refer to the Housing Transition/Navigation Services Community Supports);

ii. Locating and choosing suitable housemates;

iii. Locating household furnishings;

iv. Settling disputes with landlords (refer to the Housing Tenancy and Sustaining Services Community Supports);

v. Managing personal financial affairs;

vi. Recruiting, screening, hiring, training, supervising, and dismissing personal attendants;

vii. Dealing with and responding appropriately to governmental agencies and personnel;

viii. Asserting civil and statutory rights through self-advocacy;

ix. Building and maintaining interpersonal relationships, including a circle of support;

x. Coordination with CalOptima to link Member to any in Community Supports and or ECM services for which the Member may be eligible;

xi. Referral to non-Community Supports housing resources if the Member does not meet Housing Transition and Navigation Services Community Supports eligibility criteria;

xii. Assistance with income and benefits advocacy, including GA/GR and SSI if the Member is not receiving these services through Community Supports or ECM; and

xiii. Coordination with CalOptima to link the Member to health care, mental health services, and substance use disorder services based on the individual needs of the Member, for Members who are not receiving this linkage through Community Supports or ECM.

E. The services provided should utilize best practices for Members who are experiencing homelessness or formerly experienced homelessness including housing first, harm reduction, progressive engagement, motivational interviewing, and trauma informed care. Day Habilitation Program services are available for as long as necessary and can be provided continuously or through intermittent meetings, in an individual or group setting.

2. Eligibility

Members who are experiencing homelessness, Members who exited homelessness and entered housing in the last twenty-four (24) months, and Members at risk of homelessness or institutionalization whose housing stability could be improved through participation in a Day Habilitation Program.

3. Restrictions and Limitations

Members may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

4. Licensing and Allowable Community Supports Providers

County Associates must have experience and expertise with providing these unique services. This list is provided as an example of the types of services County Associates may offer, but it is not an exhaustive list of services.

A. Mental health or substance use disorder treatment providers, including county behavioral health agencies

B. Licensed psychologists

C. Licensed certified social workers

D. Registered nurses

E. Home health agencies

F. Professional fiduciary

G. Vocational skills agencies

County Associates that have a state-level enrollment pathway and are enrolled in the Medi-Cal program, pursuant to relevant DHCS APLs, including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, CalOptima

has a process for vetting County Associates, which may extend to individuals employed by or delivering services on behalf of County, to ensure County Associates can meet the capabilities and standards required to be a CSP.

G. Short-Term Post-Hospitalization Housing Services

1. Description/Overview

A. Short-Term Post-Hospitalization Housing, as defined in this Section 1, provides Members who do not have a residence and who have high medical or behavioral health needs with the opportunity to continue their medical/psychiatric/substance use disorder recovery immediately after exiting an inpatient hospital (either acute or psychiatric or chemical dependency and recovery hospital), residential substance use disorder treatment or recovery facility, residential mental health treatment facility, correctional facility, nursing facility, or recuperative care and avoid further utilization of state plan services. Up to 90 days of recuperative care is available under specified circumstances as a separate Community Supports Program.

B. Short-Term Post-Hospitalization Housing provides Members with ongoing supports necessary for recuperation and recovery such as gaining (or regaining) the ability to perform activities of daily living, receiving necessary medical/psychiatric/substance use disorder care, case management and beginning to access other housing supports such as Housing Transition Navigation. Housing Transition/Navigation Services are a separate Community Supports Program.

C. This setting may include an individual or shared interim housing setting, where residents receive the services described above.

D. Beneficiaries must be offered Housing Transition Navigation supports during the period of Short-Term Post-Hospitalization housing to prepare them for transition from this setting. These services shall include a housing assessment and the development of individualized housing support plan to identify preferences and barriers related to successful housing tenancy after Short-Term Post-Hospitalization Housing. The development of a housing assessment and individualized support plan are covered as a separate Community Supports Program under Housing Transition/Navigation Services.

E. Short-Term Post-Hospitalization Housing provided should utilize best practices for Members who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions, including housing first, harm reduction, progressive engagement, motivational interviewing, and trauma informed care.

2. Eligibility

A. Members exiting recuperative care.

B. Members exiting an inpatient hospital stay (either acute or psychiatric or chemical dependency and recovery hospital), residential substance use disorder treatment or recovery facility, residential mental health treatment facility, correctional facility, or nursing facility and who meet any of the following criteria:

i. Members who meet the Housing and Urban Development ("HUD") definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on

the number of days in the institution) and who are receiving ECM, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, institution for mental disease and state hospitals.

C. In addition to meeting one of these criteria at a minimum, individuals must have medical/behavioral health needs such that experiencing homelessness upon discharge from the hospital, substance use or mental health treatment facility, correctional facility, nursing facility, or recuperative care would likely result in hospitalization, re-hospitalization, or institutional readmission.

3. Restrictions and Limitations

A. Short-Term Post-Hospitalization Services are available once in a Member's lifetime and are limited and are not to exceed a duration of six (6) months per episode (but may be authorized for a shorter period based on Member needs). CalOptima is expected to make a good faith effort to review information available to them to determine if Member has previously received services.

B. The service is only available if the Member is unable to meet such an expense.

C. Members may not be receiving duplicative support from other State, local or federally funded programs, which shall always be considered first, before using Medi-Cal funding.

4. Licensing/Allowable Community Supports Providers

A. County Associates must have experience and expertise with providing Short-Term Post-Hospitalization Services. This list is provided as an example of the types of services County Associates may offer, but is not an exhaustive list of services.

i. Interim housing facilities with additional on-site support

ii. Shelter beds with additional on-site support

iii. Converted homes with additional on-site support

iv. County directly operated or contracted recuperative care facilities

v. Supportive housing providers

vi. County agencies

vii. Public hospital systems

viii. Social service agencies

ix. Providers of services for Members experiencing homelessness

B. Facilities may be unlicensed. CalOptima must apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. CalOptima can adopt or adapt local or national standards for Short-Term Post-Hospitalization Housing services. CalOptima shall monitor the provision of all the services included above.

C. County Associates that have a state-level enrollment pathway and are enrolled in the Medi-Cal program, pursuant to relevant DHCS APLs, including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, CalOptima has a process for vetting County Associates, which may extend to individuals employed by or delivering services on behalf of the County, to ensure County Associates can meet the capabilities and standards required to be a CSP.

H. Nursing Facility Transition/Diversion Services

1. Description/Overview

A. Nursing Facility Transition/Diversion Services, as defined in this Section 1, help Members live in the community and/or avoid institutionalization when possible.

B. The goal is to both facilitate nursing facility transition back into a home-like, community setting and/or prevent skilled nursing admissions for Members with an imminent need for nursing facility level of care ("LOC"). Members have the choice of residing in an assisted living setting as an alternative to long-term placement in a nursing facility when they meet eligibility requirements.

C. The assisted living Provider is responsible for meeting the needs of the Member, including helping with Activities of Daily Living ("ADLs") and Instrumental ADLs ("IADLs") and providing meals, transportation, and medication administration, as needed.

D. Nursing Facility Transition/Diversion Services are for individuals who are transitioning from a licensed health care facility to a living arrangement in a Residential Care Facility for the Elderly ("RCFE") or an Adult Residential Facility ("ARF"). They include wraparound services such as assistance with ADLs and IADLs as needed, companion services, medication oversight, and therapeutic social and recreational programming, provided in a home-like environment. It also includes 24- hour direct care staff on-site to meet scheduled unpredictable needs in a way that promotes maximum dignity and independence and to provide supervision, safety, and security. Allowable expenses are those necessary to enable a person to establish a community facility residence (except room and board), including but not limited to:

i. Assessing the Member's housing needs and presenting options. Refer to Housing Transition/Navigation Services Community Support for additional details.

ii. Assessing the service needs of the Member to determine whether the Member needs enhanced on-site services at the RCFE/ARF so the Member can be safely and stably housed in an RCFE/ARF.

iii. Assisting in securing a facility residence, including the completion of facility applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).

iv. Communicating with facility administration and coordinating the move.

v. Establishing procedures and contacts to retain facility housing.

vi. Coordinating with CalOptima to ensure that the needs of Members who

need enhanced services to be safely and stably housed in RCFE/ARF settings have Community Supports services and/or ECM services that provide the necessary enhanced services.

a. CalOptima may also fund RCFE/ARF operators directly to provide these enhanced services.

2. Eligibility

A. For Nursing Facility Transition Services:

i. Has resided 60+ days in a nursing facility;

ii. Is willing to live in an assisted living setting as an alternative to a nursing facility; and

iii. Is able to reside safely in an assisted living facility with appropriate and cost- effective supports.

B. For Nursing Facility Diversion Services:

iv. Is interested in remaining in the community;

v. Is willing and able to reside safely in an assisted living facility with appropriate and cost-effective supports and services; and

vi. Must be currently receiving medically necessary nursing facility LOC or meet the minimum criteria to receive nursing facility LOC services and, in lieu of going into a facility, is choosing to remain in the community and continue to receive medically necessary nursing facility LOC services at an assisted living facility.

3. Restrictions/Limitations

A. Members are directly responsible for paying their own living expenses.

B. Members may not be receiving duplicative support from other state, local, or federally funded programs, which should always be considered first, before using Medi-Cal funding.

4. Licensing/Allowable Community Supports Providers

A. County Associates must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner. The below list is provided as an example of the types of services County Associates may offer, but is not an exhaustive list services.

i. Case management agencies

ii. Home Health Agencies

iii. Medi-Cal managed care plans

iv. ARF/RCFE operators

B. County Associates that have a state-level enrollment pathway are enrolled in the Medi-Cal program, pursuant to relevant DHCS APLs, including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, CalOptima must have a process for vetting the County Associates, which may extend to individuals employed by or delivering services on behalf of the County, to ensure it can meet the capabilities and standards required to be a CSP.

C. RCFEs/ARFs are licensed and regulated by the California Department of Social Services, Community Care Licensing Division.

I. Community Transition Services/Nursing Facility transition to a Home

1. Description/Overview

A. Community Transition /Nursing Facility Transition to a Home Services, as described in this Section 1, help Members live in the community and avoid further institutionalization.

B. Community Transition/Nursing Facility Transition to a Home Services cover non-recurring setup expenses for Members who are transitioning from a licensed facility to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a Member to establish a basic household that do not constitute room and board and include:

i. Assessing the Member's housing needs and presenting options. Refer to the Housing Transition/Navigation Services and/or Housing Tenancy/Sustaining Services Community Supports for additional details.

ii. Assisting in searching for and securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).

iii. Communicating with the landlord (if applicable) and coordinating the move.

iv. Establishing procedures and contacts to retain housing.

v. Identifying, coordinating, securing, or funding non-emergency, nonmedical transportation to assist Members' mobility to ensure reasonable accommodations and access to housing options prior to transition and on move-in day.

vi. Identifying the need for and coordinating funding for environmental modifications to install necessary accommodations for accessibility. Refer to the Housing Transition/Navigation Services and/or Housing Tenancy/Sustaining Services for additional details.

vii. Identifying the need for and coordinating funding for services and modifications necessary to enable a Member to establish a basic household refers to funding that does not constitute room and board, such as security deposits required to obtain a lease on an apartment or home; setup fees for utilities or service access; first-month coverage of utilities, including telephone, electricity, heating, and water; funds for services necessary for the Member's health and safety, such as

pest eradication and one-time cleaning prior to occupancy; funds for home modifications, such as an air conditioner or heater; and funds for other medically necessary services, such as hospital beds and Hoyer lifts, etc. to ensure access and reasonable accommodations. Refer to the Environmental Accessibility Adaptations and/or Asthma Remediation Community Supports for additional details.

2. Eligibility

A. Is currently receiving medically necessary nursing facility level of care ("LOC") services and, in lieu of remaining in the nursing facility or Medical Respite setting, is choosing to transition home and continue to receive medically necessary nursing facility LOC services;

B. Has lived 60+ days in a nursing home and/or medical respite setting;

C. Is interested in moving back to the community; and

D. Is able to reside safely in the community with appropriate and cost-effective supports and services.

3. Restrictions/Limitations

A. Community Transition/Nursing Facility Transition to a Home Services do not include monthly rental or mortgage expense, food, regular utility charges, and/or household appliances or items that are intended for purely diversionary/recreational purposes.

B. Community Transition/Nursing Facility Transition to a Home Services are payable up to a total lifetime maximum amount of $7,500.00. The only exception to the $7,500.00 total maximum is if the Member is compelled to move from a Provider-operated living arrangement to a living arrangement in a private residence through circumstances beyond his or her control.

C. Community Transition/Nursing Facility Transition to a Home Services must be necessary to ensure the health, welfare, and safety of the Member, and without which the Member would be unable to move to the private residence and would then require continued or re-institutionalization.

D. Members may not be receiving duplicative support from other state, local, or federally funded programs, which should always be considered first, before using Medi-Cal funding.

4. Licensing/Allowable Providers

A. County Associates must have experience and expertise with providing these unique services. The list is provided to show examples of the types services County Associates may provide, but it is not an exhaustive list of services.

i. Case management agencies

ii. Home health agencies

iii. Medi-Cal managed care plans

iv. County mental health providers

v. 1915c home and community-based alternatives/assisted living waiver providers

vi. California community transitions/money follows the person providers

B. County Associates that have a state-level enrollment pathway and are enrolled in the Medi-Cal program, pursuant to relevant DHCS APLs, including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, CalOptima must have a process for vetting the County Associates, which may extend to individuals employed by or delivering services on behalf of County, to ensure it can meet the capabilities and standards required to be a CSP.

II. ADDITIONAL REQUIREMENTS

A. Delivery of Community Supports. County Associates shall deliver contracted Community Supports in accordance with the DHCS service definitions and requirements, CalOptima Policies, CalOptima Policy GG.1355: Community Supports, and this Contract.

1. County Associates shall maintain staffing that allows for timely, high-quality service delivery of the Community Supports that it is contracted to provide.

2. County Associates shall:

a. Act upon Member referrals from CalOptima or Health Network for authorized Community Supports, unless the CSP is at pre-determined capacity; or Member referral does not meet eligibility requirements of County Associates integrated treatment and service program;

b. Conduct outreach to the referred Member for authorized County Associates as soon as possible, including by making best efforts to conduct initial outreach within 24 hours of receipt of authorization, if applicable;

c. Be responsive to incoming calls or other outreach from Members, including by maintaining a phone line that is staffed or able to record voicemail 24 hours a day, 7 days a week;

d. Coordinate with other providers in the Member's care team, including ECM providers, other Community Supports providers, CalOptima and Health Networks;

e. Comply with cultural competency and linguistic requirements required by this Contract, CalOptima Policies and federal, State and local laws;

f. Comply with non-discrimination requirements set forth in this Contract and State and Federal law.

B. When federal law requires authorization for data sharing, County Associates shall obtain and/or document such authorization from each assigned Member, including sharing of protected health information ("PHI"), and shall confirm it has obtained such authorization to CalOptima. Member authorization for Community Supports-related data sharing is not required for the CSP to initiate delivery of Community Supports unless such authorization is required by federal law. CSP will be reimbursed only for Community Supports services that are authorized by CalOptima or Health Network. In the event of a Member requesting Community Supports services that are not yet authorized by CalOptima or a Health

Network, CSP shall send prior authorization request(s) to CalOptima for a CalOptima Direct Member or the Member's assigned Health Network, as applicable.

C. If a Community Supports is discontinued for any reason, County Associates shall support transition planning for the Member into other programs or services that meet their needs.

D. County Associates are encouraged to identify additional Community Supports the Member may benefit from and send any additional request(s) for Community Supports to CalOptima or Health Network for authorization.

E. Payment of Community Supports. County shall record, generate, and send a claim or invoice to CalOptima for Community Supports rendered. If County submits claims, County shall submit claims to CalOptima using specifications based Medi-Cal national standards and code sets defined by DHCS.

1.1 In the event County is unable to submit claims to CalOptima for Community Supports-related services using specifications based on national standards or DHCS-defined standard specifications and code sets, County shall submit invoices with minimum necessary data elements defined by DHCS, which includes information about the Member, the Community Supports services rendered, and County's information to support appropriate reimbursement by CalOptima, that will allow CalOptima to convert Community Supports invoice information into DHCS-defined standard specifications and code sets for submission to DHCS.

1.2 County shall not receive payment from CalOptima for the provision of any Community Supports services not authorized by CalOptima or Health Network.

1.3 CalOptima will provide expedited payments for urgent Community Supports (e.g., Recuperative Care services for a Member who no longer requires hospitalization, but still needs to heal from an injury or illness, including behavioral health conditions, and whose condition would be exacerbated by an unstable living environment), pursuant to its Contract with DHCS and any other related DHCS guidance.

F. County must have a system in place to accept payment from CalOptima for Community Supports rendered. CalOptima shall pay 90 percent of all clean claims and invoices within 30 days of receipt and 99 percent of clean claims and invoices within 90 days of receipt.

G. Data Sharing to Support Community Supports. As part of the referral process, CalOptima will ensure County Associates have access to:

1.1 Demographic and administrative information confirming the referred Member's eligibility and authorization for the requested service, inclusive of visibility of services provided by other County Associates that could preclude County Associates provision of all or a portion of further requested services due to exhaustion of Members' lifetime benefit, as deemed necessary by County;

1.2 Appropriate administrative, clinical, and social service information the CSP might need in order to effectively provide the requested service; and

1.3 Billing information necessary to support the Community Supports Provider's ability to submit invoices to and receive payment from CalOptima.

H. Quality and Oversight. County acknowledges that CalOptima will conduct oversight of its delivery of Community Supports to ensure the quality of services rendered and ongoing compliance with all legal and contractual obligations both CalOptima and County Associates have, including but not limited to, required reporting, audits, and corrective actions, among other oversight activities.

III. DEFINITIONS SPECIFIC TO THIS ATTACHMENT A, PART XV---

A. "Community Supports" means "in-lieu of services", as set forth in 42 CFR § 438.3(e)(2), services or settings that are offered in place of services or settings covered under the California Medicaid State Plan and are medically appropriate, cost-effective alternatives to the State Plan Covered Services. Community Supports are optional for both CalOptima and the Member and must be approved by the DHCS and authorized and identified in CalOptima's Medi-Cal Contract with DHCS. Effective no sooner than January 1, 2022, CalOptima shall offer the following four (4) selected DHCS-approved Community Supports, as further defined in CalOptima Policy GG.1355: Community Supports: (i) Housing Transition Navigation Services; (ii) Housing Deposits; (iii) Housing Tenancy and Sustaining Services; and (iv) Recuperative Care (Medical Respite). For purposes of this Contract, the Community Supports Provider shall offer to Members only the DHCS-approved Community Supports described in Attachment A, Part XV of this Contract.

B. "Community Supports Provider" or "CSP" means the entity or person providing DHCS-approved Community Supports to Members pursuant to this Contract. The CSP shall have the experience and/or training in providing the DHCS-approved Community Supports described in Attachment A of this Contract."

ADDENDUM 2
MEDICARE ADVANTAGE PROGRAM
(ONECARE)

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

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

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

3. Review of Credentials. County shall ensure that it regularly reviews the credentials of Providers affiliated with the County. County agrees that CalOptima will review, approve, and audit County's credentialing process on an ongoing basis.

4. COB Requirements.

   4.1 MSP Obligations. County agrees to comply with Medicare Secondary Payer ("MSP") requirements. Provider shall coordinate with CalOptima for proper determination of COB and to bill and collect from other payers and third-party liens such charges for which the other payer is responsible. Provider agrees to establish procedures to effectively identify, at the time of service and as part of their claims payment procedures, individuals and services for which there may be a financially responsible party other than MA Program. Provider will bill and collect from other payers such amounts for Covered Services for which the other payer is responsible.

   4.2 Provider Authority to Bill Third Party Payers. County may bill other individuals or entities for Covered Services for which Medicare is not the primary payer, as specified herein. If a Medicare Member receives Covered Services from Provider that are also covered under state or federal workers' compensation, any no-fault insurance, or any liability insurance policy or plan, including a self-insured plan, Provider may bill any of the following— (1) the insurance carrier, the employer, or any other entity that is liable for payment for the services under section 1862(b) of the Act and 42 C.F.R. part 411 or (2) the Medicare enrollee, to the extent that he or she has been paid by the carrier, employer, or entity for covered medical expenses.

5. Submission and Prompt Payment of Claims. County agrees to submit claims to CalOptima in such format as CalOptima may require (but at minimum the CMS forms 1500, UB 04 or other form as appropriate) within ninety (90) days after the services are rendered. CalOptima reserves the right to deny claims that are not submitted within ninety (90) days of the date of service, except where Provider bills a third party payor as primary. Provider agrees to refrain from duplicate billing any claims submitted to CalOptima, unless expressly approved by CalOptima in order to process coordination of benefit claims. CalOptima shall provide payment to Provider within forty-five (45) business days of CalOptima's receipt of a clean and uncontested claim from Provider, or, CalOptima will contest or deny Provider's claim within forty-five (45) business days following CalOptima's receipt thereof.

ADDENDUM 3
CAL MEDICONNECT PROGRAM REQUIREMENTS

The following additional terms and conditions apply to items and services furnished by County Associates to Members enrolled in the CalOptima Cal MediConnect Program. In the event that these terms and conditions in this Addendum 2 conflict with any other provision in the Contract, the terms and conditions in the Addendum 2 shall prevail.

1. County Associates shall provide services or perform other activities pursuant to the Contract in accordance with (i) applicable DHCS and CMS laws, regulations, and instructions, including, but not limited to, 42 C.F.R. Sections 422.504, 423.505, 438.3(k), and 438.414, (ii) County's contractual obligations with CalOptima, and (iii) CalOptima's contractual obligations to CMS and DHCS.

2. The performance of County Associates is monitored by CalOptima on an ongoing basis, and CalOptima may impose corrective actions, as necessary, in accordance with Section 3.15 of the Contract.

3. County acknowledges and agrees that Providers' Emergency Medical Treatment and Active Labor Act ("EMTALA") obligations shall not create any conflicts with hospital actions required to comply with EMTALA.

4. County Associates shall not be prohibited from communicating or advocating on behalf of a Member who is a prospective, current, or former patient of the County. County Associates may freely communicate the provisions, terms or requirements of CalOptima's health benefit plans as they relate to the needs of such Member, or communicate with respect to the method by which such County Associates are compensated by CalOptima for services provided to the Member. CalOptima will not refuse to contract or pay County for the provision of Covered Services under the CalOptima Cal MediConnect program solely because County Associates have in good faith communicated or advocated on behalf of a Member as set forth above.

5. Downstream Entity Contracts.

   5.1 If any services under this Contract are to be provided by a Subcontractor on behalf of County, County Associates shall ensure that such subcontracts comply with 42 C.F.R. Sections 422.504, 423.505, 438.3(k), 438.414 and 438.6(1). Such Subcontracts shall include all language required by DHCS and CMS for subcontractors as provided in this Contract.

6. In instances where CMS, DHCS, and/or CalOptima determines that the County and/or its Subcontractors have not performed satisfactorily, County and its Subcontractors agree to (i) the revocation of the delegation of activities or obligations and related reporting requirements, or (ii) other remedies set forth in Section 3.15 of the Contract.

7. Review of Credentials. County shall ensure that it regularly reviews the credentials of Providers affiliated with the County. County agrees that CalOptima will review, approve, and audit County's credentialing process on an ongoing basis.

8. Provider Terminations. In the event a Provider is terminated for cause by County, County shall comply with applicable Federal and State laws.

9. In addition to Section 3.4 of the Contract, County agrees to assist CalOptima in the transfer of care of Members in the event of termination for any reason by County Associate.

10. County is not required to indemnify CalOptima for any expenses and liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs, and any associated charges, incurred in connection with any claim or action brought against CalOptima based on CalOptima's management decisions, utilization review provisions, or other policies, guidelines, or actions relative to CalOptima Cal MediConnect program.

11. County agrees to timely gather, preserve, and provide to DHCS or CalOptima, as applicable, any records in the County's or its Subcontractor's possession.

12. In addition to Section 5.7.7 of the Contract, County acknowledges and agrees that Medicare Parts A and B services shall be provided at zero cost-sharing to Members.

CalOptima Board Action Agenda Referral

Action To Be Taken April 7, 2022
Regular Meeting of the CalOptima Board of Directors

Report Item

18. Ratify Amendments to the Medi-Cal Health Network Contract for Health Care Services and approve the CalAIM Community Supports Provider Incentive Payment Program Agreement.

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 246-8408
Shelly Myers, Director, Contracting, (714) 246-8433

Recommended Actions

Staff requests that the CalOptima Board of Directors Ratify:

1. An amendment to the Medi-Cal Health Network Contract for Health Care Services, except Heritage Provider Network Inc., reflecting requirements for the California Advancing and Innovating Medi-Cal (CalAIM) Provider Incentive Payment Program, effective March 1, 2022.

2. An Amendment to the Medi-Cal Health Network Contract for Health Care Services for Heritage Provider Network Inc. (Heritage), reflecting notice of action requirements for discontinuation of ECM services, effective March 1, 2022.

3. The Community Supports Provider Incentive Payment Program agreement for Community Supports providers, reflecting requirements for the CalAIM Provider Incentive Payment Program, effective March 1, 2022.

Background and Discussion

Staff requests ratification of an amendment to the Medi-Cal Health Network Contract for Health Care Services, except Heritage Provider Network Inc., the Community Supports Provider Incentive Payment Program (IPP) agreement, and an amendment to the Heritage Medi-Cal health network contract. All three documents, effective March 1, 2022, detail Incentive Payment Program requirements, including payments for delivery system infrastructure and ECM and Community Supports provider capacity, and reflect notice of action language for ECM services.

Incentive Payment Program

Under CalAIM, DHCS recently launched the "Provider Incentive Payment Program," an elective program that incentivizes Managed Care Plans (MCPs) to enhance and expand access to ECM and Community Supports services. CalOptima's ECM and Community Supports Services providers are both eligible for the program. Under the Incentive Payment Program, DHCS will allocate funds to MCPs to distribute to providers for investing in necessary delivery system infrastructure, achieving improvements in quality performance, recruiting, and training an experienced workforce, implementing the needed electronic systems to submit invoices and claims, and engaging and onboarding new providers and community partners.

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Incentive Payment Disbursement
CalOptima will receive the incentive payments from DHCS in two parts, and in turn CalOptima will distribute the funding to health networks and Community Support providers in two parts. CalOptima will make the first payment to health networks providing ECM and Community Support providers within seven (7) days after receiving the funds from DHCS. CalOptima anticipates receiving the second payment from DHCS at the end of 2022. This payment will be linked to health networks achieving performance benchmarks. The initial payment for health networks and Community Support providers will be equivalent to no more than 50% of the total Program Year 1 provider incentive monies that have been allocated. Should the health networks and/or Community Supports providers be unable to meet the Provider Incentive Payment Program requirements, CalOptima may recoup a portion, or all of the incentive monies paid as per these agreements.

Notice of Action Language
Per DHCS guidance, ECM providers are required to provide members advanced notification in the event that ECM services are discontinued or plan to be discontinued. Under this guidance the health network is required to send a notice of action to members informing them of the discontinuation of the ECM benefit and ensure that the member is aware of their right to appeal the notice of action.

Except as proposed in the amendments and agreement, the ECM and Community Supports contracts will remain in full force for their full term. To ensure CalOptima's Medi-Cal members' improved access to and understanding of ECM and Community Supports services, staff requests the Board authorize amendments to the Medi-Cal Health Network Contract for Health Care Services, except Heritage Provider Network Inc., the Medi-Cal Health Network contract for Heritage, and the CalAIM Community Supports Provider Incentive Payment Program Agreement effective March 1, 2022.

Fiscal Impact
The recommended action will not have an additional fiscal impact. Previous Board actions on December 20, 2021, to approve the Program Year 1 CalAIM performance incentive payment methodology allocated up to $45.0 million in aggregate to CalOptima and delegated health networks.

Rationale for Recommendation
Authorizing the amendment to the Medi-Cal Health Network Contracts for Health Care Services and approving the CalAIM Community Supports Provider Incentive Payment Program Agreement with CalOptima's Community Supports Providers for provider incentive payments will incentivize providers to strengthen access to care under CalAIM, resulting in the best possible health outcomes for members.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

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Attachments

1. Entities Covered by this Recommended Board Action
2. Proposed IPP Program Agreement - Community Supports
3. Proposed IPP Amendment - Health Networks
4. Proposed Medi-Cal Health Network Contract Amendment -Heritage Provider Network Inc.
5. Previous Board Action dated December 20, 2021; "Consider Approving Amendment to all Health Network Medi-Cal Contracts except ARTA Western California Inc., Monarch Health Plan Inc., and Talbert Medical Group P.C. for Provision of Enhanced Care Management, Transition of Pharmacy Benefits to Medi-Cal Rx and Alignment of the Corrective Action Plan Section of the Contracts with Current Policy."
6. Previous Board Action dated November 4, 2021; "Consider Authorizing CalOptima Ancillary Services Contract with Whole Person Care and Health Homes Program Providers for the Provision of Community Supports Services.

Board Actions

N/A

/s/ Michael Hunn *03/31/2022*

Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

CalOptima Medi-Cal Health Networks				
Name	**Address**	**City**	**State**	**Zip Code**
AltaMed Health Services Corporation	2040 Camfield Ave.	Los Angeles	CA	90040
AMVI Care Health Network	600 City Parkway West Ste. 800	Orange	CA	92868
ARTA Western California, Inc.	2175 Park Place	El Segundo	CA	90245
CHOC Physicians Network and Children's Hospital of Orange County	1120 West La Veta Avenue Ste. 450	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming St. Ste. 202	Westminster	CA	92683
Heritage Provider Network Inc.	8510 Balboa Blvd. Ste. 285	Northridge	CA	91325
Kaiser Foundation Health Plan, Inc.	393 Walnut St.	Pasadena	CA	91188
Monarch Health Plan, Inc.	11 Technology Dr.	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc dba Noble Community Medical Associates, Inc.	5785 Corporate Ave.	Cypress	CA	90630
Prospect Health Plan, Inc.	600 City Parkway West Ste. 800	Orange	CA	92868
Talbert Medical Group, P.C.	2175 Park Place	El Segundo	CA	90245
United Care Medical Group, Inc.	600 City Parkway West	Orange	CA	92868
Community Supports Providers				
Name	**Address**	**City**	**State**	**Zip Code**
American Family Housing dba Orange County Housing Collaborative (aka Housing for Health OC) *(American Family Housing)* *(Friendship Shelter)* *(Jamboree Housing)* *(Mercy House Living Centers)*	15161 Jackson St. 15161 Jackson St. 24361 El Toro Rd. 17701 Cowan Ave., Suite 200 P.O. Box 1905	Midway City Midway City Laguna Woods Irvine Santa Ana	CA CA CA CA CA	92655 92655 92637 92614 92702
Blue Sky Manor, Inc.	280 N. Wilshire Blvd.	Anaheim	CA	92801
Community Action Partnership of Orange County *(Southwest Community Ctr.)* *(El Modena Family Resource Ctr.)* *(Anaheim Independencia Family Resource Ctr.)*	11870 Monarch St. 1601 W. 2nd St. 18672 E. Center Ave. 10841 Garza Ave.	Garden Grove Santa Ana Orange Anaheim	CA CA CA CA	92841 92703 92869 92804
Illumination Foundation	1091 Batavia St.	Orange	CA	92867
Lutheran Social Services of Southern California	247 East Amerige Ave.	Fullerton	CA	92832
Mom's Retreat Recuperative Care	607 S. Pine Drive	Fullerton	CA	92833
Volunteers of America Los Angeles	2100 N Broadway Str. Suite 300	Santa Ana	CA	92706

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CalAIM Community Supports Provider Incentive Payment Program Agreement

THIS CALAIM COMMUNITY SUPPORTS PROVIDER INCENTIVE PAYMENT PROGRAM AGREEMENT ("Agreement") is effective as of **March 1, 2022** ("Effective Date"), by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and _____ ("Provider"). CalOptima and Provider may each individually be referred to herein as "Party" and collectively as the "Parties".

RECITALS

A. CalOptima and Provider have entered into separate contracts under which Provider has agreed to provide or arrange for the provision of services to CalOptima members ("Contracts"), including Community Supports Services (as that term is defined below). These Contracts allow for Provider's participation in the CalAIM Community Supports Provider Incentive Payment Program ("Program").

B. CalOptima and Provider desire to enter into this Agreement to provide payment terms for the Program for Community Supports Services provided by Provider to CalOptima's members under the California Department of Health Care Services' California Advancing and Innovating Medi-Cal ("CalAIM") program.

AGREEMENT

NOW, THEREFORE, the Parties agree as follows:

1. Definitions.

   a. "Community Supports Services" shall mean any of the following services provided by Provider to CalOptima members under Contracts pursuant to CalAIM: (i) housing transition/navigation services, (ii) housing deposits, (iii) housing tenancy and sustaining services, (iv) short-term post-hospitalization housing, (v) recuperative care (medical respite), (vi) day habilitation programs, (vii) caregiver respite services, (viii) nursing facility transition/diversion to assisted living facilities, (ix) community transition services/nursing facility transition to a home, (x) personal care and homemaker services, (xi) environmental accessibility adaptations (home modifications), (xii) medically supportive food/meals/medically tailored meals, (xiii) sobering centers, and/or (xiv) asthma remediation.

2. Provider Obligations. Provider agrees, in accordance with the California Department of Health Care Services ("DHCS") standards and requirements, to do the following:

   a. Participate in delivery system infrastructure enhancements, which include implementing systems to electronically submit invoices and claims, training staff on new systems, and establishing connectivity and sharing capabilities through a CalOptima data sharing system.

   b. Participate in capacity growth and enhancements, which include development and provision of Population-of-Focus-specific trainings, recruitment and training of an experienced and diverse workforce, and engagement and onboarding of new providers and community partners; and

c. Complete the activities described in the Provider's Community Supports Incentive Payment Plan, as incorporated herein by reference, as submitted to Provider by CalOptima.

3. Payment. Upon DHCS approval of the Program, and within seven (7) calendar days after CalOptima's receipt of the incentive payment from DHCS, CalOptima shall pay Provider $_____. Provider shall, in return, comply with the requirements of the Program, as set forth in this Agreement and by DHCS.

4. Program Requirements. If Provider is unable to meet the Program requirements, including those outlined by DHCS and in CalOptima's Community Supports Incentive Payment Plan, as incorporated herein by reference. CalOptima may recoup a portion, or all the incentive payment funds paid to Provider under this Agreement. The portion of funds to be returned by Provider to CalOptima shall be based upon Provider's level of compliance with the Program requirements, as determined by CalOptima in its sole and reasonable discretion using a standard set of parameters for all Community Supports Services providers receiving payments from CalOptima under the Program. If Provider does not remit payment to CalOptima within thirty (30) days of receiving written recoupment notice from CalOptima under this Section 4, CalOptima may offset such owed amounts from any amounts that CalOptima otherwise owes Provider under Contracts.

5. Provider Termination. CalOptima reserves the right to recoup or offset any and all Program payments, in accordance with the procedures and requirements set forth in Section 4, if Provider is no longer a Community Supports Provider under the Contracts.

6. Severability. If any provision of this Agreement is held invalid or unenforceable by any court of law, the remaining provisions of this Agreement shall nevertheless continue to be valid and enforceable as though the invalid or unenforceable parts had not been included herein.

7. Independent Contractor. The Parties intend to establish an independent contractual relationship under this Agreement. Provider agrees that it is not an employee, agent, or legal representative of CalOptima for any purpose, and nothing in this Agreement shall be construed to create a partnership, joint venture, or employment contract between the Parties.

8. Waiver. Any failure of a Party to insist upon strict compliance with any provision of this Agreement shall not be deemed a waiver of such provision or any other provision of this Agreement. To be effective, a waiver must be in writing that is signed and dated by the Parties.

9. Dispute Resolution. If the Parties are unable to informally resolve any dispute arising out of or relating to this Agreement, either Party may submit the dispute for resolution exclusively through confidential, binding arbitration, instead of through trial by court or jury, in Orange County, California, in accordance with the commercial dispute rules then in effect of the Judicial Arbitration and Mediation Services ("JAMS"). The arbitration shall be conducted on an expedited basis by a single arbitrator. In making decisions about discovery and case management, it is the Parties' express agreement and intent that the arbitrator at all times promote efficiency without denying either Party the ability to present relevant evidence. In reaching and issuing decisions, the arbitrator shall have no jurisdiction to make errors of law and/or legal reasoning. The Parties shall share the costs of arbitration equally, and each Party shall bear its own attorneys' fees and costs.

10. Governing Law. This Agreement shall be governed by the laws of the state of California, and the Parties consent to venue and personal jurisdiction over them in California state courts and in U.S.

District Court for the Central District of California, as applicable, for purposes of construction and enforcement of this Agreement.

11. Interpretation. Each Party has had the opportunity to have counsel of its choice examine the provisions of this Agreement, and no implication shall be drawn against any Party by virtue of the drafting of this Agreement.

12. Recitals. The recitals to this Agreement are made part of the Agreement by this reference.

13. This Agreement is subject to approval by the government agencies with regulatory authority over the subject matter of this Agreement, including DHCS, and by the CalOptima Board of Directors.

IN WITNESS WHEREOF, CalOptima and _____have executed this Agreement:

FOR PROVIDER:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Yunkyung Kim
PRINT NAME	PRINT NAME
_____	Chief Operating Officer
TITLE	TITLE
_____	_____
DATE	DATE

AMENDMENT IX TO
CONTRACT FOR HEALTH CARE SERVICES

THIS AMENDMENT IX TO THE CONTRACT FOR HEALTH CARE SERVICES ("Amendment") is effective as of **March 1, 2022** ("Effective Date") by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and, _____ ("HMO"), with respect to the following facts:

RECITALS

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

B. CalOptima and HMO desire to amend the Contract to revise the language regarding the ECM notification requirements, and include an Incentive Payment Program for HMO's provision of ECM services under the Contract as part of the DHCS California Advancing and Innovating Medi-Cal ("CalAIM") program.

NOW, THEREFORE, the parties agree as follows:

1. Section 6.24 Enhanced Care Management; Subsection 6.24.8.3, shall be deleted in its entirety and replaced with the following:

   "6.24.8.3 When ECM is discontinued, or will be discontinued for the Member, HMO is responsible for sending a notice of action notifying the Member of the discontinuation of the ECM benefit and ensuring the Member is informed of their right to appeal and the appeals process as instructed in the notice of action. ECM Provider shall communicate to the Member other benefits or programs that may be available to the Member, as applicable (e.g., Complex Case Management, Basic Case Management, etc.)."

2. Attachment E-9, "Incentive Payment Program requirements for Enhanced Care Management (ECM) Services", which is attached to this Amendment, is added to the Contract and incorporated into the Contract by this reference.

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

[signature page follows]

IN WITNESS WHEREOF, Orange County Health Authority d/b/a CalOptima and _____ have executed this Amendment:

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

Attachment E-9

Incentive Payment Program Requirements for Enhanced Care Management (ECM) Services

1. Incentive Payment Program Payment. As part of the CalAIM Program, DHCS has implemented an incentive payment program ("Incentive Payment Program") to, among other things, provide funds for Medi-Cal managed care plans like CalOptima to distribute, in part, to providers to recruit and train an experienced and diverse workforce, as well as expand the ECM provider network through outreach, engagement, and development.

Upon DHCS approval of the Incentive Payment Program, the HMO shall receive a one-time payment of $_____ from CalOptima for the initial fifty percent (50%) of program year one for submission of the gap filling plan. HMO shall, in return, comply with the requirements of the Incentive Payment Program, as set forth in this Contract, and DHCS guidance.

2. Incentive Payment Program Requirements. If the HMO is unable to meet the Incentive Payment Program requirements listed in Section 1, CalOptima may recoup a portion, or all the incentive payment funds paid to HMO under this attachment. The portion of funds to be returned by HMO to CalOptima shall be based upon HMO's level of compliance with the Incentive Payment Program requirements, as determined by CalOptima in its sole and reasonable discretion using a standard set of parameters for all ECM providers receiving payments from CalOptima under the Incentive Payment Program. If HMO does not remit payment to CalOptima within thirty (30) days of receiving written notice from CalOptima of a recoupment under this Section 2, CalOptima may offset such owed amounts from any amounts that CalOptima otherwise owes HMO under this Contract or another agreement between the parties. Distribution will be made based on the payment methodology approved at the December 20, 2021, CalOptima Board of Directors meeting.

3. Termination. CalOptima reserves the right to recoup or offset any and all Incentive Payment Program funds, in accordance with the procedures and requirements set forth in Section 2, if HMO no longer provides ECM services under the Contract.

AMENDMENT XII TO
CONTRACT FOR HEALTH CARE SERVICES

THIS AMENDMENT XII TO THE CONTRACT FOR HEALTH CARE SERVICES ("Amendment") is effective as of **March 1, 2022** ("Effective Date") by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and, **Heritage Provider Network, 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, including Enhanced Care Management ("ECM") services.

B. CalOptima and HMO desire to amend the Contract to revise the language regarding the ECM notification requirements as part of the DHCS California Advancing and Innovating Medi-Cal ("CalAIM") program.

NOW, THEREFORE, the parties agree as follows:

1. Section 6.23 Enhanced Care Management; Subsection 6.23.8.3, shall be deleted in its entirety and replaced with the following:

"6.23.8.3 When ECM is discontinued, or will be discontinued for the Member, HMO is responsible for sending a notice of action notifying the Member of the discontinuation of the ECM benefit and ensuring the Member is informed of their right to appeal and the appeals process as instructed in the notice of action. ECM Provider shall communicate to the Member other benefits or programs that may be available to the Member, as applicable (e.g., Complex Case Management, Basic Case Management, etc.)."

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

[signature page follows]

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IN WITNESS WHEREOF, Orange County Health Authority d/b/a CalOptima and Heritage Provider Network, Inc. have executed this Amendment:

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

Report Item

38. Consider Approving Amendments to all Health Network Medi-Cal Contracts Other than Kaiser Foundation Health Plan Inc., ARTA Western California Inc., Monarch Health Plan Inc., and Talbert Medical Group P.C, for Provision of Enhanced Care Management, Transition of Pharmacy Benefits to Medi-Cal Rx and Alignment of the Corrective Action Plan Section of the Contracts with Current Policy

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 246-8408
Michelle Laughlin, Executive Director, Network Operations, (657) 900-1116

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend all health network Medi-Cal contracts other than Kaiser Foundation Health Plan Inc., ARTA Western California Inc. (ARTA), Monarch Health Plan Inc. (Monarch), and Talbert Medical Group P.C. (Talbert), for health care services, as follows:

1. Include the Enhanced Care Management benefit, as part of the Department of Health Care Services (DHCS) California Advancing and Innovating Medi-Cal initiative;
2. Revise references to Medi-Cal pharmacy services to support the transition of pharmacy benefits to the DHCS Medi-Cal Rx delivery system; and
3. Align the Corrective Action Plan section of the contracts with current policy.

Background

California Advancing and Innovating Medi-Cal / Enhanced Care Management

On January 8, 2021, DHCS released a revised California Advancing and Innovating Medi-Cal (CalAIM) proposal that takes a whole-person care approach to improving health outcomes for Medi-Cal members by incorporating both clinical and nonclinical services. Implementation of CalAIM initiatives by managed care plans spans five years, beginning January 1, 2022. Two key CalAIM initiatives are Enhanced Care Management (ECM) and Community Supports. ECM creates a single, intensive and comprehensive benefit that is designed to meet the needs of CalOptima's most vulnerable members. Community Supports are medically appropriate, cost-effective alternatives that are provided as a substitute for services covered under the California Medicaid State Plan and are delivered by a different provider or in a different setting than those described in the State Plan. ECM and Community Supports are optional for members. CalOptima and delegated health networks will provide ECM services, and the current Whole Person Care (WPC) and Health Homes Program (HHP) providers will deliver Community Supports. For the initial launch of CalAIM and to ensure a smooth transition for WPC and HHP members, CalOptima will offer the following Community Supports currently offered through the County's WPC and CalOptima's HHP:

- Housing Transition Navigation Services
- Housing Tenancy and Sustaining Services
- Housing Deposits
- Recuperative Care (Medical Respite)

Following the initial January 1, 2022, implementation of ECM and Community Supports, CalOptima will explore expanding the network of providers and Community Supports offerings and will return to this Board for future consideration.

Transition of Pharmacy Benefits to Medi-Cal Rx
In 2020, DHCS announced it would "carve out" the pharmacy benefit from Medi-Cal managed care plans and transition it to the State-administered, fee-for-service "Medi-Cal Rx" delivery system. Health network contracts currently include language that references CalOptima's drug formulary and pharmacy benefit manager (PBM).

Alignment of the Corrective Action Plan Section of the Contracts with Current Policy
CalOptima Policy HH.2005: Corrective Action Plan serves as a guideline for addressing Corrective Action Plans (CAPs) issued by CalOptima's Office of Compliance. Previously, the policy allowed an internal department or First Tier, Downstream, and Related Entities to respond to a CAP within 30 calendar days. As a result of policy updates, this response time has been modified to 14 calendar days.

Discussion

Enhanced Care Management
Starting January 1, 2022, members will receive ECM services through their assigned health network, which will support care coordination with area hospitals as well as primary, dental, behavioral health, specialist, and long term services & supports providers. Health networks are currently providing similar services under HHP. To ensure members' access to ECM services starting January 1, 2022, staff recommend amending all health network Medi-Cal contracts except ARTA, Monarch, and Talbert to reflect the provision of ECM services by CalOptima's Medi-Cal health networks for their assigned members.

Transition of Pharmacy Benefits to Medi-Cal Rx
With DHCS assuming management of Medi-Cal members' pharmacy benefit services through the Medi-Cal Rx delivery system, it is necessary to remove references to CalOptima's drug formulary and PBM from the health network Medi-Cal contracts. Therefore, staff recommend amending the all health network Medi-Cal contracts except ARTA, Monarch, and Talbert to revise references to Medi-Cal pharmacy services to reflect the new DHCS Medi-Cal Rx delivery system.

Alignment of the Corrective Action Plan Section of the Contracts with Current Policy
To ensure that CalOptima's contracts continue to reflect the most current policy, staff recommend approving amendments to all health network Medi-Cal contract amendments except ARTA, Monarch, and Talbert, reflecting the updated CAP response timeframe from 30 calendar days to 14 calendar days.

Fiscal Impact

The recommended action to amend health network Medi-Cal Contracts for Healthcare Services is a budgeted item under the CalOptima Fiscal Year (FY) 2021-22 Operating Budget approved by the Board on June 3, 2021.

CalAIM ECM Services: Management included projected revenues and expenses associated with ECM services in the CalOptima FY 2021-22 Operating Budget, using the best available information at the time. With the addition of this new benefit, utilization associated with eligible Medi-Cal members is difficult to predict. However, staff anticipates forecasted Medi-Cal revenue for the new benefit will be sufficient to cover the anticipated costs through June 30, 2022.

Medi-Cal Rx Carve-out: The CalOptima FY 2021-22 Operating Budget assumed the removal of the pharmacy benefit in the Medi-Cal line of business on January 1, 2022. There is no additional fiscal impact.

CAP Provision: The contract language change is operational in nature and not expected to have any fiscal impact.

Rationale for Recommendation

Approving the health network Medi-Cal contract amendments will ensure access to medically appropriate, cost-effective care for CalOptima's Medi-Cal members and ensure contracts align with Medi-Cal Rx and current policy.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Board Action
2. Proposed Health Network Contract Amendment
3. Board Action Dated December 3, 2020: Consider Authorizing an Amendment to the Contract with Pharmacy Benefit Manager, MedImpact Healthcare Systems, Inc. to Change the Effective Date Removing the Medi-Cal Line of Business
4. Previous Board Action Dated October 1, 2020: Consider Authorizing an Amendment to the Contract with Pharmacy Benefit Manager, MedImpact Healthcare Systems, Inc. to Extend the Contract and Remove the Medi-Cal Line of Business
5. CalOptima Policy HH.2005 Corrective Action Plan

Board Actions

Board Meeting Dates	Action	Term	Not to Exceed Amount
December 3, 2020	Consider Authorizing an Amendment to the Contract with Pharmacy Benefit Manager, MedImpact Healthcare Systems, Inc. to Change the Effective Date Removing the Medi-Cal Line of Business		
October 1, 2020	Consider Authorizing an Amendment to the Contract with Pharmacy Benefit Manager, MedImpact Healthcare Systems, Inc. to Extend and Amend the Contract to Remove the Medi-Cal Line of Business		
August 6, 2020	Consider Ratification of Data Sharing Agreement with Magellan Medicaid Administration		
August 1, 2019	Consider Authorizing an Amendment to the Contract with Pharmacy Benefit Manager, MedImpact Healthcare Systems, Inc. to extend the Contract		
October 4, 2018	Consider Ratification of Extension of Contract with MedImpact Healthcare Systems, Inc. for Pharmacy Benefit Management Services		
May 7, 2015	Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016		

Michael Hunn *12/15/2021*
Authorized Signature **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 4, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item

14. Consider Authorizing CalOptima Ancillary Services Contract with Whole Person Care and Health Homes Program Providers for the Provision of Community Supports Services

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 246-8408
Michelle Laughlin, Executive Director, Network Operations, (657) 900-1116

Recommended Action

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to enter into CalOptima ancillary services contracts with providers currently engaged in the County of Orange's (County) Whole Person Care (WPC) program and CalOptima's Health Homes Program (HHP), for the provision of Community Supports Services, effective January 1, 2022.

Background

On January 8, 2021, the Department of Health Care Services (DHCS) released a revised California Advancing and Innovating Medi-Cal (CalAIM) proposal that takes a whole-person care approach to improving health outcomes for Medi-Cal members by incorporating both clinical and nonclinical services. Implementation of CalAIM initiatives by managed care plans spans five years, beginning January 1, 2022. Two key CalAIM initiatives are Enhanced Care Management (ECM) and Community Supports Services. ECM creates a single, intensive and comprehensive benefit that is designed to meet the needs of CalOptima's most vulnerable members. Community Supports Services are medically appropriate, cost-effective alternatives that are provided as a substitute for services covered under the California Medicaid State Plan and are delivered by a different provider or in a different setting than those described in the State plan. ECM and Community Supports Services are optional for members. CalOptima and delegated health networks will provide ECM services, and the current WPC and HHP providers will deliver Community Supports Services. For the initial launch of CalAIM, and to ensure a smooth transition for WPC and HHP members, CalOptima will offer the following Community Supports Services currently offered through the County's WPC and CalOptima's HHP:

- Housing Transition Navigation Services
- Housing Tenancy and Sustaining Services
- Housing Deposits
- Recuperative Care (Medical Respite)

Following the initial January 1, 2022, implementation of ECM and Community Supports Services, staff will explore expanding the network of providers and Community Supports Services offerings and will return to this Board for future consideration.

Discussion

For the provision of Community Supports Services, effective January 1, 2022, CalOptima will contract with the same eight providers currently engaged in providing these services under the County's WPC

and CalOptima's HHP. The following provides additional detail on the Community Supports Services that CalOptima will offer for qualified members.

Housing Transition Navigation Services
Housing Transition Navigation Services are designed to assist highly vulnerable members obtain housing. Eligible members are those experiencing homelessness and/or disabilities, serious chronic conditions, mental illness or institutionalization. Services include, but are not limited to, identifying barriers to successful tenancy, developing individualized housing support plans, searching for housing, support and assistance with moving, and educating and engaging with landlords.

Housing Tenancy and Sustaining Services
Housing Tenancy and Sustaining Services are a series of services to help members maintain safe and stable tenancy once housing is secured. These include, but are not limited to, identification and intervention of behaviors that may jeopardize housing, coordination with landlords and case management providers to address issues that could impact housing, and health and safety visits including habitability inspections. The ultimate goal of these services is to provide members experiencing homelessness and/or complex health issues (including behavioral health issues) with best practices for continued tenancy.

Housing Deposits
Housing deposits are monetary assistance for homeless members to cover one-time services and costs required for establishing basic housing. These include, but are not limited to, security deposits, utilities set-up fees and first and last months' rent. Housing deposits are targeted to members experiencing homelessness as well as complex health conditions (including behavioral health conditions) and/or disabilities. The service is provided in conjunction with Housing Transition Navigation Services.

Recuperative Care (Medical Respite)
Recuperative care (or "medical respite") is intended for members living alone who lack formal support, face housing insecurity, are at risk of hospitalization, are in post-hospitalization or live in housing conditions that jeopardize their health and safety. This service will provide members a stable environment to stay for an extended period of time, typically at a short-term residential care facility. Included in this recovery care setting is the continuation of post-hospital discharge treatment along with primary care, behavioral health services and case management.

Staff recommends contracting with providers currently engaged in the County's WPC and CalOptima's HHP for the provision of these Community Supports Services, effective January 1, 2022.

Fiscal Impact
The recommended action to execute contracts for ancillary services with providers currently engaged in the County WPC or CalOptima's HHP to provide Community Supports Services effective January 1, 2022, is a budgeted item under the CalOptima Fiscal Year (FY) 2021-22 Operating Budget approved by the Board on June 3, 2021. Staff anticipates the fiscal impact to be budget neutral. According to DHCS's assumptions, decreased utilization will be sufficient to support the additional cost for Community Supports Services.

Rationale for Recommendation

Approving the ancillary services contract for Community Supports Services providers will ensure CalOptima's Medi-Cal members have access to medically appropriate, alternative services provided under CalAIM.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Board Action
2. Proposed Ancillary Services Contract

/s/ Richard Sanchez *10/28/2021*

Authorized Signature **Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
American Family Housing dba Orange County Housing Collaborative (aka Housing for Health OC)	15161 Jackson St.	Midway City	CA	92655
(American Family Housing)	15161 Jackson St.	Midway City	CA	92655
(Friendship Shelter)	24361 El Toro Rd.	Laguna Woods	CA	92637
(Jamboree Housing)	17701 Cowan Ave., Suite 200	Irvine	CA	92614
(Mercy House Living Centers)	P.O. Box 1905	Santa Ana	CA	92702
Blue Sky Manor, Inc.	280 N. Wilshire Blvd.	Anaheim	CA	92801
Community Action Partnership of Orange County	11870 Monarch St.	Garden Grove	CA	92841
(Southwest Community Ctr.)	1601 W. 2nd St.	Santa Ana	CA	92703
(El Modena Family Resource Ctr.)	18672 E. Center Ave.	Orange	CA	92869
(Anaheim Independencia Family Resource Ctr.)	10841 Garza Ave.	Anaheim	CA	92804
Illumination Foundation	1091 Batavia St.	Orange	CA	92867
Lutheran Social Services of Southern California	247 East Amerige Ave.	Fullerton	CA	92832
Mom's Retreat Recuperative Care	607 S. Pine Drive	Fullerton	CA	92833
Volunteers of America Los Angeles	2100 N Broadway Str. Suite 300	Santa Ana	CA	92706

ANCILLARY SERVICES CONTRACT

This Ancillary Services Contract (the "Contract") is entered into by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and **[Provider Name]** ("Provider"), with respect to the following:

RECITALS

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

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

C. "DHCS is adding Enhanced Care Management (ECM) services to the Medi-Cal benefit set, effective January 1, 2022, and transitioning the Whole Person Care (WPC) and the Health Homes Program (HHP) to ECM."

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

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

NOW, THEREFORE, the parties agree as follows:

ARTICLE 1
DEFINITIONS

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

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

1.2 "California Children's Services (CCS)" means those services authorized by the CCS Services Program for the diagnosis and treatment of the CCS Services Eligible Conditions of a specific Member.

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

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

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

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

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

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

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

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

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

1.10 "Community Supports" means "in-lieu of services", as set forth in 42 CFR § 438.3(e)(2), services or settings that are offered in place of services or settings covered under the California Medicaid State Plan and are medically appropriate, cost-effective alternatives to the State Plan Covered Services. Community Supports are optional for both CalOptima and the Member must be approved by the DHCS and are authorized and identified in CalOptima's Medi-Cal Contract with DHCS. Effective no sooner than January 1, 2022, CalOptima shall offer the following four (4) selected DHCS-approved Community Supports, as further defined in CalOptima Policy GG.1355: Community Supports: (i) Housing Transition Navigation Services; (ii) Housing Deposits; (iii) Housing Tenancy and Sustaining Services; and (iv) Recuperative Care (Medical Respite). For purposes of this Contract, the Community Supports Provider shall offer to Members the DHCS-approved Community Supports described in Attachment A of this Contract.

1.11 "Community Supports Provider" means the Provider when providing DHCS-approved Community Supports to Members pursuant to this Contract. The Provider shall have the experience and/or

training in providing the DHCS-approved Community Supports described in Attachment A of this Contract.

1.12 "Compliance Program" means the program (including, without limitation, the compliance manual, code of conduct and CalOptima Policies) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of the members of its Board of Directors, employees, contractors and providers comply with applicable law and ethical standards. The Compliance Program includes CalOptima's Fraud, Waste and Abuse ("FWA") plan.

1.13 "Coordination of Benefits" or "COB" refers to the determination of order of financial responsibility which applies when two or more health benefit plans provide coverage of items and services for an individual.

1.14 "Covered Services" means those services provided under the Fee-for-Service Medi-Cal program, as set forth in Article 4, Chapter 3 (beginning with Section 51301), Subdivision 1, Division 3, Title 22, CCR, and Article 4 (beginning with Section 6840), Subchapter 13, Chapter 4, Division 1 of Title 17, CCR, which (i) are included as Covered Services under the DHCS Contract; and (ii) are Medically Necessary, as described in Attachment A (which may be revised from time to time at the discretion of CalOptima), 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 effective July 1, 2019, or such later date as the CalOptima Whole Child Model Program becomes effective, Covered Services shall also include CCS Services (as defined in Subdivision 7 of Division 2 of Title 22 of the California Code of Regulations), which shall be covered for Members, notwithstanding whether such benefits are provided under the Fee-for-Service Medi-Cal Program.

1.15 "ECM Provider" means CalOptima Direct or Health Network, as applicable, when providing ECM services to their assigned ECM Members under CalOptima's Medi-Cal Program.

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

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

1.18 "Enhanced Care Management" or "ECM" means a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high need and/or high-cost Members through systematic coordination of services and comprehensive care management that is community-based, high-touch, and person-centered. ECM is a Medi-Cal benefit.

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

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

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

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

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

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

1.25 "Medically Necessary" or "Medical Necessity" means reasonable and necessary services to protect life, to prevent illness or disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury, achieve age appropriate growth and development, and attain, maintain, or regain functional capacity per Title 22, CCR Section 51303 (a) and 42 CFR 438.210 (a)(5). When determining the Medical Necessity for a Medi-Cal beneficiary under the age of 21, "Medical Necessity" is expanded to include the standards set forth in 42 USC Section 1396d(r), and W & I Code Section 14132(v).

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

1.27 "Medicare Secondary Payer" or "MSP" means the Medicare coordination of benefits requirements as incorporated in MA regulations.

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

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

1.30 "Participating Provider" means an institutional, professional or other Provider of health care services who has entered into a written agreement with CalOptima to provide Covered Services to Members.

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

1.32 "Preclusion List" means the CMS-compiled list of providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.

1.33 "Subcontract" means a contract entered into by Provider with a party that agrees to furnish items and/or services to CalOptima Members, or administrative functions or services related to Provider

fulfilling its obligation to CalOptima under the terms of this Contract if, and to the extent, permitted under this Contract.

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

ARTICLE 2
FUNCTIONS AND DUTIES OF PROVIDER

2.1 Provision of Covered Services.

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

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

2.1.3 In accordance with Section 2.22 of this Contract, Provider and its Subcontractors shall furnish Covered Services to Members under this Contract in the same manner as those services are provided to other patients.

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

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

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

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

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

2.7 Notices and Citations. Provider shall notify CalOptima in writing of any report or other writing of any State or Federal agency and/or Accreditation Organization that regulates Provider that contains a citation, sanction and/or disapproval of Provider's failure to meet any material requirement of State or Federal law or any material standards of an Accreditation Organization.

2.8 Professional Standards. All Provider Services provided or arranged for under this Contract shall be provided or arranged by duly licensed, certified or otherwise authorized professional personnel in manner that (i) meets the cultural and linguistic requirements of this Contract; (ii) within professionally recognized standards of practice at the time of treatment; (iii) in accordance with the provisions of CalOptima's UM and QMI Programs; and (iv) in accordance with the requirements of State and Federal law and all requirements of this Contract.

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

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

2.11 Not applicable to this Contract.

2.12 CalOptima QMI Program. Provider acknowledges and agrees that CalOptima is accountable for the quality of care furnished to its Members in all settings including services furnished by Provider. Provider agrees, when reasonable and within capability of Provider, that it is subject to the requirements of CalOptima's QMI Program and that it shall participate in QMI Program activities as required by CalOptima. Such activities may include, but are not limited to, the provision of requested data and the participation in assessment and performance audits and projects (including those required by CalOptima's regulators) that support CalOptima's efforts to measure, continuously monitor, and evaluate the quality of items and services furnished to Members. Provider shall participate in CalOptima's QMI Program development and implementation for the purpose of collecting and studying data reflecting clinical status and quality of life outcomes for CalOptima Members. Provider shall cooperate with CalOptima and Government Agencies in any complaint, appeal or other review of Provider Services (e.g., medical necessity) and shall accept as final all decisions regarding disputes over Provider Services by CalOptima or such Government Agencies, as applicable, and as required under the applicable CalOptima Program. Provider shall also allow CalOptima to use performance data for quality and reporting purposes including, but not limited to, quality improvement activities and public reporting to consumers, and performance data reporting to regulators as identified in CalOptima Policies.

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

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

2.14 CalOptima Oversight. Provider understands and agrees that CalOptima is responsible for the monitoring and oversight of all duties of Provider under this Contract, and that CalOptima has the

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

2.15 Transfer of Care. Upon request by a CalOptima Member, Provider shall assist the CalOptima Member in the orderly transfer of such CalOptima Member's medical care. In doing so, Provider shall make available to the new provider of care for the Member, copies of the medical records, patient files, and other pertinent information, including information maintained by any Subcontractor, necessary for efficient medical case management of Member. In no circumstance shall a CalOptima Member be billed for this service.

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

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

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

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

available to Provider and Provider shall make them available to Provider's Agents. Provider agrees to comply with, and be bound by, any and all MOUs.

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

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

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

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

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

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

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

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

2.21 No Discrimination/Harassment (Employees). During the performance of this Contract, Provider and its Subcontractors shall not unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of race, religion, creed, color, national origin, ancestry, physical disability (including Human Immunodeficiency Virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS)), mental disability, medical condition, marital status, age (over 40), gender or the use of family and medical care leave and pregnancy disability leave. Provider and Subcontractors shall ensure that the evaluation and treatment of their employees and applicants for employment are free of such discrimination and harassment. Provider and Subcontractors shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900 et seq.) and the applicable regulations promulgated thereunder, (Title 2, CCR, Section 7285.0 et seq.). The applicable regulations of the Fair Employment and

Housing Commission implementing Government Code, Section 12990, set forth in Chapter 5 of Division 4 of Title 2 of the CCR are incorporated into this Contract by reference and made a part hereof as if set forth in full. Provider and its Subcontractors shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement.

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

For the purpose of this Contract, if based on any of the foregoing criteria, the following constitute prohibited discrimination: (a) denying any Member any Covered Services or availability of a Provider, (b) providing to a Member any Covered Service which is different or is provided in a different name or at a different time from that provided to other similarly situated Members under this Contract, except where medically indicated, (c) subjecting a Member to segregation or separate treatment in any manner related to the receipt of any Covered Service, (d) restricting a Member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service, (e) treating a Member differently than others similarly situated in determining compliance with admission, enrollment, quota, eligibility, or other requirements or conditions that individuals must meet in order to be provided any Covered Service, or in assigning the times or places for the provision of such services. Provider and its Subcontractors agree to render Covered Services to Members in the same manner, in accordance with the same standards, and within the same time availability as offered to non-CalOptima patients. Provider and its Subcontractors shall take affirmative action to ensure that all Members are provided Covered Services without discrimination, except where medically necessary. For the purposes of this section, physical handicap includes the carrying of a gene which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genetic handicap shall include, but not be limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia. Provider and its Subcontractors shall act upon all complaints alleging discrimination against Members in accordance with CalOptima's Policies.

2.23 Reporting Obligations. In addition to any other reporting obligations under this Contract, Provider shall submit such reports and data relating to services covered under this Contract as are required by CalOptima, including, without limitations, to comply with the requests from Government Agencies to CalOptima. CalOptima shall reimburse Provider for reasonable costs for producing and delivering such reports and data.

2.24 Subcontract Requirements. If permitted by the terms of this Contract, Provider may subcontract for certain functions covered by this Contract, subject to the requirements of this Contract.

Subcontracts shall not terminate the legal liability of Provider under this Contract. Provider must ensure that all Subcontracts are in writing and include any and all provisions required by this Contract or applicable Government Programs to be incorporated into Subcontracts. Provider shall make all Subcontracts available to CalOptima or its regulators upon request. Provider is required to inform CalOptima of the name and business addresses of all Subcontractors. Additionally, Provider shall require that all Subcontracts relating to the provision of Covered Services include, without limitation, the following provisions:

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

2.24.2 An agreement to maintain such books and records (a) in accordance with the general standards applicable to such books and records and any record requirements in this Contract and CalOptima Policies; (b) at the Subcontractor's place of business or at such other mutually agreeable location in California.

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

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

2.24.5 An agreement to comply with all provisions of this Contract and applicable law with respect to providing and paying for Emergency Services.

2.24.6 An agreement that Subcontractors shall notify Provider of any investigations into Subcontractors' professional conduct, or any suspension of or comment on a Subcontractor's professional licensure, whether temporary or permanent.

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

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

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

2.26 Participation Status. Provider shall have Policies and Procedures to verify the Participation Status of Provider's Agents. In addition, Provider attests and agrees as follows:

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

2.26.2 Provider shall immediately disclose to CalOptima, including, but not limited to, any pending investigation involving, or any determination of, suspension, exclusion or

debarment of Provider or Provider's Agents occurring and/or discovered during the term of this Contract.

2.26.3 Provider shall take immediate action to remove any employee of Provider that does not meet Participation Status requirements from furnishing items or services related to this Contract (whether medical or administrative) to CalOptima Members which may include but is not limited to adverse decisions and licensure issues.

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

2.26.5 CalOptima shall not make payment for a healthcare item or service furnished by an individual or entity that does not meet Participation Status requirements or is included on the Preclusion List. Provider shall provide written notice to the Member who received the services and the excluded provider or provider listed on the Preclusion List that payment will not be made, in accordance with CMS requirements.

2.27 Credentialing and Recredentialing. Prior to providing any Covered Services under, and throughout the duration of, this Contract, Provider, and all Subcontractors, shall be credentialed and periodically recredentialed by CalOptima in the manner and to the extent required by CalOptima Policy.

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

2.29 Smoke Free Workplace. Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible party. By signing this Contract, Provider certifies that it will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The prohibitions herein are effective December 26, 1994. Provider further agrees that it will insert this certification into any subcontracts entered into that provide for children's services as described in the Act.

2.30 CLIA Laboratories. Provider shall only use laboratories with a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. Those laboratories with certificates of waiver shall provide only the types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

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

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

2.33 Advanced Directives. Provider shall maintain written Policies and Procedures related to Advanced Directives in compliance with State and Federal laws and regulations. Provider shall document patient records with respect to the existence of an Advanced Directive in accordance with applicable law. Provider shall not discriminate against any Member on the basis of that Member's Advanced Directive status. Nothing in this Contract shall be interpreted to require a Member to execute an Advance Directive or agree to orders regarding the provision of life-sustaining treatment as a condition of receipt of services.

2.34 Not applicable to this Contract.

2.35 Not applicable to this Contract.

2.36 Provider Terminations. In the event that a Participating Provider is terminated or leaves Provider, Provider shall ensure that there is no disruption in services provided to Members who are receiving treatment for a chronic or ongoing medical condition or LTSS, Provider shall ensure that there is no disruption in services provided to the CalOptima Member.

2.37 Government Claims Act. Provider shall ensure that Provider and its agents and Subcontractors comply with the applicable provisions of the Government Claims Act (California Government Code section 900 et seq.), including, but not limited to Government Code sections 910 and 915, for any disputes arising under this Contract, and in accordance with CalOptima Policy AA.1217.

2.38 Certification of Document and Data Submissions. All data, information, and documentation provided by Provider to CalOptima pursuant to this Contract and/or CalOptima Policies, which are specified in 42 CFR 438.604 and/or as otherwise required by CalOptima and/or CalOptima's Regulators, shall be accompanied by a certification statement on the Provider's letterhead sign by the Provider's Chief Executive Officer or Chief Financial Officer (or an individual who reports directly to and has delegated authority to sign for such Officer) attesting that based on the best information, knowledge, and belief, the data, documentation, and information is accurate, complete, and truthful.

2.39 Community Supports.

2.39.1 Community Supports Provider Requirements.

2.39.1.1 If a State-level enrollment pathway exists for the Community Supports Provider, the Community Supports Provider shall enroll in the Medi-Cal program pursuant to relevant APLs, including APL 19-004: Provider Credentialing/Recredentialing and Screening/Enrollment. If APL 19-004 does not apply to the Community Supports Provider, the Community Supports Provider will comply with CalOptima's process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering

services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

2.39.1.2 The Community Supports Provider shall have experience and/or training in the provision of the Community Supports being offered.

2.39.1.3 The Community Supports Provider shall have the capacity to provide the Community Supports in a culturally and linguistically competent manner, as demonstrated by a successful history of providing such services, training or other factors identified by CalOptima.

2.39.1.4 Subject to all applicable requirements set forth in this Contract (including but not limited to, subcontracting requirements) and CalOptima's prior written approval, if the Community Supports Provider subcontracts with other entities to administer its function of Community Supports, the Community Supports, the Community Supports Provider shall ensure agreements with each entity bind each entity to applicable terms and conditions set forth in Section 2.39 and Attachment A of this Contract and CalOptima Policies. Notwithstanding and subcontracting arrangements, Community Supports Provider shall remain responsible and accountable for any subcontracted Community Supports Functions.

2.39.2 Delivery of Community Supports. Community Supports Provider shall deliver contracted Community Supports in accordance with the DHCS service definitions and requirements, CalOptima Policies, including but not limited to, CalOptima Policy GG.1355: Community Supports, and this Contract.

2.39.2.1 Community Supports Provider shall maintain staffing that allows for timely, high-quality service delivery of the Community Supports that it is contracted to provide.

2.39.2.2 Community Supports Provider shall:

a. Accept and act upon Member referrals from CalOptima or Health Network for authorized Community Supports, unless the Community Supports Provider is at pre-determined capacity;
b. Conduct outreach to the referred Member for authorized Community Supports Providers as soon as possible, including by making best efforts to conduct initial outreach within 24 hours of assignment, if applicable;
c. Be responsive to incoming calls or other outreach from Members, including by maintaining a phone line that is staffed or able to record voicemail 24 hours a day, 7 days a week;
d. Coordinate with other providers in the Member's care team, including ECM Providers, other Community Supports providers, CalOptima and Health Networks;
e. Comply with cultural competency and linguistic requirements required by this Contract, CalOptima Policies and federal, State and local laws;
f. Comply with non-discrimination requirements set forth in this Contract and State and Federal law.

2.39.3 When federal law requires authorization for data sharing, Community Supports Provider shall obtain and/or document such authorization from each assigned Member, including sharing of protected health information (PHI), and shall confirm it has obtained such authorization to CalOptima. Member authorization for Community Supports-related data sharing is not required for the Community Supports Provider to initiate delivery of Community Supports unless such authorization is required by federal law. Community Supports Provider will be reimbursed only for Community Supports services that are authorized by CalOptima or Health Network. In the event of a Member requesting Community Supports services that are not yet authorized by CalOptima or a Health Network, Community Supports Provider shall send prior authorization request(s) to CalOptima for a CalOptima Direct Member or the Member's assigned Health Network, as applicable.

2.39.4 If a Community Supports is discontinued for any reason, Community Supports Provider shall support transition planning for the Member into other programs or services that meet their needs.

2.39.5 Community Supports Provider is encouraged to identify additional Community Supports the Member may benefit from and send any additional request(s) for Community Supports to CalOptima or Health Network for authorization.

2.39.6 Payment of Community Supports. Community Supports Provider shall record, generate, and send a claim or invoice to CalOptima for Community Supports rendered. If Community Supports Provider submits claims, Community Supports Provider shall submit claims to CalOptima using specifications based Medi-Cal national standards and code sets defined by DHCS.

2.39.6.1 In the event Community Supports Provider is unable to submit claims to CalOptima for Community Supports-related services using specifications based on national standards or DHCS-defined standard specifications and code sets, Community Supports Provider shall submit invoices with minimum necessary data elements defined by DHCS, which includes information about the Member, the Community Supports services rendered, and Community Supports Providers' information to support appropriate reimbursement by CalOptima, that will allow CalOptima to convert Community Supports invoice information into DHCS-defined standard specifications and code sets for submission to DHCS.

2.39.6.2 Community Supports Provider shall not receive payment from CalOptima for the provision of any Community Supports services not authorized by CalOptima or Health Network.

2.39.6.3 CalOptima will provide expedited payments for urgent Community Supports (e.g., Recuperative Care services for a Member who no longer requires hospitalization, but still needs to heal from an injury or illness, including behavioral health conditions, and whose condition would be exacerbated by an unstable living environment), pursuant to its Contract with DHCS and any other related DHCS guidance.

2.39.7 Community Supports Provider must have a system in place to accept payment from CalOptima for Community Supports rendered. CalOptima shall pay 90 percent of all clean

claims and invoices within 30 days of receipt and 99 percent of clean claims and invoices within 90 days of receipt.

2.39.8 Data Sharing to Support Community Supports. As part of the referral process, CalOptima will ensure Community Supports Provider has access to:

2.39.8.1 Demographic and administrative information confirming the referred Member's eligibility for the requested service;

2.39.8.2 Appropriate administrative, clinical, and social service information the Community Supports Provider might need in order to effectively provide the requested service; and

2.39.8.3 Billing information necessary to support the Community Supports Provider's ability to submit invoices to CalOptima.

2.39.9 Quality and Oversight. Community Supports Provider acknowledges that CalOptima will conduct oversight of its delivery of Community Supports to ensure the quality of services rendered and ongoing compliance with all legal and contractual obligations both CalOptima and the Community Supports Provider have, including but not limited to, required reporting, audits, and corrective actions, among other oversight activities.

ARTICLE 3
FUNCTIONS AND DUTIES OF CALOPTIMA

3.1 Payment. CalOptima shall pay Provider for Covered Services provided to CalOptima Members. Provider agrees to accept the compensation set forth in Attachment C as payment in full from CalOptima for such Covered Services. Upon submission of a Clean Claim, CalOptima shall pay Provider pursuant to CalOptima Policies and Attachment C. Notwithstanding the foregoing, Provider may also collect other amounts (e.g., copayments, deductibles, OHC and/or third party liability payments) where expressly authorized to do so under the CalOptima Program(s) and applicable law. Provider agrees that Members will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts and that the provider will (A) accept the plan payment as payment in full, or (B) bill the appropriate State source as required at 42 CFR §422.504(g)(1)(iii).

3.2 Service Authorization. CalOptima shall provide a written authorization process for Covered Services pursuant to CalOptima Policies.

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

ARTICLE 4
PAYMENT PROCEDURES

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

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

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

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

4.5 COB. Provider shall coordinate benefits with other programs or entitlements recognizing where OHC is primary coverage in accordance with CalOptima Program requirements. Provider acknowledges that Medi-Cal is the payor of last resort.

4.6 (This section left intentionally blank)

4.7 Member Financial Protections. Provider and its Subcontractors shall comply with Member financial protections as follows:

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

4.7.2 In no event, including, but not limited to, non-payment by CalOptima, CalOptima's or Provider's insolvency, or breach of this contract by CalOptima, shall Provider, or any of its Subcontractors, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against the State of California or any Member or person acting on behalf of a Member for Covered Services pursuant to this Contract. Notwithstanding the foregoing, Provider may collect SOC, co-payments, and deductibles if, and to the extent, required under a specific CalOptima Program and applicable law.

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

4.7.4 Upon receiving notice of Provider invoicing or balance billing a Member for the difference between the Provider's billed charges and the reimbursement paid by CalOptima for any Covered Services, CalOptima may sanction the Provider or take other action as provided in this Contract.

4.7.5 This section shall survive the termination of this Contract for Covered Services furnished to CalOptima Members prior to the termination of this Contract, regardless of the cause

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

4.8 Overpayments and CalOptima Right to Recover. Provider has an obligation to report any overpayment identified by Provider, and to repay such overpayment to CalOptima within sixty (60) days of such identification by Provider, or of receipt of notice of an overpayment identified by CalOptima. Provider acknowledges and agrees that, in the event that CalOptima determines that an amount has been overpaid or paid in duplicate, or that funds were paid which were not due under this Contract to Provider, CalOptima shall have the right to recover such amounts from Provider by recoupment or offset from current or future amounts due from CalOptima to Provider, after giving Provider notice and an opportunity to return/pay such amounts. This right to recoupment or offset shall extend to any amounts due from Provider to CalOptima, including, but not limited to, amounts due because of:

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

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

4.8.3 Unpaid Conlan reimbursements owed by provider to a Member.

4.8.4 Payments made for services provided by a Provider that has entered into a private contract with a Medicare beneficiary for Covered Services.

ARTICLE 5
INSURANCE AND INDEMNIFICATION

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

5.2 Provider Professional Liability. Provider, at its sole cost and expense, shall ensure that it and Subcontractors providing professional services under this Contract shall maintain professional liability insurance coverage with minimum per incident and annual aggregate amounts which are at least equal to the community minimum amounts in Orange County, California, for the specialty or type of service which Provider provides, with a minimum of $1,000,000 per incident/$3,000,000 aggregate per year.

5.3 Provider Commercial General Liability ("CGL")/Automobile Liability. Provider at its sole cost and expense shall maintain such policies of commercial general liability and automobile liability insurance and other insurance as shall be necessary to insure it and its business addresses, customers (including Members), employees, agents, and representatives against any claim or claims for

damages arising by reason of a) personal injuries or death occasioned in connection with the furnishing of any Covered Services hereunder, b) the use of any property of the Provider, and c) activities performed in connection with the Contract, with minimum coverage of $1,000,000 per incident/$3,000,000 aggregate per year.

5.4 Workers Compensation Insurance. Provider at its sole cost and expense shall maintain workers compensation insurance within the limits established and required by the State of California and employers liability insurance with minimum limits of liability of $1,000,000 per occurrence/$1,000,000 aggregate per year.

5.5 Insurer Ratings. All above insurance shall be provided by an insurer:

5.5.1 rated by Best's with a rating of B or better; and

5.5.2 "admitted" to do business in California or an insurer approved to do business in California by the California Department of Insurance and listed on the Surplus Lines Association of California List of Eligible Surplus Lines Insurers (LESLI) or licensed by the California Department of Corporations as an Unincorporated Interindemnity Trust Arrangement as authorized by the California Insurance Code 12180.7.

5.6 Captive Risk Retention Group/Self Insured. Where any of the insurances mentioned above are provided by a Captive Risk Retention Group or are self insured, such above provisions may be waived at the sole discretion of CalOptima, but only after CalOptima reviews the Captive Risk Retention Group's or self-insured's audited financial statements and approves the waiver.

5.7 Cancellation or Material Change. The Provider shall not of its own initiative cause such insurances as addressed in this Article to be canceled or materially changed during the term of this Contract.

5.8 Certificates of Insurance. Prior to execution of this Contract, Provider shall provide Certificates of Insurance to CalOptima showing the required insurance coverage and further providing that CalOptima is named as an additional insured on the Comprehensive General Liability Insurance and Automobile Liability Insurance with respect to the performance hereunder and coverage is primary and non-contributory as to any other insurance with respect to performance hereunder.

ARTICLE 6
RECORDS, AUDITS AND REPORTS

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

reserves the right to suspend or terminate the Provider and its Subcontractors from participation in the Medi-Cal program; seek recovery of payments made to the Provider; impose other sanctions provided under the State Plan, and Provider's contract may be terminated due to fraud.

6.2 Medical Records. Provider and its Subcontractors shall establish and maintain for each Member who has obtained Covered Services, medical records which are organized in a manner which contain such demographic and clinical information as is necessary to provide and ensure accurate and timely documentation as to the medical problems and Covered Services provided to the Member. Such medical records shall be consistent with State and Federal laws and CalOptima Program requirements and shall include a historical record of diagnostic and therapeutic services recommended or provided by, or under the direction of, the Provider. Such medical records shall be in such a form as to allow trained health professionals, other than the Provider, to readily determine the nature and extent of the Member's medical problem and the services provided, and to permit peer review of the care furnished to the Member.

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

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

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

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

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

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

6.6 Data Submission. Provider shall submit to CalOptima complete, accurate, reasonable, and timely provider data, encounter date, and other data and reports (a) needed by CalOptima in order for CalOptima to meet its reporting requirements to DHCS, and/or (b) required by CalOptima and CalOptima's Regulators as provided in this Contract and in CalOptima's Policies.

ARTICLE 7
TERM AND TERMINATION

7.1 Term. The term of this Contract shall become effective on the Effective Date through June 30, 2022. This Contract shall then automatically extend for additional one-year terms (July 1st through June 30th) upon formal approval by the CalOptima Board of Directors, unless earlier terminated by either party as provided for in this Contract.

7.2 Termination for Default. CalOptima may, in its sole discretion, terminate this Contract whenever CalOptima determines that the Provider or any Subcontractor (a) has repeatedly and inappropriately withheld Covered Services to a CalOptima Member(s), (b) has failed to perform its contracted duties and responsibilities in a timely and proper manner including, without limitation, service procedures and standards identified in this Contract, (c) has committed acts that discriminate against CalOptima Members on the basis of their health status or requirements for health care services; (d) has not provided Covered Services in the scope or manner required under the provisions of this Contract; (e) has engaged in prohibited marketing activities; (f) has failed to comply with CalOptima's Compliance Program, including Participation Status requirements; (g) has committed fraud or abuse relating to Covered Services or any and all obligations, duties and responsibilities under this Contract; or (h) has materially breached any covenant, condition, or term of this Contract. A termination as described above shall be referred to herein as "Termination for Default." In the event of a Termination for Default, CalOptima shall give Provider prior written notice of its intent to terminate with a thirty (30)-day cure period if the Termination for Default is curable, in the sole discretion of CalOptima. In the event the default is not cured within the thirty (30)-day period, CalOptima may terminate the Contract immediately following such thirty (30)-day period. The rights and remedies of CalOptima provided in this clause are not exclusive and are in addition to any other rights and remedies provided by law or under the Contract. The Provider shall not be relieved of its liability to CalOptima for damages sustained by virtue of breach of the Contract by the Provider or any Subcontractor.

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

7.4 Termination for Provider Insolvency. If the Provider and/or any of its Subcontractors becomes insolvent, the Provider shall immediately so advise CalOptima, and CalOptima shall have, at its sole option, the right to terminate the Contract immediately. In the event of the filing of a petition for bankruptcy by or against the Provider or a principal Subcontractor, the Provider shall assure

that all tasks related to the Contract or the Subcontract are performed in accordance with the terms of the Contract.

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

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

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

7.8 Obligations Upon Termination. Upon termination of this Contract, it is understood and agreed that Provider shall continue to provide authorized Covered Services to Members who retain eligibility and who are under the care of Provider at the time of such termination, until the services being rendered to Members are completed, unless CalOptima, in its sole discretion, makes reasonable and medically appropriate provisions for the assumption of such services. Payment for services under this paragraph shall be at the contracted rates. Prior to the termination or expiration of this Contract, and upon request by CalOptima or one of its regulatory agencies to assist in the orderly transfer of Members' medical care, Provider shall make available to CalOptima and/or such regulatory agency, copies of any pertinent information, including information maintained by Provider and any Subcontractor necessary for efficient case management of Members. Costs of reproduction shall be borne by CalOptima or the government agency, as applicable. For purposes of this section only, "under the care of Provider" shall mean that a Member has an authorization from CalOptima to receive services from the Provider issued prior to the Termination, all of the services authorized under that authorization have not yet been completed, and the time period covered by the authorization has not yet expired.

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

ARTICLE 8
GRIEVANCES AND APPEALS

8.1 Provider Grievances. CalOptima has established a fast and cost-effective complaint system for provider complaints, grievances and appeals. Provider shall have access to this system for any

issues arising under this Contract, as provided in CalOptima Policies related to the applicable CalOptima Program(s). Provider complaints, grievances, appeals, or other disputes regarding any issues arising under this Contract shall be resolved through such system.

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

ARTICLE 9
GENERAL PROVISIONS

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

9.2 Documents Constituting Contract. This Contract and its attachments, schedules, addenda and exhibits and all CalOptima Policies applicable to Covered Services and CalOptima Members (and any amendments thereto) shall constitute the entire agreement between the parties. It is the express intention of Provider and CalOptima that any and all prior or contemporaneous agreements, promises, negotiations or representations, either oral or written, relating to the subject matter and period governed by this Contract which are not expressly set forth herein shall be of no further force, effect or legal consequence after the effective date hereunder.

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

9.4 Governing Law and Venue. This Contract shall be governed by and construed in accordance with all laws of the State of California and Federal laws and regulations applicable to the CalOptima Programs and all contractual obligations of CalOptima. Provider shall bring any and all legal proceedings against CalOptima under this Contract in California State courts located in Orange County, California, unless mandated by law to be brought in federal court, in which case such legal proceedings shall be brought in the Central District Court of California.

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

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

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

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

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

If to CalOptima:

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

If to Provider:

_____
Name

_____
Title

_____
Address

_____

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

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

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

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

9.13 Authority to Execute. The persons executing this Contract on behalf of the parties warrant that they are duly authorized to execute this Contract, and that by executing this Contract, the parties are formally bound.

9.14 Severability. In the event any provision of this Contract is rendered invalid or unenforceable by Act of Congress, by statute of the State of California, by any regulation duly promulgated by the United States or the State of California in accordance with law or is declared null and void by any court of competent jurisdiction, the remainder of the provisions hereof shall remain in full force and effect.

ARTICLE 10
EXECUTION

10.1 Subject to the State of California and United States providing funding for the term of this Contract and for the purposes with respect to which it is entered into, and execution of the Government Contracts and the approval of the Contract by the Government Agencies, this Contract shall become effective January 1, 2022 (the "Effective Date").

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

Provider	**CalOptima**
_____	_____
Signature	Signature
_____	_____
Print Name	Print Name
_____	Chief Operating Officer
Title	Title
_____	_____
Date	Date

ATTACHMENT A

COVERED SERVICES

ARTICLE 1

CALOPTIMA PROGRAMS

1.1 CalOptima Medi-Cal Program. Provider shall furnish Community Supports Covered Services under the CalOptima Medi-Cal Program and to CalOptima's eligible Medi-Cal Members.

ARTICLE 2
SERVICES

Scope of Covered Services. "Covered Services" as referred to in this Contract means XXXXXXXX described below.

Recuperative Care (Medical Respite)

2.1 Description/Overview

2.1.1 Recuperative care, also referred to as medical respite care, is short-term residential care for Members who no longer require hospitalization, but still need to heal from an injury or illness (including behavioral health conditions) and whose condition would be exacerbated by an unstable living environment. An extended stay in a recovery care setting allows Members to continue their recovery and receive post-discharge treatment while obtaining access to primary care, behavioral health services, case management and other supportive social services, such as transportation, food, and housing.

2.1.2 At a minimum, the service will include interim housing with a bed and meals and ongoing monitoring of the Member's ongoing medical or behavioral health condition (e.g., monitoring of vital signs, assessments, wound care, medication monitoring). Based on Member needs, the service may also include:

2.1.2.1 Limited or short-term assistance with Instrumental Activities of Daily Living (IADLs) &/or Activities of Daily Living ADLs

2.1.2.2 Coordination of transportation to post-discharge appointments

2.1.2.3 Connection to any other on-going services a Member may require including mental health and substance use disorder services

2.1.2.4 Support in accessing benefits and housing

2.1.2.5 Gaining stability with case management relationships and programs

2.1.3 Recuperative care is primarily used for those Members who are experiencing homelessness or those with unstable living situations who are too ill or frail to recover from an illness (physical or behavioral health) or injury in their usual living environment; but are not otherwise ill enough to be in a hospital.

2.1.4 The services provided to a Member while in Recuperative Care shall not replace or be duplicative of the services provided to members utilizing the ECM program. Recuperative Care may be utilized in conjunction with other housing Community Supports. Whenever possible, other housing Community Supports shall be provided to members onsite in the Recuperative Care facility. When enrolled in ECM, Community Supports shall be managed in coordination with ECM providers.

2.1.5 The services provided shall utilize best practices for Members who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

2.2 Eligibility (Population Subset)

2.2.1 Members who are at risk of hospitalization or are post-hospitalization, and

2.2.2 Members who live alone with no formal supports; or

2.2.3 Members who face housing insecurity or have housing that would jeopardize their health and safety without modification.

2.3 Restrictions and Limitations

2.3.1 Recuperative Care/medical respite is an allowable Community Supports service if it is 1) necessary to achieve or maintain medical stability and prevent hospital admission or re-admission, which may require behavioral health interventions, 2) not more than 90 days in continuous duration, and 3) does not include funding for building modification or building rehabilitation.

2.3.2 Members may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

2.4 Licensing/Allowable Providers

2.4.1 Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers CalOptima may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

2.4.1.1 Interim housing facilities with additional on-site support

2.4.1.2 Shelter beds with additional on-site support

2.4.1.3 Converted homes with additional on-site support

2.4.1.4 County directly operated or contracted Recuperative Care facilities

2.4.2 Facilities are unlicensed. CalOptima shall apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. CalOptima can adopt

or adapt local or national standards for Recuperative Care or interim housing. CalOptima shall monitor the provision of all the services included above.

2.4.3 Providers that have a state-level enrollment pathway must enroll in the Medi-Cal program pursuant to relevant DHCS All Plan Letters (APLs), including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, CalOptima must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

Housing Deposits

2.1 Description/Overview

2.1.1 Housing Deposits assist with identifying, coordinating, securing, or funding one-time services and modifications necessary to enable a person to establish a basic household that do not constitute payment for room and board, such as:

2.1.1.1 Security deposits required to obtain a lease on an apartment or home.

2.1.1.2 Set-up fees/deposits for utilities or service access and utility arrearages.

2.1.1.3 First month coverage of utilities, including but not limited to telephone, gas, electricity, heating, and water.

2.1.1.4 First month's and last month's rent as required by landlord for occupancy.

2.1.1.5 Services necessary for the Member's health and safety, such as pest eradication and one-time cleaning prior to occupancy.

2.1.1.6 Goods such as an air conditioner or heater, and other medically-necessary adaptive aids and services, designed to preserve a Members' health and safety in the home such as hospital beds, Hoyer lifts, air filters, specialized cleaning or pest control supplies etc., that are necessary to ensure access and safety for the Member upon move-in to the home.

2.1.2 The services provided shall be based on individualized assessment of needs and documented in the individualized housing support plan. Members may require and access a subset of the services listed above.

2.1.3 The services provided shall utilize best practices for Members who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

2.1.4 Services do not include the provision of room and board or payment of ongoing rental costs beyond the first and last month's coverage as noted above.

2.2 Eligibility (Population Subset)

2.2.1 Any Member who received Housing Transition/Navigation Services Community Supports.

2.2.2 Members who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable Members with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services as a result of a substance use disorder and/or is exiting incarceration; or

2.2.3 Members who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those

exiting institutions but not including any limits on the number of days in the institution) and who are receiving ECM, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals.

2.3 Restrictions and Limitations

2.3.1 Housing Deposits are available once in a Member's lifetime. Housing Deposits can only be approved one additional time with documentation as to what conditions have changed to demonstrate why providing Housing Deposits would be more successful on the second attempt. Plans are expected to make a good faith effort to review information available to them to determine if Member has previously received services.

2.3.2 These services must be identified as reasonable and necessary in the Member's individualized housing support plan and are available only when the Member is unable to meet such expense.

2.3.3 Members must also receive Housing Transition/Navigation services (at a minimum, the associated tenant screening, housing assessment and individualized housing support plan) in conjunction with this service.

2.3.4 Members may not be receiving duplicative support from other State, local or federally funded programs, which shall always be considered first, before using Medi-Cal funding.

2.4 Licensing/Allowable Providers

2.4.1 Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner.

2.4.2 The entity that is coordinating a Member's Housing Transition Navigation Services, or the CalOptima case manager, care coordinator or housing navigator may coordinate these services and pay for them directly (e.g., to the landlord, utility company, pest control company, etc.) or subcontract the services.

2.4.3 Providers must have demonstrated or verifiable experience and expertise with providing these unique services.

2.4.4 Providers that have a state-level enrollment pathway must enroll in the Medi-Cal program pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment (APL 19-004). If there is no state-level enrollment pathway, CalOptima must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

Housing Transition Navigation Services

2.1 Description/Overview

2.1.1 Housing Transition Navigation services assist Members with obtaining housing and include:

2.1.1.1 Conducting a tenant screening and housing assessment that identifies the participant's preferences and barriers related to successful tenancy. The assessment may include collecting information on the Member's housing needs, potential Housing Transition barriers, and identification of housing retention barriers.

2.1.1.2 Developing an individualized housing support plan based upon the housing assessment that addresses identified barriers, includes short- and long-term measurable goals for each issue, establishes the Member's approach to meeting the goal, and identifies when other providers or services, both reimbursed and not reimbursed by Medi-Cal, may be required to meet the goal.

2.1.1.3 Searching for housing and presenting options.

2.1.1.4 Assisting in securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).

2.1.1.5 Assisting with benefits advocacy, including assistance with obtaining identification and documentation for SSI eligibility and supporting the SSI application process. Such service can be subcontracted out to retain needed specialized skillset.

2.1.1.6 Identifying and securing available resources to assist with subsidizing rent (such as Section 8, state and local assistance programs etc.) and matching available rental subsidy resources to Members.

2.1.1.7 Identifying and securing resources to cover expenses, such as security deposit, moving costs, adaptive aids, environmental modifications, moving costs, and other one-time expenses. Actual payment of these Housing Deposits and move-in expenses is a separate Community Supports under Housing Deposits.

2.1.1.8 Assisting with requests for reasonable accommodation, if necessary as related to expenses incurred by the housing navigator supporting the Member moving into the home.

2.1.1.9 Educating and engaging with landlords.

2.1.1.10 Ensuring that the living environment is safe and ready for move-in.

2.1.1.11 Communicating and advocating on behalf of the Member with landlords.

2.1.1.12 Assisting with arranging for and supporting the details of the move.

2.1.1.13 Establishing procedures and contacts to retain housing, including developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized. The services associated with the crisis plan are a separate Community Supports under Housing Tenancy and Sustaining Services.

2.1.1.14 Identifying, coordinating, securing, or funding non-emergency, non-medical transportation to assist members' mobility to ensure reasonable accommodations and access to housing options prior to transition and on move in day.

2.1.1.15 Identifying and coordinating, environmental modifications to install necessary accommodations for accessibility.

2.1.2 The services provided shall be based on individualized assessment of needs and documented in the individualized housing support plan. Members may only require and access a subset of the services listed above.

2.1.3 The services provided shall utilize best practices for Members who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions. Examples of best practices include Housing First Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

2.1.4 The services may involve additional coordination with other entities to ensure the Member has access to supports needed for successful tenancy. These entities may include County Health, Public Health, Substance Use, Mental Health and Social Services Departments; County and City Housing Authorities; Continuums of Care and Coordinated Entry System; Sheriff's Department and Probation Officers, as applicable and to the extent possible; local legal service programs, community-based organizations housing providers, local housing agencies and housing development agencies. For Members who will need rental subsidy support to secure permanent housing, the services will require close coordination with local Coordinated Entry Systems, homeless services authorities, public housing authorities, and other operators of local rental subsidies. Some housing assistance (including recovery residences and emergency assistance or rental subsidies for Full Service Partnership Members) is also funded by county behavioral health agencies, and CalOptima and their contracted Community Supports Providers shall expect to coordinate access to these housing resources through county behavioral health when appropriate.

2.1.5 Services should be seamless for Members experiencing homelessness entering the Housing Transition Navigation Services to Community Supports.

2.1.6 Services do not include the provision of room and board or payment of rental costs. Coordination with local entities is crucial to ensure that available options for room and board or rental payments are also coordinated with housing services and supports.

2.2 Eligibility (Population Subset)

2.2.1 Members who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable Members with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or

requiring residential services as a result of a substance use disorder and/or is exiting incarceration; or

2.2.2 Members who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving ECM, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals; or

2.2.3 Members who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:

2.2.3.1 A Member or family who:

2.2.3.1.1 Has an annual income below 30 percent of median family income for the area, as determined by HUD;

2.2.3.1.2 Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in section 2.2.3 of the "Homeless" definition in this section; and

2.2.3.1.3 Meets one of the following conditions:

a. Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;
b. Is living in the home of another because of economic hardship;
c. Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance;

2.2.3.1.4 Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income Members;

2.2.3.1.5 Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;

2.2.3.1.6 Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or

2.2.3.1.7 Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;

2.2.3.2 A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or

2.2.3.3 A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him; or

2.2.4 Members who are determined to be at risk of experiencing homelessness are eligible to receive Housing Transition Navigation services if they have significant barriers to housing stability and meet at least one of the following:

2.2.4.1 Have one or more serious chronic conditions;

2.2.4.2 Have a Serious Mental Illness;

2.2.4.3 Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder; or

2.2.4.4 Have a Serious Emotional Disturbance (children and adolescents);

2.2.4.5 Are receiving Enhanced Care Management; or

2.2.4.6 Are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking or domestic violence..

2.3 Restrictions and Limitations

2.3.1 Housing Transition/Navigation services must be identified as reasonable and necessary in the Member's individualized housing support plan. The service duration can be as long as necessary.

2.3.2 Members may not be receiving duplicative support from other State, local tax or federally funded programs, which shall always be considered first, before using Medi-Cal funding.

2.4 Licensing/Allowable Providers

2.4.1 Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner. This list is provided as an example of the types of providers CalOptima may choose to contract with, but it is not an exhaustive list of providers who may offer the services. Providers must have demonstrated experience with providing housing-related services and supports and may include providers such as:

2.4.1.1 Vocational services agencies;

2.4.1.2 Providers of services for Members experiencing homelessness;

2.4.1.3 Life skills training and education providers;

2.4.1.4 County agencies;

2.4.1.5 Public hospital systems;

2.4.1.6 Mental health or substance use disorder treatment providers, including county behavioral health agencies;

2.4.1.7 Social services agencies;

2.4.1.8 Affordable housing providers;

2.4.1.9 Supportive housing providers; and

2.4.1.10 Federally qualified health centers and rural health clinics.

2.4.2 Providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, CalOptima must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

2.4.3 Members who meet the eligibility requirements for Housing Transition/Navigation services shall also be assessed for ECM and Housing and Tenancy Support Services. When enrolled in ECM, Community Supports shall be managed in coordination with ECM providers. When Members receive more than one of these services, CalOptima shall ensure services are coordinated by an ECM provider whenever possible to minimize the number of care/case management transitions experienced by Members and to improve overall care coordination and management. One exception to this is for benefits advocacy, which may require providers with a specialized skill set.

2.4.4 If the CalOptima case manager, care coordinator or housing navigator is providing the service, that individual must have demonstrated experience working with Members experiencing homelessness or with the provision of housing-related services and supports to vulnerable populations.

Housing Tenancy and Sustaining Services

2.1 Description/Overview

2.1.1 This service provides tenancy and sustaining services, with a goal of maintaining safe and stable tenancy once housing is secured. Services include:

2.1.1.1 Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment, hoarding, substance use, and other lease violations.

2.1.1.2 Education and training on the role, rights and responsibilities of the tenant and landlord.

2.1.1.3 Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy.

2.1.1.4 Coordination with the landlord and case management provider to address identified issues that could impact housing stability.

2.1.1.5 Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action including developing a repayment plan or identifying funding in situations in which the Member owes back rent or payment for damage to the unit.

2.1.1.6 Advocacy and linkage with community resources to prevent eviction when housing is or may potentially become jeopardized.

2.1.1.7 Assisting with benefits advocacy, including assistance with obtaining identification and documentation for SSI eligibility and supporting the SSI application process. Such service can be subcontracted out to retain needed specialized skillset.

2.1.1.8 Assistance with the annual housing recertification process.

2.1.1.9 Coordinating with the tenant to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers.

2.1.1.10 Continuing assistance with lease compliance, including ongoing support with activities related to household management.

2.1.1.11 Health and safety visits, including unit habitability inspections. This does not include housing quality inspections.

2.1.1.12 Other prevention and early intervention services identified in the crisis plan that are activated when housing is jeopardized (e.g., assisting with reasonable accommodation requests that were not initially required upon move-in).

2.1.1.13 Providing independent living and life skills including assistance with and training on budgeting, including financial literacy and connection to community resources.

2.1.2 The services provided shall be based on individualized assessment of needs and documented in the individualized housing support plan. Members may only require and access a subset of the services listed above.

2.1.3 The services provided shall utilize best practices for Members who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

2.1.4 The services may involve coordination with other entities to ensure the Member has access to supports needed to maintain successful tenancy. Final program guidelines shall adopt, as a standard, the demonstrated need to ensure seamless service to Members experiencing homelessness entering the Housing Tenancy and Sustaining Services Community Supports.

2.1.5 Services do not include the provision of room and board or payment of rental costs.

2.2 Eligibility (Population Subset)

2.2.1 Any Member who received Housing Transition/Navigation Services Community Supports.

2.2.2 Members who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable Members with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services as a result of a substance use disorder and/or is exiting incarceration; or

2.2.3 Members who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving ECM, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals; or

2.2.4 Members who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:

2.2.4.1 A Member or family who:

2.2.4.1.1 Has an annual income below 30 percent of median family income for the area, as determined by HUD;

2.2.4.1.2 Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately

available to prevent them from moving to an emergency shelter or another place described in section 2.2.3 of the "Homeless" definition in this section; and

2.2.4.1.3 Meets one of the following conditions:

a. Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;
b. Is living in the home of another because of economic hardship;
c. Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance;

2.2.4.1.4 Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income Members;

2.2.4.1.5 Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;

2.2.4.1.6 Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or

2.2.4.1.7 Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;

2.2.4.2 A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or

2.2.4.3 A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him; or

2.2.5 Members who are determined to be at risk of experiencing homelessness are eligible to receive Housing Transition Navigation services if they have significant barriers to housing stability and meet at least one of the following:

2.2.5.1 Have one or more serious chronic conditions;

2.2.5.2 Have a Serious Mental Illness;

2.2.5.3 Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder, or

2.2.5.4 Have a Serious Emotional Disturbance (children and adolescents);

2.2.5.5 Are receiving Enhanced Care Management; or

2.2.5.6 Are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking or domestic violence. .

2.3 Restrictions and Limitations

2.3.1 These services are available from the initiation of services through the time when the Member's housing support plan determines they are no longer needed. They are only available for a single duration in the Member's lifetime. Housing Tenancy and Sustaining Services can only be approved one additional time with documentation as to what conditions have changed to demonstrate why providing Housing Tenancy and Sustaining Services would be more successful on the second attempt. CalOptima is expected to make a good faith effort to review information available to them to determine if Member has previously received services. The service duration can be as long as necessary.

2.3.2 These services must be identified as reasonable and necessary in the Member's individualized housing support plan and are available only when the enrollee is unable to successfully maintain longer-term housing without such assistance.

2.3.3 Many Members will have also received Housing Transition/Navigation services (at a minimum, the associated tenant screening, housing assessment and individualized housing support plan) in conjunction with this service but it is not a prerequisite for eligibility.

2.3.4 Members may not be receiving duplicative support from other State, local or federally funded programs, which shall always be considered first, before using Medi-Cal funding.

2.4. Licensing/Allowable Providers

2.4.1 Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner. This list is provided as an example of the types of providers CalOptima may choose to contract with, but it is not an exhaustive list of providers who may offer the services. Providers must have demonstrated or verifiable experience or expertise with providing housing-related services and supports and may include providers such as:

2.4.1.1 Vocational services agencies

2.4.1.2 Providers of services for Members experiencing homelessness

2.4.1.3 Life skills training and education providers

2.4.1.4 County agencies

2.4.1.5 Public hospital systems

2.4.1.6 Mental health or substance use disorder treatment providers, including county behavioral health agencies

2.4.1.7 Supportive housing providers

2.4.1.8 Federally qualified health centers and rural health clinics

2.4.2 Providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs, including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, CalOptima must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

2.4.3 If the CalOptima case manager, care coordinator or housing navigator is providing the service, that individual must have demonstrated experiencing working with Members experiencing homelessness or with the provision of housing-related services and supports to vulnerable populations. CalOptima shall coordinate with county homelessness entities to provide these services.

2.4.4 Members who meet the eligibility requirements for Housing and Tenancy Support Services shall also be assessed for ECM and may have received Housing Transition/Navigation services. When enrolled in ECM, Community Supports shall be managed in coordination with ECM providers. When Members receive more than one of these services, CalOptima shall ensure it is coordinated by an ECM provider whenever possible to minimize the number of care/case management transitions experienced by Members and to improve overall care coordination and management.

ATTACHMENT B

PROCEDURES FOR REQUESTING INTERPRETATION SERVICES

ARTICLE 1
CALOPTIMA DIRECT MEMBERS

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

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

a. Member name and ID, date of birth and telephone number;

b. Name and phone number of the care taker, if applicable;

c. Language or sign language needed;

d. Date and time of the appointment;

e. Address and telephone number of the facility where the appointment is to take place;

f. Estimated amount of time the interpretation service will be needed; and

g. Type of appointment: assessment, fitting/delivery or other.

1.3 Provider's Responsibilities.

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

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

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

ARTICLE 2
HEALTH NETWORK MEMBERS

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

ATTACHMENT C

COMPENSATION

CalOptima shall reimburse Provider, and Provider shall accept as payment in full from CalOptima, the following amounts:

I. Medi-Cal Program Reimbursement
For Medi-Cal Members, CalOptima shall reimburse for Covered Services as follows:

Recuperative Care (Medical Respite)

Rate	$
Unit of Service	Per Diem
HCPCS Billing Code	T2033 (Modifier U6 for both)

Housing Deposits

Service Rate	Up to a Maximum of $
Unit of Service	The amount of the Housing Deposit advanced, up to the Maximum allowed
HCPCS Billing Code	H0044 (U2 Modifier)

Housing Transition Navigation Service Rate

Bundled Payments (per Enrollee per Month (PEPM))	$
Unit of Service	PEPM
HCPCS Billing Code	H0043, H2016 (Modifier U6 for both)

Housing Tenancy and Sustaining Service Rate

Bundled Payments (per Enrollee per Month (PEPM))	$
Unit of Service	PEPM
HCPCS Billing Code	T2040, T2041 (Modifier U6 for both)

ATTACHMENT D

DISCLOSURE FORM

_____
Name of Provider

The undersigned hereby certifies that the following information regarding

_____ (the "Provider") is true and correct as of the date set forth below:

Officer(s)/Director(s)/General Partner(s):

_____

_____

Co-Owner(s):

_____

_____

Stockholder(s) owning more than five percent (5%) of the Provider's stock:

_____

_____

Major creditor(s) holding more than five percent (5%) of the Provider's debt:

_____

_____

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

_____

_____

Dated: _____ Signature: _____

Name: _____
(Please type or print)

Title: _____
(Please type or print)

ADDENDUM 1
MEDI-CAL PROGRAM

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

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

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

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

2. Access to Books and Records. Provider agrees to make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of the Contract, available for the purpose of an audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State's Right to Monitor, as set forth in the DHCS Contract, Exhibit E, Attachment 2, Provision 20: (a) by CalOptima, the Government Agencies, CalOptima's Regulators, DOJ, Bureau of Medi-Cal Fraud, Comptroller General and any other entity statutorily entitled to have oversight responsibilities of the COHS program, (b) at all reasonable times at Provider's place of business or at such other mutually agreeable location in California, and (c) in a form maintained in accordance with the general standards applicable to such book or record keeping for a term of at least ten (10) years from the final date of the Contract between CalOptima and DHCS, or from the date of completion of any audit, whichever is later, in which the records or data were created or applied, and for which the financial record was completed, and including, if applicable, all Medi-Cal 35 file paid claims data and encounter data for a period of at least ten (10) years from the date of expiration or termination. Provider shall provide access to all security areas and shall provide reasonable facilities, cooperation and assistance to State representatives in the performance of their duties. If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit Provider at any time. Upon resolution of a full investigation of fraud, DHCS reserves the right to

suspend or terminate the Provider from participation in the Medi-Cal program; seek recovery of payments made to the Subcontractor; impose other sanctions provided under the State Plan, and direct CalOptima to terminate this Contract for provision of services to CalOptima Medi-Cal Members due to fraud.

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

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

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

4. Third Party Tort Liability/Estate Recovery. Provider shall make no claim for the recovery of the value of Covered Services rendered to a Member when such recovery would result from an action involving tort liability of a third party, recovery from the estate of deceased Member, or casualty liability insurance awards and uninsured motorist coverage. Provider shall identify and notify CalOptima, within five (5) calendar days of discovery, which shall in turn notify DHCS, of any action by the CalOptima Member involving the Tort Workers' Compensation liability of a third party or estate recovery that could result in recovery by the CalOptima Member of funds to which DHCS has lien rights under Article 3.5 (commencing with Section 14124.70), Part 3, Division 9, Welfare and Institutions Code.

5. Records Related to Recovery for Litigation.

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

   5.2 In addition to the payments provided for elsewhere in this Contract, CalOptima agrees to pay Provider for complying with Paragraph 5.1, above, as follows:

5.2.1 CalOptima shall reimburse Provider amounts paid by Provider to third parties for services necessary to comply with Paragraph 5.1. Any third party assisting Provider with compliance with Paragraph 5.1 shall comply with all applicable confidentiality requirements. Amounts paid by Provider to any third party for assisting Provider in complying with Paragraph 5.1, shall not exceed normal and customary charges for similar services and such charges and supporting documentation shall be subject to review by CalOptima.

5.2.2 If Provider uses existing personnel and resources to comply with Paragraph 5.1, CalOptima shall reimburse Provider as specified below. Provider shall maintain and provide to CalOptima time reports supporting the time spent by each employee as a condition of reimbursement. Reimbursement claims and supporting documentation shall be subject to review by CalOptima.

5.2.2.1 Compensation and payroll taxes and benefits, on a prorated basis, for the employees' time devoted directly to compiling information pursuant to Paragraph 5.1.

5.2.2.2 Costs for copies of all documentation submitted to CalOptima pursuant to Paragraph 5.1, subject to a maximum reimbursement of ten (10) cents per copied page.

5.2.2.3 Provider shall submit to CalOptima all information needed by CalOptima to determine reimbursement to Provider under this provision, including, but not limited to, copies of invoices from third parties and payroll records.

6. Medical Records. All medical records shall meet the requirements of Section 1300.80(b)(4) of Title 28 of the California Code of Regulations, and Section 1936a(w) of Title 42 of the United States Code. Such records shall be available to health care providers at each encounter, in accordance with Section 1300.67.1(c) of Title 28 of the California Code of Regulations. Provider shall ensure that an individual is delegated the responsibility of securing and maintaining medical records at each Participating Provider or Subcontractor site.

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

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

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

10. Changes in Availability or Location of Services. Any substantial change in the availability or location of services to be provided under this Contract requires the prior written approval of DHCS. Provider's proposal to reduce or change the hours, days, or location at which the services are

available shall be given to CalOptima at least 75 days prior to the proposed effective date. DHCS' denial of the proposal shall prohibit implementation of the proposed changes.

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

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

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

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

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

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

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

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

and its principals:

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

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

12.1.3 Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in Subprovision 12.1.2 herein; and

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

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

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

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

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

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

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

14. Lobbying Restrictions and Disclosure Certification.

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

14.2 Certification and Disclosure Requirements

14.2.1 Each person (or recipient) who requests or receives a contract, subcontract, grant, or subgrant, which is subject to Section 1352 of the 31, U.S.C., and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in Attachment 1 to this Addendum 1, consisting of one page, entitled "Certification Regarding Lobbying") that the recipient has not made, and will not make, any payment prohibited by Paragraph 14.3 of this provision.

14.2.2 Each recipient shall file a disclosure (in the form set forth in Attachment 2 to this Addendum 1, entitled "Standard Form-LLL 'disclosure of Lobbying Activities'") if such recipient has made or has agreed to make any payment using nonappropriated funds (to include profits from any covered federal action) in connection with a contract or grant or any extension or amendment of that contract or grant, which would be prohibited under Paragraph 14.3 of this provision if paid for with appropriated funds.

14.2.3 Each recipient shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by such person under Paragraph 14.2.2 herein. An event that materially affects the accuracy of the information reported includes:

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

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

14.2.3.3 A change in the officer(s), employee(s), or member(s) contacted for the purpose of influencing or attempting to influence a covered federal action.

14.2.4 Each person (or recipient) who requests or receives from a person referred to in Paragraph 14.2.1 of this provision a contract, subcontract, grant or subgrant exceeding $100,000 at any tier under a contract or grant shall file a certification, and a disclosure form, if required, to the next tier above.

14.2.5 All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in Paragraph 14.2.1 of this provision. That person shall forward all disclosure forms to DHCS program contract manager.

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

continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

15. Additional Subcontracting Requirements.

15.1 Provider shall ensure that all Subcontracts are in writing and require that the Provider and its Subcontractors:

15.1.1 Make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to this Contract, available at all reasonable times for audit, inspection, examination, or copying by CalOptima, DHCS, CalOptima's Regulators, and/or DOJ, or their designees.

15.1.2 Retain such books and all records and documents for a term minimum of at least ten (10) years from the final date of the DHCS Contract period or from the date of completion of any audit, whichever is later.

15.2 Provider shall require all Subcontracts that relate to the provision of Medi-Cal Covered Services to Members pursuant to the Contract include the following:

15.2.1 Services to be provided by the Subcontractor, term of the Subcontract (beginning and ending dates), methods of extension, renegotiation, termination, and full disclosure of the method and amount of compensation or other consideration to be received by the Subcontractor.

15.2.2 Subcontract or its amendments are subject to DHCS approval as provided in the DHCS Contract, and the Subcontract shall be governed by and construed in accordance with all laws and applicable regulations governing the DHCS Contract.

15.2.3 An agreement that the assignment or delegation of the Subcontract will be void unless prior written approval is obtained pursuant to Section 21 of this Addendum 1.

15.2.4 An agreement to submit provider data, encounter data, and reports related to the Subcontract in accordance with Sections 2.23 of the Contract, and to gather, preserve, and provide any records in the Subcontractor's possession in accordance with Section 5 of this Addendum 1.

15.2.5 An agreement to make all premises, facilities, equipment, books, records, contracts, computer, and other electronic systems of the Subcontractor pertaining to the goods and services furnished by Subcontractor under the Subcontract, available for purpose of an audit, inspection, evaluation, examination, or copying, in accordance with Section 6.1 of the Contract and Sections 2 and 16 of this Addendum 1.

15.2.6 An agreement to maintain and make available to DHCS, CalOptima, and/or Provider, upon request, all sub-subcontracts related to the Subcontract, and to ensure all sub-contractors are in writing and require the sub-subcontractors to comply with the requirements set forth in Section 15.1 of this Addendum 1.

15.2.7 An agreement to comply with CalOptima's Compliance Program (including, without limitations, CalOptima Policies), all applicable requirements or the DHCS Medi-Cal Managed Care Program, and all monitoring provisions and requests set forth in Section 16 of this Addendum 1.

15.2.8 An agreement to assist Provider and/or CalOptima in the transfer of care of a Member in the event of termination of the DHCS Contract or the Contract for any reason, in accordance with Section 19 of this Addendum 1, and in the event of termination of the Subcontract for any reason.

15.2.9 An agreement to hold harmless the State, Members, and CalOptima in the event the Provider cannot or will not pay for services performed by the Subcontractor pursuant to the Subcontract, and to prohibit Subcontractors from balance billing a Member as set forth in Section 4.7 of the Contract.

15.2.10 An agreement to notify DHCS in the manner provided in Section 7.9 of the Contract in the event the Subcontract is amended or terminated.

15.2.11 An agreement to the provision of interpreter services to Members at all provider sites as set forth in Section 2.17 of the Contract, to comply with the language assistance standards developed pursuant to Health and Safety Code section 1367.04, and to the requirements for cultural and linguistic sensitivity as set forth in Section 2.16 or the Contract.

15.2.12 Subcontractors shall have access to CalOptima's dispute resolution mechanism in accordance with Section 8.1 of the Contract.

15.2.13 An agreement to participate and cooperate in quality improvement system as set forth in Section 2.12 of the Contract, and to the revocation of the delegation of activities or obligations under the Subcontract or other specified remedies in instances where DHCS, CalOptima and/or Provider determines that the Subcontractor has not performed satisfactorily.

15.2.14 If and to the extent Subcontractor is responsible for the coordination of care of Members, an agreement to comply with Section 25 of this Addendum 1 and Section 6.5.3 of the Contract.

15.2.15 An agreement by the Provider to notify the Subcontractor of prospective requirements and the Subcontractor's agreement to comply with the new requirements, in accordance with Section 7.5. of the Contract.

15.2.16 An agreement for the establishment and maintenance of and access to medical and administrative records as set forth in Sections 6.2 and 6.3 of the Contract and Sections 1, 3 and 6 of this Addendum 1.

15.2.17 An agreement that Subcontractors shall notify Provider of any investigations into Subcontractor's professional conduct, or any suspension of or comment on a Subcontractor's professional licensure, whether temporary or permanent.

15.2.18 An agreement requiring Subcontractor to sign a Declaration of Confidentiality pursuant to Section 6.5.3 or the Contract, which shall be signed and filed with DHCS prior to the Subcontractor being allowed access to computer files or any other data or files, including identification of Members.

16. State's Right to Monitor. Provider shall comply with all monitoring provisions of this Contract and the DHCS Contract between CalOptima and DHCS, and any monitoring requests by CalOptima and DHCS. Without limiting the foregoing, CalOptima and authorized State and Federal agencies will have the right to monitor, inspect or otherwise evaluate all aspects of the Provider's operation for compliance with the provisions of this Contract and applicable Federal and State laws and regulations. Such monitoring, inspection or evaluation activities will include, but are not limited to, inspection and auditing of Provider, Subcontractor, and provider facilities, management systems and procedures, and books and records as the Director of DHCS deems appropriate, at anytime, pursuant to 42 CFR Section 438.3(h). The monitoring activities will be either announced or unannounced. To assure compliance with the Contract and for any other reasonable purpose, the State and its authorized representatives and designees will have the right to premises access, with or without notice to the Provider. The monitoring activities will be either announced or announced. Staff designated by authorized State agencies will have access to all security areas and the Provider will provide, and will require any and all of its subcontractors to provide, reasonable facilities, cooperation and assistance to State representative(s) in the performance of their duties. Access will be undertaken in such a manner as to not unduly delay the work of the Provider and/or the subcontractor(s).

17. Provider shall comply with language assistance standards developed pursuant to Health & Safety Code Section 1367.04.

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

19. Prior to the termination or expiration of this Contract, including termination due to termination or expiration of CalOptima's DHCS Contract, and upon request by DHCS or CalOptima to assist in the orderly transfer of Members' medical care and all necessary data and history records to DHCS or a successor DHCS Contractor, the Provider shall make available to DHCS and/or CalOptima copies of medical records, patient files, and any other pertinent information, including information maintained by any Subcontractor necessary for efficient case management of Members, and the preservation, to the extent possible, of Member-Provider relationships. Costs of reproduction shall be borne by DHCS and CalOptima, as applicable.

20. This Contract shall be governed by and construed in accordance with all laws and applicable regulations governing the DHCS Contract between CalOptima and DHCS.

21. Provider agrees that the assignment or delegation of this Contract or Subcontract, either in whole or in part, will be void unless prior written approval is obtained from DHCS and CalOptima, as applicable, provided that approval may be withheld in their sole and absolute discretion. For purposes of this Section, and with respect to this Contract and any Subcontracts, as applicable, an assignment constitutes any of the following: (i) the change of more than twenty-five percent (25%) of the ownership or equity interest in Provider or Subcontractor (whether in a single transaction or

in a series of transactions); (ii) the change or more than twenty-five percent (25%) of the directors of trustees of Provider of Subcontractor; (iii) the merger, reorganization, or consolidation of Provider or Subcontractor, with another entity with respect to which Provider or Subcontractor is not the surviving entity; and/or (iv) a change in the management of Provider or Subcontractor from management by persons appointed, elected or otherwise selected by the governing body of Provider or Subcontractor (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

22. Provider further agrees to timely gather, preserve, and provide to DHCS any records in the Provider's or its Subcontractor's possession, in accordance with the State Contract, Exhibit E, Attachment 2, "Records Related to Recovery for Litigation Provision".

23. Provider agrees to assist CalOptima in the transfer of care in the event of any Subcontract termination for any reason.

24. Notwithstanding anything in this Contract to the contrary, Provider shall be entitled to the protections of the Health Care Providers' Bill of Rights, California Health and Safety Code section 1375.7, in the administration of this Contract relative to the Medi-Cal program.

25. If and to the extent that the Provider is responsible for the coordination of care for Members, CalOptima shall share with Provider, in accordance with the appropriate Declaration of Confidentiality signed by Provider and filed with DHCS, any utilization data that DHCS has provided to CalOptima, and Provider shall receive the utilization data provided by CalOptima and use it as the Provider is able for the purpose of Members care coordination.

Addendum 1--Attachment 1

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES

CERTIFICATION REGARDING LOBBYING

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

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

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

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

Name of Contractor	Printed Name of Person Signing for Contractor
Contract / Grant Number	Signature of Person Signing for Contractor
Date	Title

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

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

Addendum 1--Attachment 2

CERTIFICATION REGARDING LOBBYING

Approved by OMB 0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

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

4. Name and Address of Reporting Entity: Prime Subawardee Tier , if known: Congressional District, If known:	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District, If known:
6. Federal Department/Agency:	Federal Program Name/Description: CDFA Number, if applicable:
8. Federal Action Number, if known:	9. Award Amount, if known:
10. a. Name and Address of Lobbying Entity (If individual, last name, first name, MI): (attach Continuation Sheets(s)	b. Name and Address of Lobbying Entity (If individual, last name, first name, MI): SF-LLL-A, If necessary)
Amount of Payment (check all that apply): $ actual planned Form of Payment (check all that apply): a. cash b. in-kind, specify: Nature Value	13. Type of Payment (check all that apply): a. retainer b. one-time fee c. commission d. contingent fee e. deferred f. other, specify:

14. Brief Description of Services Performed or to be Performed and Dates(s) of Service, including Officer(s), Employee(s), or Member(s) Contracted for Payment indicated in item 11:

15. Continuation Sheet(s) SF-LLL-A Attached: Yes No

16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $19,000 and not more than $100,000 for each such failure.	Signature: Print Name: Title: Telephone No.: Date:

Federal Use Only	Authorized for Local Reproduction Standard Form-LLL

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

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

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

Identify the status of the covered federal action.

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

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

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

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

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

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

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

10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.

10. (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).

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

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

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

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

Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

The certifying official shall sign and date the form, print his/her name, title, and telephone number.

Continued to a Future Meeting

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 7, 2022
Regular Meeting of the CalOptima Board of Directors

Report Item
19. Authorize Extension and Amendments of CalOptima Provider Contracts

Contact
Yunkyung Kim, Chief Operating Officer, (714) 246-8408

Recommended Actions
1. Approve Amendments to the Medi-Cal Health Network Full-Risk Health Maintenance Organization (HMO) Except Kaiser Foundation Health Plan, Inc., Shared-Risk Group (SRG), Physician Hospital Consortia Hospital (PHC-H) and Physician Hospital Consortia Physician (PHC-P) contracts to:
    a. Extend the contract term through June 30, 2023;
    b. Add language reflecting annual autorenewal after 2023; and
    c. Add language reflecting the provision of arbitration where necessary.
2. Approve Amendments to the Fee-for-Service Medi-Cal, OneCare, and OneCare Connect Medical and Non-Medical Ancillary Services, Hospital, and Professional Services contracts to:
    a. Extend the contract term through June 30, 2023;
    b. Add language reflecting annual autorenewal after 2023;
    c. Add language reflecting the provision of arbitration as necessary; and
    d. Add language for termination without cause after 90 days.
3. Approve Amendments to the Kaiser Foundation Health Plan, Inc. HMO contract to:
    a. Add language reflecting the annual autorenewal after 2023; and
    b. Add language reflecting the provision of arbitration as necessary

Background and Discussion
Staff seeks to extend the above-named contracts until June 30, 2023, which are set to termination on June 30, 2022, and amend the terms as described below. These providers care for CalOptima's Medi-Cal, OneCare, and OneCare Connect members assigned to CalOptima Direct, SRG, HMO, and PHC networks. The Kaiser Foundation Health Plan Inc. HMO contract term is not set to expire until June 30, 2023, and therefore is not being renewed, however is subject to all other applicable amendments.

Autorenewal Language
Current language in provider contracts requires annual Board approval for renewal of contracts. Language has been added to allow for autorenewal of contracts annually. This revision will add operational efficiency and will ensure continuity of member access to care.

Arbitration Language
To expedite resolution of any disputes efficiently, cost-effectively, and avoid disruption of member access to care to the extent possible, arbitration will be the method for dispute resolution. This will avoid the expense and time of litigating contract disputes in Superior Court.

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Termination Without Cause
Language was added to allow for either party (CalOptima or provider) to terminate the contract after the initial term, without cause, with 90-days written notice.

To ensure continuity of access to care and support the stability of CalOptima's contracted provider network, staff requests approval of all proposed extensions and amendments for the above-named contracts through June 30, 2023.

Fiscal Impact
Management will include expenses associated with the extended contracts in the CalOptima Fiscal Year 2022-23 Operating Budget. There is no additional fiscal impact for the recommended contract language changes.

Rationale for Recommendation
CalOptima staff recommends this action to maintain and continue the contractual relationship with its providers, and maintain the stability of CalOptima's contracted provider network.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Entities Covered by this Recommended Board Action (Health Networks)
2. Entities Covered by this Recommended Board Action (Hospitals)
3. Proposed Contract Amendment: FFS Medical Ancillary Contract
4. Proposed Contract Amendment: Non-Medical Ancillary Contract
5. Proposed Contract Amendment: Professional Services Contract
6. Proposed Contract Amendment: FFS Hospital Contract
7. Proposed Contract Amendment: Medi-Cal Health Maintenance Organization Contract
8. Proposed Contract Amendment: Medi-Cal Shared Risk Group Contract
9. Proposed Contract Amendment: Medi-Cal Physician Hospital Consortia (Hospital) Contract
10. Proposed Contract Amendment: Medi-Cal Physician Hospital Consortia (Physician) Contract
11. Proposed Contract Amendment: Kaiser Foundation Health Plan, Inc.

Board Actions
N/A

/s/ Michael Hunn — *03/31/2022*
Authorized Signature — **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

CalOptima Medi-Cal Health Networks				
Name	**Address**	**City**	**State**	**Zip Code**
AltaMed Health Services Corporation	2040 Camfield Ave.	Los Angeles	CA	90040
AMVI Care Health Network	600 City Parkway West Ste. 800	Orange	CA	92868
ARTA Western California, Inc.	2175 Park Place	El Segundo	CA	90245
CHOC Physicians Network and Children's Hospital of Orange County	1120 West La Veta Avenue Ste. 450	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming St. Ste. 202	Westminster	CA	92683
Fountain Valley Regional Hospital and Medical Center	17100 Euclid St.	Fountain Valley	CA	92708
Heritage Provider Network, Inc.	8510 Balboa Blvd. Ste. 285	Northridge	CA	91325
Kaiser Foundation Health Plan, Inc.	393 Walnut St.	Pasadena	CA	91188
Monarch Health Plan, Inc.	11 Technology Dr.	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc dba Noble Community Medical Associates, Inc.	5785 Corporate Ave.	Cypress	CA	90630
Prospect Health Plan, Inc.	600 City Parkway West Ste. 800	Orange	CA	92868
Talbert Medical Group, P.C.	2175 Park Place	El Segundo	CA	90245
United Care Medical Group, Inc.	600 City Parkway West	Orange	CA	92868

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Anaheim Global Medical Center	1025 S Anaheim Blvd	Anaheim	CA	92805
Anaheim Regional Medical Center	1111 W La Palma Ave	Anaheim	CA	92801
Beverly Hospital	309 W Beverly Blvd	Montebello	CA	90640
Chapman Global Medical Center	2601 E Chapman Ave	Orange	CA	92869
Children's Hospital of Orange County	1201 W La Veta Ave	Orange	CA	92868
Children's Hospital of Los Angeles	4650 W Sunset Blvd	Los Angeles	CA	900276062
CHOC Children's at Mission Hospital	27700 Medical Center Rd	Mission Viejo	CA	92691
College Hospital Costa Mesa	301 Victoria St	Costa Mesa	CA	92627
Foothill Regional Medical Center	14662 Newport Ave	Tustin	CA	927806064
Fountain Valley Regional Hospital & Medical Center	17100 Euclid St	Fountain Valley	CA	92708
Garden Grove Hospital Medical Center	12601 Garden Grove Blvd	Garden Grove	CA	928431908
HealthBridge Children's Hospital - Orange	393 S Tustin St	Orange	CA	92866
Hoag Memorial Hospital Presbyterian	1 Hoag Dr	Newport Beach	CA	926634162
Hoag Memorial Hospital Presbyterian	16200 San Canyon Ave	Irvine	CA	92618
Huntington Beach Hospital	17772 Beach Blvd	Huntington Beach	CA	92647
Kindred Hospital - Brea	875 N Brea Blvd	Brea	CA	92821
Kindred Hospital - La Mirada	14900 E Imperial Hwy	La Mirada	CA	90638
Kindred Hospital - Santa Ana	1901 N College Ave	Santa Ana	CA	92706
Kindred Hospital - Westminster	200 Hospital Circle	Westminster	CA	92683
La Palma Intercommunity Hospital	7901 Walker St	La Palma	CA	90623
Long Beach Memorial Medical Center	2801 Atlantic Ave	Long Beach	CA	90806
Long Beach Memorial Medical Ctr Miller Children's	2801 Atlantic Ave	Long Beach	CA	90806
Orange Coast Memorial Medical Center	9920 Talbert Ave	Fountain Valley	CA	92708
Orange County Global Medical Center	1001 N Tustin Ave	Santa Ana	CA	92705
Placentia Linda Hospital	1301 N Rose Dr	Placentia	CA	928703802
Pomona Valley Hospital Medical Center	1798 N Garey Ave	Pomona	CA	91767
Providence Mission Hospital	27700 Medical Center Rd	Mission Viejo	CA	92691
Providence Mission Hospital	31872 Coast Hwy	Laguna Beach	CA	92651
Providence Mission Hospital Regional Medical Ctr	27700 Medical Center Rd	Mission Viejo	CA	92691
Providence Mission Hospital Regional Medical Ctr	31872 Coast Hwy	Laguna Beach	CA	92651
Providence St Joseph Hospital	1100 W Stewart Dr	Orange	CA	92868
Providence St Joseph Hospital of Orange	1100 W Stewart Dr	Orange	CA	92868
Providence St Jude Medical Center	101 E Valencia Mesa Dr	Fullerton	CA	92835
Providence St Jude Medical Center	101 E Valencia Mesa Dr	Fullerton	CA	92835
Saddleback Memorial Medical Center	24451 Health Center Dr	Laguna Hills	CA	92653
South Coast Global Medical Center	2701 S Bristol St	Santa Ana	CA	92704
UCI Medical Center	101 The City Dr South	Orange	CA	92868
West Anaheim Medical Center	3033 W Orange Ave	Anaheim	CA	92804
Whittier Hospital Medical Center	9080 Colima Rd	Whittier	CA	90605

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AMENDMENT No. X TO
ANCILLARY SERVICES CONTRACT

This Amendment No. X to the Ancillary Services Contract ("**Amendment**") is effective as of [insert date] ("**Amendment Effective Date**"), by and between Orange County Health Authority, a Public Agency, dba CalOptima ("**CalOptima**"), and [insert provider name] ("**Provider**"), with respect to the following:

RECITALS

A. CalOptima and Provider entered into an Ancillary Services Contract ("**Contract**") under which Provider has agreed to furnish certain items and services to CalOptima Members.

B. CalOptima and Provider desire to amend certain terms of the Contract.

NOW, THEREFORE, the parties agree as follows:

1. Delete Section 7.1 of the Contract in its entirety and replace it with the following new Section 7.1:

"7.1 Term. The term of this Contract shall become effective on the Effective Date and continue in effect through June 30, 2023 ("Initial Term"). This Contract shall then automatically extend for additional one-year-terms (July 1st through June 30th), unless earlier terminated by either party as provided for in this Contract."

2. Delete Section 7.6 of the Contract in its entirety and replace it with the following new Section 7.6:

"7.6 Termination Without Cause. Either party may terminate this Contract after the Initial Term, without cause, upon ninety (90) days' prior written notice to the other party as provided herein."

3. Add the following new Section 9.15 to the Contract:

"9.15 Dispute Resolution.

9.15.1 Meet and Confer. For any dispute not subject to or resolved by the provider appeals process, or if either party has a dispute it seeks to address informally, the parties shall use reasonable efforts to informally meet and confer to try and resolve the dispute. The parties shall meet and confer within thirty (30) days of a written request submitted by either party in an effort to settle any dispute. At each meet-and-confer meeting, each party shall be represented by persons with final authority to settle the dispute. If either party fails to meet within the thirty (30)-day period, that party shall be deemed to have waived the meet-and-confer requirement, and at the other party's option, the dispute may proceed immediately to arbitration under Section 9.15.2.

9.15.2 Arbitration. If the parties are unable to resolve any dispute arising out of or relating to this Contract under Section 9.15.1, either party may submit the dispute for resolution exclusively through confidential, binding arbitration, instead of through trial by court or jury, in Orange County, California. The parties may agree in writing prior to commencing the arbitration on the dispute resolution rules and arbitration service that will be used to resolve the dispute. If the parties cannot reach such an agreement, the arbitration will be conducted by Judicial Arbitration and Mediation Services ("JAMS") in accordance with the commercial dispute rules then in effect for JAMS; provided, however, that this Contract shall control in instances where it conflicts with JAMS's (or the applicable arbitration service's) rules. The arbitration shall be conducted on an expedited basis by a single arbitrator. The parties prefer that the arbitrator be a retired judge of the California Superior, Appellate, or Supreme Court or of a United States court sitting in California. If no such retired judge is available, the arbitrator may be an attorney with at least fifteen (15) years of experience, including at least five (5) years in managed health care. If the parties are unable to agree on the arbitrator within thirty (30) days of the date that the arbitration service accepts the arbitration, the arbitrator shall be selected by the arbitration service from a list of four potential arbitrators (all of whom shall be on arbitration services' panel of arbitrators) submitted by the parties, two from each side; provided, however, that nothing stated in this section shall prevent a party from disqualifying an arbitrator based on a conflict of interest. In making decisions about discovery and case management, it is the parties' express agreement and intent that the arbitrator at all times promote efficiency without denying either party the ability to present relevant evidence. In reaching and issuing decisions, the arbitrator shall have no jurisdiction to make errors of law and/or legal reasoning. The parties shall share the costs of arbitration equally, and each party shall bear its own attorneys' fees and costs.

9.15.3 Waiver. By agreeing to binding arbitration as set forth in Section 9.15.2, the parties acknowledge that they are waiving certain substantial rights and protections which otherwise may be available if a dispute between them was determined by litigation in a court, including the right to a jury trial, attorneys' fees, and certain rights of appeal."

4. **CONTRACT REMAINS IN FULL FORCE AND EFFECT**. Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. After the Amendment Effective Date, any reference to the Contract shall mean the Contract as amended and supplemented by this Amendment. Notwithstanding anything to the contrary in the Contract, in the event of a conflict between the terms and conditions of this Amendment and those contained within the Contract, the terms and conditions of this Amendment shall prevail. Capitalized terms not otherwise defined in this Amendment shall have the meanings ascribed to them in the Contract. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

[signature page follows]

IN WITNESS WHEREOF, CalOptima and Provider have executed this Amendment:

FOR PROVIDER:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Yunkyung Kim
PRINT NAME	PRINT NAME
_____	Chief Operating Officer
TITLE	TITLE
_____	_____
DATE	DATE

AMENDMENT No. X TO
ANCILLARY SERVICES CONTRACT FOR NON-MEDICAL PROVIDER

This Amendment No. X to the Ancillary Services Contract, Non-Medical Provider ("**Amendment**") is effective as of [insert date] ("**Amendment Effective Date**"), by and between Orange County Health Authority, a Public Agency, dba CalOptima ("**CalOptima**"), and [insert provider name] ("**Provider**"), with respect to the following:

RECITALS

A. CalOptima and Provider entered into an Ancillary Services Contract, Non-Medical Provider ("**Contract**") under which Provider has agreed to furnish certain items and services to CalOptima Members.

B. CalOptima and Provider desire to amend certain terms of the Contract.

NOW, THEREFORE, the parties agree as follows:

1. Delete Section 7.1 of the Contract in its entirety and replace it with the following new Section 7.1:

"7.1 Term. The term of this Contract shall become effective on the Effective Date and continue in effect through June 30, 2023 ("Initial Term"). This Contract shall then automatically extend for additional one-year-terms (July 1st through June 30th), unless earlier terminated by either party as provided for in this Contract."

2. Delete Section 7.6 of the Contract in its entirety and replace it with the following new Section 7.6:

"7.6 Termination Without Cause. Either party may terminate this Contract after the Initial Term, without cause, upon ninety (90) days' prior written notice to the other party as provided herein."

3. Add the following new Section 9.15 to the Contract:

"9.15 Dispute Resolution.

9.15.1 Meet and Confer. For any dispute not subject to or resolved by the provider appeals process, or if either party has a dispute it seeks to address informally, the parties shall use reasonable efforts to informally meet and confer to try and resolve the dispute. The parties shall meet and confer within thirty (30) days of a written request submitted by either party in an effort to settle any dispute. At each meet-and-confer meeting, each party shall be represented by persons with final authority to settle the dispute. If either party fails to meet within the thirty (30)-day period, that party shall be deemed to have waived the meet-and-confer requirement, and at the other party's option, the dispute may proceed immediately to arbitration under Section 9.15.2.

9.15.2 Arbitration. If the parties are unable to resolve any dispute arising out of or relating to this Contract under Section 9.15.1, either party may submit the dispute for resolution exclusively through confidential, binding arbitration, instead of through trial by court or jury, in Orange County, California. The parties may agree in writing prior to commencing the arbitration on the dispute resolution rules and arbitration service that will be used to resolve the dispute. If the parties cannot reach such an agreement, the arbitration will be conducted by Judicial Arbitration and Mediation Services ("JAMS") in accordance with the commercial dispute rules then in effect for JAMS; provided, however, that this Contract shall control in instances where it conflicts with JAMS's (or the applicable arbitration service's) rules. The arbitration shall be conducted on an expedited basis by a single arbitrator. The parties prefer that the arbitrator be a retired judge of the California Superior, Appellate, or Supreme Court or of a United States court sitting in California. If no such retired judge is available, the arbitrator may be an attorney with at least fifteen (15) years of experience, including at least five (5) years in managed health care. If the parties are unable to agree on the arbitrator within thirty (30) days of the date that the arbitration service accepts the arbitration, the arbitrator shall be selected by the arbitration service from a list of four potential arbitrators (all of whom shall be on arbitration services' panel of arbitrators) submitted by the parties, two from each side; provided, however, that nothing stated in this section shall prevent a party from disqualifying an arbitrator based on a conflict of interest. In making decisions about discovery and case management, it is the parties' express agreement and intent that the arbitrator at all times promote efficiency without denying either party the ability to present relevant evidence. In reaching and issuing decisions, the arbitrator shall have no jurisdiction to make errors of law and/or legal reasoning. The parties shall share the costs of arbitration equally, and each party shall bear its own attorneys' fees and costs.

9.15.3 Waiver. By agreeing to binding arbitration as set forth in Section 9.15.2, the parties acknowledge that they are waiving certain substantial rights and protections which otherwise may be available if a dispute between them was determined by litigation in a court, including the right to a jury trial, attorneys' fees, and certain rights of appeal."

4. **CONTRACT REMAINS IN FULL FORCE AND EFFECT**. Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. After the Amendment Effective Date, any reference to the Contract shall mean the Contract as amended and supplemented by this Amendment. Notwithstanding anything to the contrary in the Contract, in the event of a conflict between the terms and conditions of this Amendment and those contained within the Contract, the terms and conditions of this Amendment shall prevail. Capitalized terms not otherwise defined in this Amendment shall have the meanings ascribed to them in the Contract. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

[signature page follows]

IN WITNESS WHEREOF, CalOptima and Provider have executed this Amendment:

FOR PROVIDER:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Yunkyung Kim
PRINT NAME	PRINT NAME
_____	Chief Operating Officer
TITLE	TITLE
_____	_____
DATE	DATE

AMENDMENT No. X TO
PROFESSIONAL SERVICES CONTRACT

This Amendment No. X to the Professional Services Contract ("**Amendment**") is effective as of [insert date] ("**Amendment Effective Date**"), by and between Orange County Health Authority, a Public Agency, dba CalOptima ("**CalOptima**"), and [insert provider name] ("**Professional**"), with respect to the following:

RECITALS

A. CalOptima and Professional entered into a Professional Services Contract ("**Contract**") under which Professional has agreed to furnish certain items and services to CalOptima Members.

B. CalOptima and Professional desire to amend certain terms of the Contract.

NOW, THEREFORE, the parties agree as follows:

1. Delete Section 7.1 of the Contract in its entirety and replace it with the following new Section 7.1:

"7.1 Term. The term of this Contract shall become effective on the Effective Date and continue in effect through June 30, 2023 ("Initial Term"). This Contract shall then automatically extend for additional one-year-terms (July 1st through June 30th), unless earlier terminated by either party as provided for in this Contract."

2. Delete Section 7.7 of the Contract in its entirety and replace it with the following new Section 7.7:

"7.7 Termination Without Cause. Either party may terminate this Contract after the Initial Term, without cause, upon ninety (90) days' prior written notice to the other party as provided herein."

3. Add the following new Section 9.18 to the Contract:

"9.18 Dispute Resolution.

9.18.1 Meet and Confer. For any dispute not subject to or resolved by the provider appeals process, or if either party has a dispute it seeks to address informally, the parties shall use reasonable efforts to informally meet and confer to try and resolve the dispute. The parties shall meet and confer within thirty (30) days of a written request submitted by either party in an effort to settle any dispute. At each meet-and-confer meeting, each party shall be represented by persons with final authority to settle the dispute. If either party fails to meet within the thirty (30)-day period, that party shall be deemed to have waived the meet-and-confer requirement, and at the other party's option, the dispute may proceed immediately to arbitration under Section 9.18.2.

9.18.2 Arbitration. If the parties are unable to resolve any dispute arising out of or relating to this Contract under Section 9.18.1, either party may submit the dispute for resolution exclusively through confidential, binding arbitration, instead of through trial by court or jury, in Orange County, California. The parties may agree in writing prior to commencing the arbitration on the dispute resolution rules and arbitration service that will be used to resolve the dispute. If the parties cannot reach such an agreement, the arbitration will be conducted by Judicial Arbitration and Mediation Services ("JAMS") in accordance with the commercial dispute rules then in effect for JAMS; provided, however, that this Contract shall control in instances where it conflicts with JAMS's (or the applicable arbitration service's) rules. The arbitration shall be conducted on an expedited basis by a single arbitrator. The parties prefer that the arbitrator be a retired judge of the California Superior, Appellate, or Supreme Court or of a United States court sitting in California. If no such retired judge is available, the arbitrator may be an attorney with at least fifteen (15) years of experience, including at least five (5) years in managed health care. If the parties are unable to agree on the arbitrator within thirty (30) days of the date that the arbitration service accepts the arbitration, the arbitrator shall be selected by the arbitration service from a list of four potential arbitrators (all of whom shall be on arbitration services' panel of arbitrators) submitted by the parties, two from each side; provided, however, that nothing stated in this section shall prevent a party from disqualifying an arbitrator based on a conflict of interest. In making decisions about discovery and case management, it is the parties' express agreement and intent that the arbitrator at all times promote efficiency without denying either party the ability to present relevant evidence. In reaching and issuing decisions, the arbitrator shall have no jurisdiction to make errors of law and/or legal reasoning. The parties shall share the costs of arbitration equally, and each party shall bear its own attorneys' fees and costs.

9.18.3 By agreeing to binding arbitration as set forth in Section 9.18.2, the parties acknowledge that they are waiving certain substantial rights and protections which otherwise may be available if a dispute between them was determined by litigation in a court, including the right to a jury trial, attorneys' fees, and certain rights of appeal."

4. **CONTRACT REMAINS IN FULL FORCE AND EFFECT**. Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. After the Amendment Effective Date, any reference to the Contract shall mean the Contract as amended and supplemented by this Amendment. Notwithstanding anything to the contrary in the Contract, in the event of a conflict between the terms and conditions of this Amendment and those contained within the Contract, the terms and conditions of this Amendment shall prevail. Capitalized terms not otherwise defined in this Amendment shall have the meanings ascribed to them in the Contract. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

[signature page follows]

Continued to a Future Meeting

IN WITNESS WHEREOF, CalOptima and Professional have executed this Amendment:

FOR PROFESSIONAL:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Yunkyung Kim
PRINT NAME	PRINT NAME
_____	Chief Operating Officer
TITLE	TITLE
_____	_____
DATE	DATE

AMENDMENT No. X TO
AMENDED AND RESTATED HOSPITAL SERVICES CONTRACT

This Amendment No. X to the Amended and Restated Hospital Services Contract ("**Amendment**") is effective as of [insert date] ("**Amendment Effective Date**"), by and between Orange County Health Authority, a Public Agency, dba CalOptima ("**CalOptima**"), and [insert hospital name] ("**Hospital**"), with respect to the following:

RECITALS

A. CalOptima and Hospital entered into an Amended and Restated Hospital Services Contract ("**Contract**") under which Hospital has agreed to furnish certain items and services to CalOptima Members.

B. CalOptima and Hospital desire to amend certain terms of the Contract.

NOW, THEREFORE, the parties agree as follows:

1. Delete Section 7.1 of the Contract in its entirety and replace it with the following new Section 7.1:

"7.1 Term. The term of this Contract shall become effective on the Effective Date and continue in effect through June 30, 2023 ("Initial Term"). This Contract shall then automatically extend for additional one-year-terms (July 1st through June 30th), unless earlier terminated by either party as provided for in this Contract."

2. Delete Section 7.8 of the Contract in its entirety and replace it with the following new Section 7.8:

"7.8 Termination Without Cause. Either party may terminate this Contract after the Initial Term, without cause, upon ninety (90) days' prior written notice to the other party as provided herein."

3. Add the following new Section 9.15 to the Contract:

"9.15 Dispute Resolution.

9.15.1 Meet and Confer. For any dispute not subject to or resolved by the provider appeals process, or if either party has a dispute it seeks to address informally, the parties shall use reasonable efforts to informally meet and confer to try and resolve the dispute. The parties shall meet and confer within thirty (30) days of a written request submitted by either party in an effort to settle any dispute. At each meet-and-confer meeting, each party shall be represented by persons with final authority to settle the dispute. If either party fails to meet within the thirty (30)-day period, that party shall be deemed to have waived the meet-and-confer requirement, and at the other party's option, the dispute may proceed immediately to arbitration under Section 9.15.2.

9.15.2 Arbitration. If the parties are unable to resolve any dispute arising out of or relating to this Contract under Section 9.15.1, either party may submit the dispute for resolution exclusively through confidential, binding arbitration, instead of through trial by court or jury, in Orange County, California. The parties may agree in writing prior to commencing the arbitration on the dispute resolution rules and arbitration service that will be used to resolve the dispute. If the parties cannot reach such an agreement, the arbitration will be conducted by Judicial Arbitration and Mediation Services ("JAMS") in accordance with the commercial dispute rules then in effect for JAMS; provided, however, that this Contract shall control in instances where it conflicts with JAMS's (or the applicable arbitration service's) rules. The arbitration shall be conducted on an expedited basis by a single arbitrator. The parties prefer that the arbitrator be a retired judge of the California Superior, Appellate, or Supreme Court or of a United States court sitting in California. If no such retired judge is available, the arbitrator may be an attorney with at least fifteen (15) years of experience, including at least five (5) years in managed health care. If the parties are unable to agree on the arbitrator within thirty (30) days of the date that the arbitration service accepts the arbitration, the arbitrator shall be selected by the arbitration service from a list of four potential arbitrators (all of whom shall be on arbitration services' panel of arbitrators) submitted by the parties, two from each side; provided, however, that nothing stated in this section shall prevent a party from disqualifying an arbitrator based on a conflict of interest. In making decisions about discovery and case management, it is the parties' express agreement and intent that the arbitrator at all times promote efficiency without denying either party the ability to present relevant evidence. In reaching and issuing decisions, the arbitrator shall have no jurisdiction to make errors of law and/or legal reasoning. The parties shall share the costs of arbitration equally, and each party shall bear its own attorneys' fees and costs.

9.15.3 Waiver. By agreeing to binding arbitration as set forth in Section 9.15.2, the parties acknowledge that they are waiving certain substantial rights and protections which otherwise may be available if a dispute between them was determined by litigation in a court, including the right to a jury trial, attorneys' fees, and certain rights of appeal."

4. **CONTRACT REMAINS IN FULL FORCE AND EFFECT**. Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. After the Amendment Effective Date, any reference to the Contract shall mean the Contract as amended and supplemented by this Amendment. Notwithstanding anything to the contrary in the Contract, in the event of a conflict between the terms and conditions of this Amendment and those contained within the Contract, the terms and conditions of this Amendment shall prevail. Capitalized terms not otherwise defined in this Amendment shall have the meanings ascribed to them in the Contract. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

[signature page follows]

Continued to a Future Meeting

IN WITNESS WHEREOF, CalOptima and Hospital have executed this Amendment:

FOR HOSPIAL:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Yunkyung Kim
PRINT NAME	PRINT NAME
_____	Chief Operating Officer
TITLE	TITLE
_____	_____
DATE	DATE

AMENDMENT No. X TO
THE AMENDED AND RESTATED CONTRACT FOR HEALTH CARE SERVICES

This Amendment No. X to the Amended and Restated Contract for Health Care Services ("**Amendment**") is effective as of [insert date] ("**Amendment Effective Date**"), by and between Orange County Health Authority, a Public Agency, dba CalOptima ("**CalOptima**"), and [insert HMO name] ("**HMO**"), with respect to the following:

RECITALS

A. CalOptima and HMO entered into an Amended and Restated Contract for Health Care Services ("**Contract**") under which HMO has agreed to provide or arrange for the provision of Covered Services to Members.

B. CalOptima and HMO desire to amend certain terms of the Contract.

NOW, THEREFORE, the parties agree as follows:

1. Section 14.19 of the Contract shall be added as follows:

"14.19 DISPUTE RESOLUTION".

14.19.1 Meet and Confer. For any dispute not subject to or resolved by the provider appeals process, or if either party has a dispute it seeks to address informally, the parties shall use reasonable efforts to informally meet and confer to try and resolve the dispute. The parties shall meet and confer within thirty (30) days of a written request submitted by either party in an effort to settle any dispute. At each meet-and-confer meeting, each party shall be represented by persons with final authority to settle the dispute. If either party fails to meet within the thirty (30)-day period, that party shall be deemed to have waived the meet-and-confer requirement, and at the other party's option, the dispute may proceed immediately to arbitration under Section 14.19.2.

14.19.2 Arbitration. If the parties are unable to resolve any dispute arising out of or relating to this Contract under Section 14.19.1, either party may submit the dispute for resolution exclusively through confidential, binding arbitration, instead of through trial by court or jury, in Orange County, California. The parties may agree in writing prior to commencing the arbitration on the dispute resolution rules and arbitration service that will be used to resolve the dispute. If the parties cannot reach such an agreement, the arbitration will be conducted by Judicial Arbitration and Mediation Services ("JAMS") in accordance with the commercial dispute rules then in effect for JAMS; provided, however, that this Contract shall control in instances where it conflicts with JAMS's (or the applicable arbitration service's) rules. The arbitration shall be conducted on an expedited basis by a single arbitrator. The parties prefer that the arbitrator

be a retired judge of the California Superior, Appellate, or Supreme Court or of a United States court sitting in California. If no such retired judge is available, the arbitrator may be an attorney with at least fifteen (15) years of experience, including at least five (5) years in managed health care. If the parties are unable to agree on the arbitrator within thirty (30) days of the date that the arbitration service accepts the arbitration, the arbitrator shall be selected by the arbitration service from a list of four potential arbitrators (all of whom shall be on arbitration services' panel of arbitrators) submitted by the parties, two from each side; provided, however, that nothing stated in this section shall prevent a party from disqualifying an arbitrator based on a conflict of interest. In making decisions about discovery and case management, it is the parties' express agreement and intent that the arbitrator at all times promote efficiency without denying either party the ability to present relevant evidence. In reaching and issuing decisions, the arbitrator shall have no jurisdiction to make errors of law and/or legal reasoning. The parties shall share the costs of arbitration equally, and each party shall bear its own attorneys' fees and costs.

14.19.3 Waiver. By agreeing to binding arbitration as set forth in Section 14.19.2, the parties acknowledge that they are waiving certain substantial rights and protections which otherwise may be available if a dispute between them was determined by litigation in a court, including the right to a jury trial, attorneys' fees, and certain rights of appeal."

2. Section 15.1 shall be deleted in its entirety and replaced with the following:

"15.1 SUBJECT TO (I) THE STATE OF CALIFORNIA AND THE UNITED STATES PROVIDING FUNDS FOR THE TERM OF THIS CONTRACT AND FOR THE PURPOSES FOR WHICH IT IS ENTERED INTO; (II) THE APPROVAL OF THIS CONTRACT BY CALOPTIMA AND THE STATE, THE TERM OF THIS CONTRACT SHALL BE FROM JUNE 30, 2022, THROUGH JUNE 30, 2023. THE CONTRACT SHALL THEN AUTOMATICALLY EXTEND FOR ONE (1)-YEAR TERMS (JULY 1ST THROUGH JUNE 30TH), UNLESS EARLIER TERMINATED BY EITHER PARTY AS PROVIDED FOR IN THIS CONTRACT."

3. **CONTRACT REMAINS IN FULL FORCE AND EFFECT**. Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. After the Amendment Effective Date, any reference to the Contract shall mean the Contract as amended and supplemented by this Amendment. Notwithstanding anything to the contrary in the Contract, in the event of a conflict between the terms and conditions of this Amendment and those contained within the Contract, the terms and conditions of this Amendment shall prevail. Capitalized terms not otherwise defined in this Amendment shall have the meanings ascribed to them in the Contract. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

Continued to a Future Meeting

IN WITNESS WHEREOF, CalOptima and HMO have executed this Amendment:

FOR HMO:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Yunkyung Kim
PRINT NAME	PRINT NAME
_____	Chief Operating Officer
TITLE	TITLE
_____	_____
DATE	DATE

AMENDMENT No. X TO
THE AMENDED AND RESTATED CONTRACT FOR HEALTH CARE SERVICES
(PHYSICIAN (SHARED RISK))

This Amendment No. X to the Amended and Restated Contract for Health Care Services (Physician (Shared Risk)) ("**Amendment**") is effective as of [insert date] ("**Amendment Effective Date**"), by and between Orange County Health Authority, a Public Agency, dba CalOptima ("**CalOptima**"), and [insert physician name] ("**Physician**"), with respect to the following:

RECITALS

A. CalOptima and Physician entered into an Amended and Restated Contract for Health Care Services (Physician (Shared Risk)) ("**Contract**") under which Physician has agreed to provide or arrange for the provision of Covered Services to Members.

B. CalOptima and Physician desire to amend certain terms of the Contract.

NOW, THEREFORE, the parties agree as follows:

1. Section 14.19 of the Contract shall be added as follows:

"14.19 DISPUTE RESOLUTION".

14.19.1 Meet and Confer. For any dispute not subject to or resolved by the provider appeals process, or if either party has a dispute it seeks to address informally, the parties shall use reasonable efforts to informally meet and confer to try and resolve the dispute. The parties shall meet and confer within thirty (30) days of a written request submitted by either party in an effort to settle any dispute. At each meet-and-confer meeting, each party shall be represented by persons with final authority to settle the dispute. If either party fails to meet within the thirty (30)-day period, that party shall be deemed to have waived the meet-and-confer requirement, and at the other party's option, the dispute may proceed immediately to arbitration under Section 14.19.2.

14.19.2 Arbitration. If the parties are unable to resolve any dispute arising out of or relating to this Contract under Section 14.19.1, either party may submit the dispute for resolution exclusively through confidential, binding arbitration, instead of through trial by court or jury, in Orange County, California. The parties may agree in writing prior to commencing the arbitration on the dispute resolution rules and arbitration service that will be used to resolve the dispute. If the parties cannot reach such an agreement, the arbitration will be conducted by Judicial Arbitration and Mediation Services ("JAMS") in accordance with the commercial dispute rules then in effect for JAMS; provided, however, that this Contract shall control in instances where it conflicts with JAMS's (or the applicable

arbitration service's) rules. The arbitration shall be conducted on an expedited basis by a single arbitrator. The parties prefer that the arbitrator be a retired judge of the California Superior, Appellate, or Supreme Court or of a United States court sitting in California. If no such retired judge is available, the arbitrator may be an attorney with at least fifteen (15) years of experience, including at least five (5) years in managed health care. If the parties are unable to agree on the arbitrator within thirty (30) days of the date that the arbitration service accepts the arbitration, the arbitrator shall be selected by the arbitration service from a list of four potential arbitrators (all of whom shall be on arbitration services' panel of arbitrators) submitted by the parties, two from each side; provided, however, that nothing stated in this section shall prevent a party from disqualifying an arbitrator based on a conflict of interest. In making decisions about discovery and case management, it is the parties' express agreement and intent that the arbitrator at all times promote efficiency without denying either party the ability to present relevant evidence. In reaching and issuing decisions, the arbitrator shall have no jurisdiction to make errors of law and/or legal reasoning. The parties shall share the costs of arbitration equally, and each party shall bear its own attorneys' fees and costs.

14.19.3 Waiver. By agreeing to binding arbitration as set forth in Section 14.19.2, the parties acknowledge that they are waiving certain substantial rights and protections which otherwise may be available if a dispute between them was determined by litigation in a court, including the right to a jury trial, attorneys' fees, and certain rights of appeal."

2. Section 15.1 shall be deleted in its entirety and replaced with the following:

"15.1 SUBJECT TO (I) THE STATE OF CALIFORNIA AND THE UNITED STATES PROVIDING FUNDS FOR THE TERM OF THIS CONTRACT AND FOR THE PURPOSES FOR WHICH IT IS ENTERED INTO; (II) THE APPROVAL OF THIS CONTRACT BY CALOPTIMA AND THE STATE, THE TERM OF THIS CONTRACT SHALL BE FROM JUNE 30, 2022, THROUGH JUNE 30, 2023. THE CONTRACT SHALL THEN AUTOMATICALLY EXTEND FOR ONE (1)-YEAR TERMS (JULY 1ST THROUGH JUNE 30TH), UNLESS EARLIER TERMINATED BY EITHER PARTY AS PROVIDED FOR IN THIS CONTRACT."

3. **CONTRACT REMAINS IN FULL FORCE AND EFFECT**. Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. After the Amendment Effective Date, any reference to the Contract shall mean the Contract as amended and supplemented by this Amendment. Notwithstanding anything to the contrary in the Contract, in the event of a conflict between the terms and conditions of this Amendment and those contained within the Contract, the terms and conditions of this Amendment shall prevail. Capitalized terms not otherwise defined in this Amendment shall have the meanings ascribed to them in the Contract. This

Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS WHEREOF, CalOptima and Physician have executed this Amendment:

FOR PHYSICIAN:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Yunkyung Kim
PRINT NAME	PRINT NAME
_____	Chief Operating Officer
TITLE	TITLE
_____	_____
DATE	DATE

AMENDMENT No. X TO
THE AMENDED AND RESTATED CONTRACT FOR HEALTH CARE SERVICES
(MEDI-CAL PHC – HOSPITAL)

This Amendment No. X to the Amended and Restated Contract for Health Care Services (Medi-Cal PHC – Hospital) ("**Amendment**") is effective as of [insert date] ("**Amendment Effective Date**"), by and between Orange County Health Authority, a Public Agency, dba CalOptima ("**CalOptima**"), and [insert hospital name] ("**Hospital**"), with respect to the following:

RECITALS

A. CalOptima and Hospital entered into an Amended and Restated Contract for Health Care Services (Medi-Cal PHC – Hospital) ("**Contract**") under which Hospital has agreed to provide or arrange for the provision of Covered Services to Members.

B. CalOptima and Hospital desire to amend certain terms of the Contract.

NOW, THEREFORE, the parties agree as follows:

1. Section 14.19 of the Contract shall be added as follows:

"14.19 DISPUTE RESOLUTION".

14.19.1 Meet and Confer. For any dispute not subject to or resolved by the provider appeals process, or if either party has a dispute it seeks to address informally, the parties shall use reasonable efforts to informally meet and confer to try and resolve the dispute. The parties shall meet and confer within thirty (30) days of a written request submitted by either party in an effort to settle any dispute. At each meet-and-confer meeting, each party shall be represented by persons with final authority to settle the dispute. If either party fails to meet within the thirty (30)-day period, that party shall be deemed to have waived the meet-and-confer requirement, and at the other party's option, the dispute may proceed immediately to arbitration under Section 14.19.2.

14.19.2 Arbitration. If the parties are unable to resolve any dispute arising out of or relating to this Contract under Section 14.19.1, either party may submit the dispute for resolution exclusively through confidential, binding arbitration, instead of through trial by court or jury, in Orange County, California. The parties may agree in writing prior to commencing the arbitration on the dispute resolution rules and arbitration service that will be used to resolve the dispute. If the parties cannot reach such an agreement, the arbitration will be conducted by Judicial Arbitration and Mediation Services ("JAMS") in accordance with the commercial dispute rules then in effect for JAMS; provided, however, that this Contract shall control in instances where it conflicts with JAMS's (or the applicable arbitration service's) rules. The arbitration shall be conducted on an

expedited basis by a single arbitrator. The parties prefer that the arbitrator be a retired judge of the California Superior, Appellate, or Supreme Court or of a United States court sitting in California. If no such retired judge is available, the arbitrator may be an attorney with at least fifteen (15) years of experience, including at least five (5) years in managed health care. If the parties are unable to agree on the arbitrator within thirty (30) days of the date that the arbitration service accepts the arbitration, the arbitrator shall be selected by the arbitration service from a list of four potential arbitrators (all of whom shall be on arbitration services' panel of arbitrators) submitted by the parties, two from each side; provided, however, that nothing stated in this section shall prevent a party from disqualifying an arbitrator based on a conflict of interest. In making decisions about discovery and case management, it is the parties' express agreement and intent that the arbitrator at all times promote efficiency without denying either party the ability to present relevant evidence. In reaching and issuing decisions, the arbitrator shall have no jurisdiction to make errors of law and/or legal reasoning. The parties shall share the costs of arbitration equally, and each party shall bear its own attorneys' fees and costs.

14.19.3 Waiver. By agreeing to binding arbitration as set forth in Section 14.19.2, the parties acknowledge that they are waiving certain substantial rights and protections which otherwise may be available if a dispute between them was determined by litigation in a court, including the right to a jury trial, attorneys' fees, and certain rights of appeal."

2. Section 15.1 shall be deleted in its entirety and replaced with the following:

"15.1 SUBJECT TO (I) THE STATE OF CALIFORNIA AND THE UNITED STATES PROVIDING FUNDS FOR THE TERM OF THIS CONTRACT AND FOR THE PURPOSES FOR WHICH IT IS ENTERED INTO; (II) THE APPROVAL OF THIS CONTRACT BY CALOPTIMA AND THE STATE, THE TERM OF THIS CONTRACT SHALL BE FROM JUNE 30, 2022, THROUGH JUNE 30, 2023. THE CONTRACT SHALL THEN AUTOMATICALLY EXTEND FOR ONE (1)-YEAR TERMS (JULY 1ST THROUGH JUNE 30TH), UNLESS EARLIER TERMINATED BY EITHER PARTY AS PROVIDED FOR IN THIS CONTRACT."

3. **CONTRACT REMAINS IN FULL FORCE AND EFFECT**. Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. After the Amendment Effective Date, any reference to the Contract shall mean the Contract as amended and supplemented by this Amendment. Notwithstanding anything to the contrary in the Contract, in the event of a conflict between the terms and conditions of this Amendment and those contained within the Contract, the terms and conditions of this Amendment shall prevail. Capitalized terms not otherwise defined in this Amendment shall have the meanings ascribed to them in the Contract. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

Continued to a Future Meeting

IN WITNESS WHEREOF, CalOptima and Hospital have executed this Amendment:

FOR HOSPITAL:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Yunkyung Kim
PRINT NAME	PRINT NAME
_____	Chief Operating Officer
TITLE	TITLE
_____	_____
DATE	DATE

AMENDMENT No. X TO
THE AMENDED AND RESTATED CONTRACT FOR HEALTH CARE SERVICES
(MEDI-CAL PHC – PHYISCIAN)

This Amendment No. X to the Amended and Restated Contract for Health Care Services (Medi-Cal PHC – Physician) ("**Amendment**") is effective as of [insert date] ("**Amendment Effective Date**"), by and between Orange County Health Authority, a Public Agency, dba CalOptima ("**CalOptima**"), and [insert physician name] ("**Physician**"), with respect to the following:

RECITALS

A. CalOptima and Physician entered into an Amended and Restated Contract for Health Care Services (Medi-Cal PHC – Physician) ("**Contract**") under which Physician has agreed to provide or arrange for the provision of Covered Services to Members.

B. CalOptima and Physician desire to amend certain terms of the Contract.

NOW, THEREFORE, the parties agree as follows:

1. Section 14.19 of the Contract shall be added as follows:

"14.19 DISPUTE RESOLUTION".

14.19.1 Meet and Confer. For any dispute not subject to or resolved by the provider appeals process, or if either party has a dispute it seeks to address informally, the parties shall use reasonable efforts to informally meet and confer to try and resolve the dispute. The parties shall meet and confer within thirty (30) days of a written request submitted by either party in an effort to settle any dispute. At each meet-and-confer meeting, each party shall be represented by persons with final authority to settle the dispute. If either party fails to meet within the thirty (30)-day period, that party shall be deemed to have waived the meet-and-confer requirement, and at the other party's option, the dispute may proceed immediately to arbitration under Section 14.19.2.

14.19.2 Arbitration. If the parties are unable to resolve any dispute arising out of or relating to this Contract under Section 14.19.1, either party may submit the dispute for resolution exclusively through confidential, binding arbitration, instead of through trial by court or jury, in Orange County, California. The parties may agree in writing prior to commencing the arbitration on the dispute resolution rules and arbitration service that will be used to resolve the dispute. If the parties cannot reach such an agreement, the arbitration will be conducted by Judicial Arbitration and Mediation Services ("JAMS") in accordance with the commercial dispute rules then in effect for JAMS; provided, however, that this Contract shall control in instances where it conflicts with JAMS's (or the applicable arbitration service's) rules. The arbitration shall be conducted on an

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expedited basis by a single arbitrator. The parties prefer that the arbitrator be a retired judge of the California Superior, Appellate, or Supreme Court or of a United States court sitting in California. If no such retired judge is available, the arbitrator may be an attorney with at least fifteen (15) years of experience, including at least five (5) years in managed health care. If the parties are unable to agree on the arbitrator within thirty (30) days of the date that the arbitration service accepts the arbitration, the arbitrator shall be selected by the arbitration service from a list of four potential arbitrators (all of whom shall be on arbitration services' panel of arbitrators) submitted by the parties, two from each side; provided, however, that nothing stated in this section shall prevent a party from disqualifying an arbitrator based on a conflict of interest. In making decisions about discovery and case management, it is the parties' express agreement and intent that the arbitrator at all times promote efficiency without denying either party the ability to present relevant evidence. In reaching and issuing decisions, the arbitrator shall have no jurisdiction to make errors of law and/or legal reasoning. The parties shall share the costs of arbitration equally, and each party shall bear its own attorneys' fees and costs.

14.19.3 Waiver. By agreeing to binding arbitration as set forth in Section 14.19.2, the parties acknowledge that they are waiving certain substantial rights and protections which otherwise may be available if a dispute between them was determined by litigation in a court, including the right to a jury trial, attorneys' fees, and certain rights of appeal."

2. Section 15.1 shall be deleted in its entirety and replaced with the following:

"15.1 SUBJECT TO (I) THE STATE OF CALIFORNIA AND THE UNITED STATES PROVIDING FUNDS FOR THE TERM OF THIS CONTRACT AND FOR THE PURPOSES FOR WHICH IT IS ENTERED INTO; (II) THE APPROVAL OF THIS CONTRACT BY CALOPTIMA AND THE STATE, THE TERM OF THIS CONTRACT SHALL BE FROM JUNE 30, 2022, THROUGH JUNE 30, 2023. THE CONTRACT SHALL THEN AUTOMATICALLY EXTEND FOR ONE (1)-YEAR TERMS (JULY 1ST THROUGH JUNE 30TH), UNLESS EARLIER TERMINATED BY EITHER PARTY AS PROVIDED FOR IN THIS CONTRACT."

3. **CONTRACT REMAINS IN FULL FORCE AND EFFECT**. Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. After the Amendment Effective Date, any reference to the Contract shall mean the Contract as amended and supplemented by this Amendment. Notwithstanding anything to the contrary in the Contract, in the event of a conflict between the terms and conditions of this Amendment and those contained within the Contract, the terms and conditions of this Amendment shall prevail. Capitalized terms not otherwise defined in this Amendment shall have the meanings ascribed to them in the Contract. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

Continued to a Future Meeting

IN WITNESS WHEREOF, CalOptima and Physician have executed this Amendment:

FOR PHYSICIAN:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Yunkyung Kim
PRINT NAME	PRINT NAME
_____	Chief Operating Officer
TITLE	TITLE
_____	_____
DATE	DATE

AMENDMENT No. __ TO
THE AMENDED AND RESTATED CONTRACT FOR HEALTH CARE SERVICES

This Amendment No. __ to the Amended and Restated Contract for Health Care Services ("**Amendment**") is effective as of [insert date] ("**Amendment Effective Date**"), 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:

RECITALS

A. CalOptima and HMO entered into an Amended and Restated Contract for Health Care Services ("**Contract**") under which HMO has agreed to provide or arrange for the provision of Covered Services to Members.

B. CalOptima and HMO desire to amend certain terms of the Contract.

NOW, THEREFORE, the parties agree as follows:

1. Section 14.19 of the Contract shall be added as follows:

"14.19 DISPUTE RESOLUTION.

14.19.1 Meet and Confer. For any dispute not subject to or resolved by the provider appeals process, or if either party has a dispute it seeks to address informally, the parties shall use reasonable efforts to informally meet and confer to try and resolve the dispute. The parties shall meet and confer within thirty (30) days of a written request submitted by either party in an effort to settle any dispute. At each meet-and-confer meeting, each party shall be represented by persons with final authority to settle the dispute. If either party fails to meet within the thirty (30)-day period, that party shall be deemed to have waived the meet-and-confer requirement, and at the other party's option, the dispute may proceed immediately to arbitration under Section 14.19.2.

14.19.2 Arbitration. If the parties are unable to resolve any dispute arising out of or relating to this Contract under Section 14.19.1, either party may submit the dispute for resolution exclusively through confidential, binding arbitration, instead of through trial by court or jury, in Orange County, California. The parties may agree in writing prior to commencing the arbitration on the dispute resolution rules and arbitration service that will be used to resolve the dispute. If the parties cannot reach such an agreement, the arbitration will be conducted by Judicial Arbitration and Mediation Services ("JAMS") in accordance with the commercial dispute rules then in effect for JAMS; provided, however, that this Contract shall control in instances where it conflicts with JAMS's (or the applicable arbitration service's) rules. The arbitration shall be conducted on an expedited basis by a single arbitrator. The parties prefer that the arbitrator

be a retired judge of the California Superior, Appellate, or Supreme Court or of a United States court sitting in California. If no such retired judge is available, the arbitrator may be an attorney with at least fifteen (15) years of experience, including at least five (5) years in managed health care. If the parties are unable to agree on the arbitrator within thirty (30) days of the date that the arbitration service accepts the arbitration, the arbitrator shall be selected by the arbitration service from a list of four potential arbitrators (all of whom shall be on arbitration services' panel of arbitrators) submitted by the parties, two from each side; provided, however, that nothing stated in this section shall prevent a party from disqualifying an arbitrator based on a conflict of interest. In making decisions about discovery and case management, it is the parties' express agreement and intent that the arbitrator at all times promote efficiency without denying either party the ability to present relevant evidence. In reaching and issuing decisions, the arbitrator shall have no jurisdiction to make errors of law and/or legal reasoning. The parties shall share the costs of arbitration equally, and each party shall bear its own attorneys' fees and costs.

14.19.3 Waiver. By agreeing to binding arbitration as set forth in Section 14.19.2, the parties acknowledge that they are waiving certain substantial rights and protections which otherwise may be available if a dispute between them was determined by litigation in a court, including the right to a jury trial, attorneys' fees, and certain rights of appeal."

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 HMO have executed this Amendment:

FOR HMO:	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
_____	Yunkyung Kim
PRINT NAME	PRINT NAME
_____	Chief Operating Officer
TITLE	TITLE

Continued to a Future Meeting

DATE

DATE

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 7, 2022
Regular Meeting of the CalOptima Board of Directors

Report Item

20. Authorize the Extension of the Quality Initiative Related to Post-Acute Infection Prevention and Authorize Related Funding for Quality Initiative Payments.

Contacts

Richard Pitts, D.O., Ph.D., Chief Medical Officer, (714) 246-8491
Kelly Giardina, MSG, CCM, Executive Director, Clinical Operations, (657) 900-1013

Recommended Actions

1. Authorize the 3-month extension of the Post-Acute Infection Prevention Quality Initiative (PIPQI) in an amount up to $275,000 for the period of April 1, 2022, through June 30, 2022; and
2. Authorize unbudgeted expenditures in an amount up to $275,000 from existing reserves for the PIPQI program in Fiscal Year 2021-22.

Background

In June 2019, the CalOptima Board of Directors approved the PIPQI program to prevent infections at contracted Skilled Nursing Facilities (SNFs) by replacing liquid soap with Chlorhexidine (CHG) soap for bathing and using Iodophor nasal swabs every other week.

The PIPQI program currently has 26 participating contracted SNFs. The facilities have been funded for CHG and Iodophor swab purchases in addition to quarterly financial incentives to the participating facilities during the PHE (Public Health Emergency). Compliance has been tracked by collecting product invoices for CHG and Iodophor along with Hospital Acquired Infection (HAI) rates. During the PHE there has been minimal success in collecting product invoices and infection rates in PIPQI facilities have not decreased as expected.

Discussion

The reopening of SNFs has created an opportunity to retrain the nursing facilities in broader infection prevention protocols, in addition to PIPQI protocol compliance. Therefore, staff requests the authorization of up to $275,000 to fund the 3 month extension of the PIPQI program, in addition to the introduction of training in the breath and scope of infection prevention protocols for the period of April 1, 2022, through June 30, 2023. Specifically, funds will be used for CalOptima LTSS nursing facility infection prevention training, PIPQI training, CHG/Iodophor swab funding, staffing, and quality compliance assessment and analysis of infection prevention. These activities and future training will be absorbed by the SNF's after June 30, 2022.

This program will train and equip the SNF's to continue to safeguard the health and safety of CalOptima members in nursing facilities. Staff will analyze and evaluate the program's efficacy and return to the Board in the future with additional recommendations.

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Fiscal Impact
The recommended action is unbudgeted. An appropriation of up to $275,000 from existing reserves would fund this action from April 1, 2022, through June 30, 2022.

Rationale for Recommendation
The PIPQI program has not produced the same results as the initial SHIELD study likely due to the PHE. The goal is to expand infection prevention training beyond PIPQI protocols and monitor compliance and the efficacy of the PIPQI program until June 30, 2022. Staff will analyze and evaluate the program's efficacy and return to the Board in the future with additional recommendations.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Entities Covered by Recommended Action

Board Action(s)

Board Meeting Dates	Action	Term	Not to Exceed Amount
6/6/2019	COBAR	1 Year	$2.3 million
4/2/2020	COBAR	3 Year	$3.4 million
4/20/2020	COBAR	Concurrent with 3 year	No change

/s/ Michael Hunn — **Authorized Signature**
03/31/2022 — **Date**

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LIST OF CONTRACTED LONG TERM CARE (LTC) FACILITIES

As of January 2022

	PROVIDER NAME	ADDRESS 1	ADDRESS 2	CITY	STATE	ZIP CODE
	ORANGE COUNTY (61)					
1	Advanced Rehab Center of Tustin	2210 E First St		Santa Ana	CA	927053802
2	Alamitos West Health and Rehabilitation	3902 Katella Ave		Los Alamitos	CA	907203304
3	Alta Gardens Care Center	13075 Blackbird St		Garden Grove	CA	92843
4	Anaheim Crest Nursing Center	3067 W Orange Ave		Anaheim	CA	92804
5	Anaheim Healthcare Center	501 S Beach Blvd		Anaheim	CA	92804
6	Anaheim Terrace Care Center	141 S Knott Ave		Anaheim	CA	92804
7	Beachside Nursing Center	7781 Garfield Ave		Huntington Beach	CA	92648
8	Buena Park Nursing Center	8520 Western Ave		Buena Park	CA	90620
9	Buena Vista Care Center	1440 S Euclid St		Anaheim	CA	92802
10	Capistrano Beach Care Center	35410 Del Rey		Capistrano Beach	CA	92624
11	Chapman Care Center	12232 Chapman Ave		Garden Grove	CA	92840
12	Country Villa Plaza Healthcare Center	1209 Hemlock Way		Santa Ana	CA	92707
13	Coventry Court Health Center	2040 S Euclid Ave		Anaheim	CA	92802
14	Crystal Cove Care Center	1445 Superior Ave		Newport Beach	CA	92663
15	Extended Care Hospital of Westminister	206 Hospital Cir		Westminster	CA	926833910
16	Flagship Healthcare Center	466 Flagship Rd		Newport Beach	CA	92663
17	Freedom Village Healthcare	23442 El Toro Rd	Bldg 2	Lake Forest	CA	92630
18	French Park Care Center	600 E Washington Ave		Santa Ana	CA	92701
19	Garden Grove Convalescent Hospital	12882 Shackelford Ln		Garden Grove	CA	92841
20	Garden Park Care Center	12681 Haster St		Garden Grove	CA	92840
21	Gordon Lane Care Center	1821 E Chapman		Fullerton	CA	92831
22	Greenfield Care Center of Fullerton	330 W Bastanchury Rd		Fullerton	CA	92835
23	Harbor Villa Care Center	861 S Harbor Blvd		Anaheim	CA	92805
24	Healthbridge Children's Hospital - Orange	393 S Tustin St		Orange	CA	92866
25	Healthcare Center of Orange County	9021 Knott Ave		Buena Park	CA	90620
26	Huntington Valley Healthcare Center	8382 Newman Ave		Huntington Beach	CA	926477038
27	La Habra Convalescent Hospital	1233 W La Habra Blvd		La Habra	CA	90631
28	La Palma Nursing Center	1130 W La Palma Ave		Anaheim	CA	92801

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29	Laguna Hills Health & Rehabilitation Center	24452 Health Center Dr		Laguna Hills	CA	92653
30	Lake Forest Nursing Center	25652 Old Trabuco Rd		Lake Forest	CA	92630
31	Leisure Court Nursing Center	1135 N Leisure Ct		Anaheim	CA	92801
32	Mainplace Post Acute	1835 W La Veta Ave		Orange	CA	928684132
33	ManorCare Health Services Fountain Valley	11680 Warner Ave		Fountain Valley	CA	92708
34	Mesa Verde Post Acute Care Center	661 Center St		Costa Mesa	CA	926272708
35	Mission Palms Healthcare Center	240 Hospital Circle		Westminster	CA	92683
36	New Orange Hills	5017 E Chapman Ave		Orange	CA	92869
37	Newport Nursing and Rehabilitation Center	1555 Superior Ave		Newport Beach	CA	92663
38	Newport Subacute Healthcare Center	2570 Newport Blvd		Costa Mesa	CA	92627
39	Orange Healthcare and Wellness Centre	920 W La Veta Ave		Orange	CA	92868
40	Orangegrove Rehabilitation Hospital	12332 Garden Grove Blvd		Garden Grove	CA	92843
41	Pacific Haven Subacute and Healthcare Center	12072 Trask Ave		Garden Grove	CA	92843
42	Palm Terrace Healthcare & Rehabilitation Center	24962 Calle Aragon		Laguna Woods	CA	92653
43	Park Anaheim Health Care Center	3435 W Ball Rd		Anaheim	CA	928043708
44	Parkview Healthcare Center	1514 E Lincoln Ave		Anaheim	CA	928052219
45	Regents Point-Windcrest	19191 Harvard Ave		Irvine	CA	92612
46	Sea Cliff Healthcare Center	18811 Florida St		Huntington Beach	CA	92648
47	Seal Beach Health & Rehabilitation Center	3000 North Gate Rd		Seal Beach	CA	90740
48	South Coast Post Acute	1030 W Warner Ave		Santa Ana	CA	92707
49	St Edna Subacute and Rehabilitation Center	1929 N Fairview St		Santa Ana	CA	92706
50	St Elizabeth Healthcare and Rehabilitation	2800 N Harbor Blvd		Fullerton	CA	92835
51	Stanley Healthcare Center	14102 Springdale St		Westminster	CA	926833538
52	Sun Mar Nursing Center - Anaheim	1720 W Orange Ave		Anaheim	CA	92804
53	Terrace View Care Center	201 E Bastanchury Rd		Fullerton	CA	92835
54	The Hills Post Acute	1800 Old Tustin Ave		Santa Ana	CA	927057810
55	The Pavillion at Sunny Hills	2222 N Harbor Blvd		Fullerton	CA	92835
56	Town & Country Manor	555 E Memory Ln		Santa Ana	CA	92706
57	Victoria Healthcare and Rehabilitation	340 Victoria St		Costa Mesa	CA	92627
58	West Anaheim Extended Care	645 S Beach Blvd		Anaheim	CA	92804
59	West Anaheim Medical Center -Adult Subacute	3033 W Orange Ave		Anaheim	CA	92804
60	Windsor Gardens Care Center of Fullerton	245 E Wilshire Ave		Fullerton	CA	92832
61	Windsor Gardens of Anaheim	3415 W Ball Rd		Anaheim	CA	92804

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Source: Provider Relations 1272022

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 7, 2022
Regular Meeting of the CalOptima Board of Directors

Report Item
21. Adopt Resolution Approving and Adopting Updated CalOptima Policy GA.8042: Supplemental Compensation and Appropriation of Funds and Authorization of Unbudgeted Expenditures

Contacts
Michael Hunn, Chief Executive Officer, (657) 900-1481
Brigette Hoey, Executive Director, Human Resources, (714) 246-8405

Recommended Actions
1. Adopt Resolution Approving Updated CalOptima Policy GA.8042: Supplemental Compensation.
2. Appropriate funds and authorize unbudgeted expenditures in an amount up to $350,000 from existing reserves to fund commuter allowance for the period of ~~April 10, 2022~~ April 24, 2022, through June 30, 2022. *Rev. 04/07/2022*
3. Appropriate funds and authorize unbudgeted expenditures in an amount up to $16,000 from existing reserves to fund holiday premium pay for the period of ~~April 10, 2022~~ April 24, 2022, through June 30, 2022.

Background and Discussion
Near CalOptima's inception, the Board of Directors delegated authority to the CEO to develop and implement employee policies and procedures, and to amend them as appropriate from time to time, subject to annual updates to the Board, with emphasis on changes. CalOptima's Bylaws require that the Board adopt by resolution, and from time to time amend, procedures, practices, and policies for, among other things, hiring employees and managing personnel.

Commuter Allowance

As CalOptima transitions temporary teleworkers into full office work, partial telework, or full telework it is acknowledged that employee costs associated with working in the office are greater than the costs associated with working from home. According to several estimates, office workers have increased costs associated with compliance with employer dress codes and commuting to and from the office that average $4,000 per year. To offset the costs associated with Full Office Workers and Partial Teleworkers commuting to and from the office and complying with CalOptima's Dress Code, staff recommends the following Commuter Allowance under GA.8042 Supplemental Compensation.

- Full-time employees designated Full Office Workers will receive one hundred fifty dollars ($150.00) per pay period starting on the beginning of the first full pay period assigned to full office work.
- Full-time employees designated Partial Teleworkers will receive seventy-five dollars ($75.00) per pay period starting on the beginning of the first full pay period assigned to partial office work.

The Commuter Allowance will be in effect April 24, 2022 through ~~July 1, 2023~~ June 30, 2023 and may *Rev. 4/7/2022*

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continue beyond July 1, 2023 and/or be reinstated after July 1, 2023 with approval of the Chief Executive Officer.

Holiday Premium Pay

CalOptima observes ten (10) paid holidays and one (1) floating holiday during the calendar year as described in GA.8056 – Paid Holidays. At times, due to business needs, employees are required to work on a CalOptima observed paid holiday. Because the Fair Labor Standards Act (FLSA) overtime calculation is based on hours worked over forty (40) in a workweek, employees who work on a CalOptima observed paid holiday do not automatically incur overtime pay of one and one half (1.5) times their regular rate of pay. Staff recommends that full-time employees who are eligible to receive a CalOptima observed paid holiday but are required to work the holiday be paid at two (2) times their regular base pay, for the time worked in addition to the holiday pay. For purposes of this provision, the paid holiday begins at 12:00 a.m. and ends at 11:59 p.m. the same day.

Policy Section	Proposed Change	Rationale	Impact
II, II.C, and III.B	Add Holiday Premium Pay of two (2) times employees' regular base pay for eligible, non-exempt employees required to work during an observed CalOptima paid holiday.	To compensate employees at a premium for being required to work during a CalOptima observed paid holiday.	Because overtime is calculated based on hours worked, the hours an employee works on a CalOptima observed paid holiday are not considered hours worked in the FLSA overtime calculation. Compensating employees required to work on a CalOptima observed paid holiday will guarantee they are paid a premium for working the holiday.
II.C.	Added statements to On Call that employee can be engaged "so long as they are fit to respond when called."	Clarify that employees must be fit to respond in order to engage in On Call work.	Clarity and setting expectations for performance.
II.H and III.G	Add Commuter Allowance of one hundred fifty dollars ($150.00) and seventy-five dollars ($75.00) per pay period for full-time employees designated as Full Office Workers and Partial Teleworkers respectively.	To mitigate the differences in costs associated with working in the office versus working at home.	Employees designated as Full Office Workers and Partial Teleworkers will have greater compensation parity with their counterparts designated as Full Teleworkers.
II.J and III.I.2	Changed "superior" performance to "outstanding" performance.	To align with CalPERS approved executive incentive form.	Aligns with form.

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Policy Section	Proposed Change	Rationale	Impact
IX	Added the following terms to the Glossary: Central Worksite, Full Office Worker, Full Teleworker, Partial Teleworker, and Executive Level Positions	To provide definitions for terms used in policy.	Provides clarity and consistency.
Attachment A	Minor edits to text.	To align with current terminology and practice.	Provides clarity and consistency.
Attachment B	Minor edits to align with current template, include gender neutral language, and adjust formatting.	Provides consistency and incorporates gender neutral language.	Provides consistency.

Fiscal Impact

The recommended actions to authorize expenditures to fund commuter allowances and holiday premium pay for the period of April 24, 2022, through June 30, 2022, are unbudgeted. A proposed allocation of up to $366,000 from existing reserves will fund these actions.

The annual fiscal impact for commuter allowances is approximately $1,800,000 and approximately $160,000 for holiday premium pay. Staff will include updated administrative expenses in the CalOptima Fiscal Year 2022-23 Operating Budget.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Resolution No. 22-0407-02, Approve Updated Human Resources Policy
2. Revised CalOptima Policy
   a. GA.8042: Supplemental Compensation
3. CalOptima Policy GA.8056 Paid Holidays
4. CalOptima Policy GA.8059 Attendance and Timekeeping

/s/ Michael Hunn — *03/31/2022*

Authorized Signature — **Date**

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RESOLUTION NO. 22-0407-02

RESOLUTION OF THE BOARD OF DIRECTORS ORANGE COUNTY HEALTH AUTHORITY
d.b.a. CalOptima

APPROVE UPDATED CALOPTIMA POLICY GA 8042: Supplemental Compensation

WHEREAS, section 13.1 of the Bylaws of the Orange County Health Authority, dba CalOptima, provide that the Board of Directors shall adopt by resolution, and may from time to time amend, procedures, practices and policies for, inter alia, hiring employees, and managing personnel; and

WHEREAS, in 1994, the Board of Directors designated the Chief Executive Officer as the Appointing Authority with full power to hire and terminate CalOptima employees at will, to set compensation within the boundaries of the budget limits set by the Board, to promulgate employee policies and procedures, and to amend said policies and procedures from time to time, subject to annual review by the Board of Directors, or a committee appointed by the Board for that purpose; and

WHEREAS, California Code of Regulations, Title 2, Section 570.5, requires CalOptima to adopt a publicly available pay schedule that identifies the position title and pay rate for every employee position, and CalOptima regularly reviews CalOptima's salary schedule accordingly.

NOW, THEREFORE, BE IT RESOLVED:

Section 1. That the Board of Directors hereby approves and adopts the attached updated CalOptima Policy:

a. GA.8042: Supplemental Compensation with Attachments A-B

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this April 7, 2022.

AYES: _____
NOES: _____
ABSENT: _____
ABSTAIN: _____

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Andrew Do, Chair, CalOptima Board of Directors

Attest:
/s/_____
Sharon Dwiers, Clerk of the Board

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Policy:	GA.8042
Title:	**Supplemental Compensation**
Department:	CalOptima Administrative
Section:	Human Resources
CEO Approval:	*/s/*
Effective Date:	01/01/2011
Revised Date:	04/07/2022
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy establishes general guidelines concerning the use of supplemental compensation above regular base pay to compensate for business needs and to identify items to be reported to CalPERS as "Special Compensation."

II. POLICY

A. CalOptima considers the following as Special Compensation pursuant to Title 2, Section 571 of the California Code of Regulations (CCR):

1. Bilingual Pay/Bilingual Premium;

2. Holiday Premium Pay;

~~2.~~3. Night Shift Premium/Shift Differential;

~~3.~~4. Active Certified Case Manager (CCM) Pay/Educational Incentive; and

~~4.~~5. Executive Incentive Program/Bonus Pay.

B. Overtime Pay: As a public agency, CalOptima follows Federal wage and hour laws. Overtime pay for non-exempt employees will be provided for all hours worked in excess of forty (40) in any one (1) workweek at the rate of one and one half (1.5) times the employee's regular rate of pay~~.~~, as defined by the federal Fair Labor Standards Act (FLSA). Employees should obtain prior authorization from their supervisors or managers prior to working overtime or incurring overtime pay. Exempt employees are not covered by the overtime provisions and do not receive overtime pay.

C. Holiday Premium Pay: All regular, non-exempt, full-time employees who are eligible for paid holidays but who may be required to work on a holiday observed by CalOptima under GA.8056 Paid Holidays will be paid at two (2) times their regular base pay for the hours worked in addition to the holiday pay. Flex Holiday is not eligible for Holiday Premium Pay. This is considered Holiday

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Pay pursuant to Title 2, CCR, Section 571(a) and is to be reported to CalPERS as Special Compensation.

~~C.~~D. Bilingual Pay: CalOptima provides supplemental bilingual pay for qualified exempt and non-exempt employees who are fluent in at least one (1) of CalOptima's threshold languages. This is considered a Bilingual Premium pursuant to Title 2, CCR, Section 571(a) and is to be reported to CalPERS as Special Compensation. The rate for Bilingual Pay is based on the following schedule:

Proficiency	Rate Per Pay Period
Bilingual language usage with members is required in the job description and used more than fifty percent (50%) of the time in the performance of the employee's job duties.	$60.00
Bilingual language usage with members is preferred in the job description and used less than fifty percent (50%) of the time in the performance of the employee's job duties.	$40.00

~~D.~~E. Translation Pay: In certain circumstances when, for business reasons and for the benefit of CalOptima members, there is a need to translate documents and other written material into languages other than English, the Exempt Employee providing such service will be paid supplemental pay. Non-exempt employees are not eligible for translation pay.

1. ~~A CalOptima~~ Exempt ~~Employee~~Employees, who ~~does~~do not work in the Cultural & Linguistic Services Department (C&L) and who ~~is~~are not required as part of ~~his or her~~their regular job responsibilities to translate but ~~is~~are qualified to translate based on successfully passing the CalOptima Bilingual Screening Process, may be eligible for translation pay for performing translation work. Eligible employees, who are interested in performing translation work during non-work hours, may elect to provide translation services during ~~his or her~~their own personal time based on the rates indicated below. The C&L Department shall assign the work to qualified Exempt Employees on an occasional, as-needed basis.

2. There are two (2) key activities in providing translation services:

   a. Translation of materials from English into the desired language, or from another language into English; and

   b. Review and revision of the translation to ensure quality and consistency in usage of terms.

3. Translating is more difficult and time-consuming than reviewing and editing of the already translated materials, and as a result, translation of materials will be reimbursed at a higher rate. CalOptima will reimburse for services at the following rates:

   a. Translation – Thirty-five dollars ($35.00) per page; and

   b. Review and revision of translated materials – Twenty-five dollars ($25.00) per page.

4. The use of this supplemental pay is limited to situations where the use of professional translation services is either not available or unfeasible due to business constraints.

~~E.~~F. Night Shift: CalOptima provides supplemental pay for work performed as part of a Night Shift. Assignments for Night Shift are subject to business needs and are at the discretion of CalOptima management. This is considered a Shift Differential pursuant to Title 2, CCR, Section 571(a) and is

to be reported to CalPERS as Special Compensation. The rate for Night Shift is based on the following schedule:

Definition	Eligibility	Rates (per hour)
Night Shift – Seven (7) consecutive hours or more of work between 3 p.m. and 8 a.m.	Non-exempt employees	$2.00 per hour.

~~F.~~G. Call Back and On Call: CalOptima provides supplemental pay for work performed as part of a Call Back and On Call requirement. Assignments for Call Back and On Call are subject to business needs and are at the discretion of CalOptima management. The rates for Call Back and On Call Pay are based on the following schedule:

Definition	Eligibility	Rates (per hour)
Call Back – ~~Must~~Employees must physically return to work within one (1) hour when requested by a Supervisor. A Supervisor may assign ~~the employee~~employees other work until the guaranteed four (4) hour time elapses.	Non-exempt employees	One and one half (1.5) times of regular base ~~hourly rate~~pay with a minimum of four (4) hours of pay.
On Call – ~~Must~~Employees must remain accessible after normally scheduled work hours and be available to fix problems or report to work, if necessary. ~~Employee~~Employees will be informed of the need for their availability to work either from home or at the work site. Employees on call are waiting to be engaged and are free to use their On Call time as they deem appropriate~~.~~, so long as they are fit to respond when called. Employees must respond within one (1) hour, as required.	Non-exempt employees	$3.00~~/~~ per hour for being on-call. If a call is taken, employee is paid one and one half (1.5) times the ~~regularly hourly rate~~regular base pay with a thirty (30) minute minimum call.
On Call Medical Case Managers (RN or LVN) and Clinical Pharmacists - Must remain accessible to accept or respond to calls within a reasonable time designated by ~~Employee's supervisor.~~employee's supervisors. In no event shall ~~Employee's supervisor~~employees' supervisors require a response time less than thirty (30) minutes. ~~Employee~~Employees will be informed of the need for their availability to work either from home or at the work site. Employees on call are waiting to be engaged and are free to use their On Call time as they deem appropriate~~.~~, so long as they are fit to respond when called.	Exempt Employees, excluding those in supervisory positions	Twenty five percent (25~~%~~%) of the employee's base pay as an hourly ~~rate~~ equivalent multiplied by the number of hours on call.

H. Commuter Allowance: Effective April 24, 2022 through July 1, 2023, CalOptima shall provide a Commuter Allowance in an amount of one hundred fifty dollars ($150.00) per pay period to full-time employees designated as Full Office Workers, and seventy-five dollars ($75.00) per pay period to full-time employees designated as Partial Teleworkers. The Commuter Allowance begins the first full pay period as a Full Office Worker or Partial Teleworker. Eligible full-time employees will continue to receive the Commuter Allowance until the first full pay period in which an employee is not assigned to partial telework or full office work. The Commuter Allowance will be provided only

for full pay periods in which employees are designated a Full Office Worker or Partial Teleworker and will not be prorated for being designated as a Full Office Worker or Partial Teleworker for a portion of the pay period. Executive Level Positions and Full Teleworkers are not eligible for the Commuter Allowance. With approval of the Chief Executive Officer, the Commuter Allowance may continue beyond July 1, 2023 and/or be reinstated after July 1, 2023.

~~G.~~I. Active Certified Case Manager (CCM) Pay: CalOptima may recognize supplemental pay of one hundred dollars ($100.00) per pay period to an RN who holds an active CCM certification when such certification is required or preferred in the job description and used regularly in performance of the employee's job duties. This is considered as an Educational Incentive pursuant to Title 2 CCR Section 571(a) and is to be reported to CalPERS as Special Compensation.

~~H.~~J. Executive Incentive Program: The Chief Executive Officer (CEO) may recognize ~~executive staff~~Executive Level Positions, including interim appointments, using incentive compensation as described in this Policy. ~~For executive staff~~For employees in Executive Level Positions who achieve ~~superior~~outstanding performance, the incentive compensation is considered bonus pay pursuant to Title 2 CCR Section 571(a) and is to be reported to CalPERS as Special Compensation for CalPERS classic members.

~~I.~~K. Sales Incentive Program: The OneCare/OneCare Connect Community Partner and Senior (Sr.) Community Partner staff in the Member Outreach & Education Department shall have an active Resident Insurance Producer license to enroll eligible members into the OneCare and OneCare Connect programs.

1. The licensed Community Partner and Sr. Community Partner staff will receive a monthly Sales Incentive based on the number of eligible members enrolled into the OneCare and OneCare Connect program in accordance with the table in Paragraph II.I.2. below. No incentive will be paid for the first thirty (30) enrollments each month, regardless of how many enrollments are made under, at or over thirty (30). For enrollments over thirty (30), licensed Community Partner and Sr. Community Partner staff will be eligible to receive the incentive payment of one hundred sixty-five dollars ($165.00) for each new enrollment within that tier between thirty-one (31) – fifty (50). In other words, each tier is independent and does not alter the amount paid per enrollment in any other tier. For example, eligible staff who enroll fifty-three (53) members in a month will be eligible to receive payment based on the following calculation (from tier thirty-one (31) – fifty(50)) twenty (20) members multiplied by one hundred sixty--five dollars ($165), plus (from tier fifty-one (51) – sixty-five (65)) three (3) members multiplied by one hundred seventy-five ($175), which equals an incentive of three thousand eight hundred twenty--five dollars ($3,825) for that month.

2. Enrollment is paid per eligible member above the minimum tier at the rate specified within each tier as follows:

Tier Min	Tier Max	Payout for Enrollment within Each Tier
1	30	**$0.00**
31	50	**$165.00**
51	65	**$175.00**
66+		**$200.00**

3 The sales incentive for the Manager, Member Outreach & Education shall be based on the number of eligible members enrolled into the OneCare and OneCare Connect programs by the Community Partner and Sr. Community Partner in the Member Outreach & Education Department. The Manager, Member Outreach & Education will receive ten dollars ($10.00) per member enrolled, if and only if, the Community Partner or Sr. Community Partner reporting to

the Manager, Member Outreach & Education, enrolls thirty-six (36) or more members per month. If a Community Partner or Sr. Community Partner fails to enroll at least thirty-six (36) members per month, the Manager, Member Outreach & Education, would not be eligible for the sales incentive for that Community Partner or Sr. Community Partner.

~~J.~~L. Employee Incentive Program: At the discretion of the CEO, specific employees may be recognized through incentive compensation, when doing so is consistent with CalOptima's business needs and mission, vision, and values.

~~K.~~M. Retention Incentive: In order to preserve organizational talent and to maintain business continuity when the loss of key personnel may cause risk or damage to operational efficiency, regulatory compliance, and/or strategic imperatives, CalOptima may, at the discretion of the CEO, and on an exception basis, award a retention incentive.

~~L.~~N. Recruitment Incentive: At the discretion of the CEO, a recruitment incentive of up to fifteen percent (15%) of the ~~median~~midpoint of base pay for the applicable position may be offered to entice an individual to join CalOptima. Recruitment incentives offered for Executive Director and Chief ~~positions~~position~~,~~s, to a maximum of $50,000, require informing the Board of Directors ~~approval~~after approved.

~~M.~~O. Incentive programs may be modified or withdrawn, at any time. ~~Award~~An award of incentive compensation is entirely at the discretion of the CEO and/or Board of Directors, as applicable. It is not intended to be a binding contract between ~~executive staff~~Executive Level Positions or employees and CalOptima.

~~N.~~P. Employer-Paid Member Contribution (EPMC): CalOptima contributes seven percent (7%) of compensation earnable, on behalf of eligible employees who hold management staff positions as identified in the CalOptima salary schedule, and who qualify based on all of the following:

1. Hired, promoted, or transferred into a management staff position, including interim appointments; and

2. Included in one (1) of the following categories:

   a. A CalPERS Classic Member; or

   b. A member prior to ~~01/01/~~January 1, 2013 of another California public retirement system that is eligible for reciprocity with CalPERS.

~~O.~~Q. Annual Performance Lump Sum Bonus: Employees paid at or above the pay range maximum are not eligible for future base pay increases. As a result, in lieu of future base pay increases, these employees may be eligible for ~~a~~ merit bonus pay delivered as a lump sum bonus in accordance with Section III.J of this Policy, provided that their performance meets the goals and objectives set forth by their managers.

~~P.~~R. Automobile Allowance: CalOptima may, at the discretion of the CEO, provide employees in ~~executive staff positions~~Executive Level Positions, including interim appointments, with a monthly automobile allowance in an amount not to exceed five hundred dollars ($500.00) for the use of their personal vehicle for CalOptima business.

~~Q.~~S. Supplemental Retirement Benefit: Consistent with applicable Board actions, the CEO is authorized to determine CalOptima's contribution rate for employees to the supplemental retirement benefit (SRB) plan administered by the Public Agency Retirement System (PARS) within the limits

of the budget and subject to contribution limits established by applicable laws. With the exception of employees in ~~executive staff positions~~Executive Level Positions, the contribution rate shall be uniform for all employees. Executive ~~staff positions~~Level Positions will also receive the same uniform contribution rate applicable to all employees. However, for employees in ~~executive staff positions~~Executive Level Positions who earn more than the applicable compensation limits, the CEO is authorized to provide additional supplemental contributions to PARS, subject to the limitations of applicable laws. ~~The executive staff member~~An employee in an Executive Level Position must still be employed by CalOptima at the time the additional supplemental ~~contributions~~contribution to PARS is distributed in order to be eligible to receive the additional supplemental contributions. These SRB ~~contribution rates~~contributions to the PARS retirement plan shall continue from year to year, unless otherwise adjusted or discontinued.

III. PROCEDURE

A. Overtime Pay: Overtime must be approved in advance by an employee's manager. Adjustments for overtime pay cannot be calculated until the completion of an employee's workweek. This may result in one (1) pay period's delay in the employee receiving the additional compensation.

B. Holiday Premium Pay: Working on a CalOptima observed holiday must be approved in advance by the employee's manager. Unauthorized work that occurs on an observed holiday is not eligible for Holiday Premium Pay and will be paid at the employee's regular base pay. Holiday Premium Pay is not to be considered hours worked in the computation of overtime.

~~B.~~C. Bilingual Pay: An employee or potential employee shall undergo a written and verbal bilingual evaluation when bilingual proficiency is a part of the employee's or potential employee's job description and used in the performance of the employee's job duties with members. If the employee or potential employee passes the evaluations, the bilingual pay shall be established.

~~C.~~D. Translation Pay: If an eligible exempt employee elects to provide translation services, and such services are not part of the employee's regular job duties, the employee shall submit their interest to the C&L Department. If selected, the translation pay~~,~~ identified above, will be provided depending on the variables noted above, taking into account whether professional translation services are either not available or unfeasible due to business constraints.

~~D.~~E. Night Shift:

1. Night Shift differential is automatically calculated for those employees regularly working a night shift, defined as seven (7) consecutive hours or more of work between 3 p.m. and 8 a.m.

2. Employees who, at their own request and for their own convenience, adjust their work schedule, such as requesting make up time or alternative hours, and as a result, would be eligible for night shift pay, shall be deemed as having waived their right to same. When appropriate, a new Action Form should be submitted, removing the employee from the night shift.

~~E.~~F. Call Back and On Call Pay:

1. If ~~an employee is~~employees are on call or ~~gets~~get called back to work, the ~~employee is~~employees are responsible for adding this time to their ~~schedule~~schedules through CalOptima's time keeping system, which is then approved by their ~~supervisor~~supervisors.

G. Commuter Allowance

1. Commuter Allowance is automatically calculated for eligible employees based on system designation of Full Office Worker or Partial Teleworker . Employees and leaders are responsible for maintaining accurate designations in the timekeeping system. Designation changes require a request and approval per the Telework Program Guidelines. CalOptima may periodically audit and validate employee Office/Telework designations.

~~F.~~H. Active Certified Case Manager (CCM) Pay:

1. To receive CCM supplemental pay, an employee is responsible for providing a copy of the employee's case management certification issued by the Case Management Society of America to the Human Resources Department.

~~G.~~I. Incentive Compensation

1. The Board of Directors approves CalOptima's strategic plan for each fiscal year, and the CEO is expected to meet the goals set forth in the strategic plan. The CEO in turn sets goals for the ~~executive staff~~Executive Level Positions.

2. The CEO may establish an incentive compensation program for ~~executive staff~~Executive Level Positions based on the Executive Incentive Program attached within budgeted parameters in accomplishing specific results according to the department and individual goals set forth by the CEO and the level of achievement. Executive ~~staff~~Level Positions will receive a performance evaluation based on the Performance Review of Executives Template attached, which measures their performance against the established goals. Based on the level of performance, the executive staff member may be eligible for a lump sum bonus payment. The executive staff member must still be employed by CalOptima and in good standing at the time the bonus is distributed in order to be eligible to receive the bonus payment. For eligible ~~executive staff members~~Executive Level Positions who achieve ~~superior~~outstanding performance, CalOptima will report the bonus payment to CalPERS as Special Compensation. The CEO is authorized to make minor revisions to the Executive Incentive Program and Performance Review of Executives Template from time to time, as appropriate.

3. As circumstances warrant and at the discretion of the CEO, employees not ~~at the executive staff level~~in Executive Level Positions, whose accomplishments have provided extraordinary results, may be considered for incentive compensation.

~~H.~~J. Sales Incentive Program

1. The OneCare/OneCare Connect Community Partner and Sr. Community Partner staff, in the Member Outreach & Education Department, shall have an active Resident Insurance Producer license to enroll eligible members into the OneCare and OneCare Connect Programs.

2. The Community Partner and Sr. Community Partner staff shall be eligible to receive sales incentive pay as described in Section II.I.1 of this Policy for successfully enrolling new members into the OneCare and OneCare Connect Programs. Sales incentive pay for the Manager, Member Outreach & Education, shall be based on the number of members enrolled into the OneCare and OneCare Connect Programs by the Community Partner and Sr. Community Partner as described in Section II.I.2 of this Policy.

a. CalOptima shall follow the Medicare Marketing Guidelines (MMGs) charge-back guidelines of ninety (90) calendar day rapid disenrollment and recouping the sales incentive with the exceptions as specified under the guidelines and applicable CalOptima policies.

3. CalOptima shall ~~pay~~advance the sales incentive to the eligible employee on a monthly basis approximately one and a half (1 ½) months after the month in which the eligible employee ~~earned the sales incentive~~enrolled the new member. However, the sales incentive is not earned until the member has been enrolled in the respective program for ninety-one (91) days.

   a. In the event a OneCare or OneCare Connect member disenrolls from their respective program within ninety (90) calendar days for reasons other than the exceptions specified under the guidelines and applicable CalOptima policies, the sales incentive previously ~~earned~~paid will be deducted from a future sales incentive.

4. The Chief Operating Officer, Executive Director of Network Operations, and Director Network Management who oversee the Member Outreach & Education Department shall approve the sales incentive payout.

5. Enrollment goals for the Community Partner and Community Partner Sr. staff will be pro-rated for the month if the employee misses one (1) or more full weeks due to vacations, sick days, or a leave of absence.

6. The Director, Network Management, Executive Director of Network Operations, and the Chief Operations Officer will review the sales incentive structure on an annual basis.

~~I.~~K. Retention Incentive: As circumstances warrant, the CEO may award an employee a retention incentive to prevent or delay departures that may adversely impact business operations. The employee offered a retention incentive must be in good standing and accept and sign a retention agreement which contains the condition(s) to be met in order to receive payment. Payment of the incentive will be made when the terms of the agreement have been fully met and at the conclusion of the retention period. The CEO has the authority to offer retention incentives for up to twenty-five (25) employees per fiscal year in an amount not to exceed twenty percent (20%) of the employee's current base annual salary. Retention incentives that exceed twenty percent (20%) of the employee's current base annual salary require Board of Directors approval.

~~J.~~L. Recruitment Incentive: As circumstances warrant, the CEO may offer a recruitment incentive based on the Compensation Administration Guidelines managed by the Human Resources Department to entice an individual to join CalOptima. Board of ~~Directors~~Director approval is required for recruitment incentives offered for Executive ~~Director and Chief positions~~Level Positions. In order to receive the recruitment incentive, the individual offered the incentive is required to accept and sign an offer letter which contains a "claw-back" provision obligating the recipient of a recruitment incentive to return the full amount of the recruitment incentive if the recipient voluntarily terminates employment with CalOptima within twenty-four (24) months of the date of hire.

~~K.~~M. Annual Performance Lump Sum Bonus: Once ~~an employee has~~employees have reached the pay range maximum, ~~the employee~~employees may be eligible for merit bonus pay delivered as a lump sum bonus, provided that ~~his or her~~their annual performance ~~evaluation meets~~evaluations meet the established goals and objectives set forth by their managers. Merit bonus pay will not exceed the maximum percentage of the merit increase matrix and reflects ~~the employee's~~employees' superior performance measured against established objectives. Annual performance lump sum bonuses are paid out in two (2) incremental amounts – the first half when merit salary increases are normally distributed and the second half six (6) months later. The employee must still be employed by CalOptima in order to be eligible to receive the lump sum bonus payments.

~~L.~~N. Automobile Allowance: As circumstances warrant, the CEO may offer ~~to~~ employees in ~~executive staff positions~~Executive Level Positions an automobile allowance in lieu of the IRS standard mileage reimbursement rate that would otherwise apply ~~in~~for the use of their personal vehicle in the performance of their duties. Such automobile allowance will be identified on the ~~executive staff's~~employees' W-2 forms as taxable income. In addition, as a condition of receiving such allowance, the ~~executive staff member~~employee must comply with the following requirements:

1. ~~He or she must maintain~~Maintain adequate levels of personal vehicle insurance coverage;

2. ~~He or she shall purchase his or her~~Purchase their own fuel for the vehicle; and

3. ~~He or she shall ensure that~~Ensure the vehicle is properly maintained.

IV. ATTACHMENT(S)

A. Executive Incentive Program
B. Performance Review of Executives Template

V. REFERENCE(S)

A. CalOptima Employee Handbook
B. Compensation Administration Guidelines
C. Government Code, §20636 and 20636.1
D. Title 2, California Code of Regulations (CCR), §571

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
01/05/2012	Regular Meeting of the CalOptima Board of Directors
05/01/2014	Regular Meeting of the CalOptima Board of Directors
12/03/2015	Regular Meeting of the CalOptima Board of Directors
09/07/2017	Regular Meeting of the CalOptima Board of Directors
06/07/2018	Regular Meeting of the CalOptima Board of Directors
02/07/2019	Regular Meeting of the CalOptima Board of Directors
04/02/2020	Regular Meeting of the CalOptima Board of Directors
04/07/2022	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2011	GA.8042	Pay Differentials	Administrative
Revised	01/05/2012	GA.8042	Pay Differentials	Administrative
Revised	05/20/2014	GA.8042	Supplemental Compensation	Administrative
Revised	12/03/2015	GA.8042	Supplemental Compensation	Administrative
Revised	09/07/2017	GA.8042	Supplemental Compensation	Administrative
Revised	06/07/2018	GA.8042	Supplemental Compensation	Administrative
Revised	02/07/2019	GA.8042	Supplemental Compensation	Administrative

Action	Date	Policy	Policy Title	Program(s)
Revised	04/02/2020	GA.8042	Supplemental Compensation	Administrative
Revised	04/07/2022	GA.8042	Supplemental Compensation	Administrative

IX. GLOSSARY

Term	Definition
Bilingual Certified Employee	An employee who has passed CalOptima's Bilingual Screening Process either upon hire or any time during their employment.
Bilingual Screening Process	Prospective staff translators are identified by Cultural and Linguistic (C&L) Services Department based on qualifications obtained through CalOptima's bilingual screening process. The screening is either conducted as part of their initial hiring process or later during their employment. All staff translators must possess a strong ability to read, write and understand the target language. Once identified as potential staff translators, they are required to take a proficiency test created by C&L Services Department. They are evaluated on their vocabulary, grammar, orthography, flow, accuracy, cultural sensitivity, as well as consistency in usage of translated terms. The selection is based on their overall score.
Bonus Pay	Compensation to employees for superior performance such as "annual performance bonus" and "merit pay." If provided only during a member's final compensation period, it shall be excluded from final compensation as "final settlement" pay. A program or system must be in place to plan and identify performance goals and objectives to count as Special Compensation for CalPERS purposes.
CalPERS	California Public Employees Retirement System
CalPERS Classic Member	A member enrolled in CalPERS prior to January 1, 2013.
Classic Director	A Management Staff who is either a CalPERS Classic Member or a member prior to ~~01/01/~~January 1, 2013 of another California public retirement system ~~that~~who is eligible for reciprocity with CalPERS.
Classic Executive	An Executive Staff who is either a CalPERS Classic Member or a member prior to ~~01/01/~~January 1, 2013 of another California public retirement system ~~that~~who is eligible for reciprocity with CalPERS.
Compensation Earnable	The pay rate and Special Compensation as defined in Government Code sections 20636 and 20636.1.
Central Worksite	CalOptima's primary physical location of business applicable to the employee, which is either CalOptima's administration building at 505 City Parkway West, the PACE building or other CalOptima operated location.
Executive ~~Staff~~Level Position	~~Staff holding Executive level positions as specifically designated by the Board of Directors.~~The position of Executive Director or above.
Exempt Employee	Employees who are exempt from the overtime provisions of the federal Fair Labor Standards Act (FLSA) and state regulations governing wages and salaries. Exempt status is determined by the duties and responsibilities of the position and is defined by Human Resources for each position.
Full Office Worker	An employee who is assigned to work their full schedule at the Central Worksite.
Full Teleworker	An eligible employee who is approved to routinely work their entire regularly scheduled work hours from a Remote Work Location unless business needs require otherwise.
Leave of Absence (LOA)	A term used to describe a scheduled period of time off longer than five (5) days that ~~an employee is~~employees are to be away from ~~his or her~~their primary ~~job~~jobs, while maintaining the status of employee.
Management Staff	Staff holding positions at or above Director level.

Term	Definition
Partial Teleworker	An eligible employee who is approved to work a pre-established consistent weekly work schedule split between two (2) or more full days per week at the Central Worksite, and the remainder of full days at the Remote Work Location.
Sales Incentive	An amount of money paid, in addition to base pay, to an employee for successfully enrolling a member into the OneCare or/ OneCare Connect Program.
Special Compensation	Payment of additional compensation earned separate from an employee's base pay that meets the criteria listed in Title 2, California Code of Regulations (CCR) section 571(a).
Threshold Language	For purposes of this policy, a threshold language as defined by the Centers for Medicare & Medicaid Services (CMS) for Medicare programs, or Department of Health Care Services for the Medi-Cal program.

Policy:	GA.8042
Title:	**Supplemental Compensation**
Department:	CalOptima Administrative
Section:	Human Resources
CEO Approval:	*/s/*
Effective Date:	01/01/2011
Revised Date:	04/07/2022
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy establishes general guidelines concerning the use of supplemental compensation above regular base pay to compensate for business needs and to identify items to be reported to CalPERS as "Special Compensation."

II. POLICY

A. CalOptima considers the following as Special Compensation pursuant to Title 2, Section 571 of the California Code of Regulations (CCR):

1. Bilingual Pay/Bilingual Premium;
2. Holiday Premium Pay;
3. Night Shift Premium/Shift Differential;
4. Active Certified Case Manager (CCM) Pay/Educational Incentive; and
5. Executive Incentive Program/Bonus Pay.

B. Overtime Pay: As a public agency, CalOptima follows Federal wage and hour laws. Overtime pay for non-exempt employees will be provided for all hours worked in excess of forty (40) in any one (1) workweek at the rate of one and one half (1.5) times the employee's regular rate of pay, as defined by the federal Fair Labor Standards Act (FLSA). Employees should obtain prior authorization from their supervisors or managers prior to working overtime or incurring overtime pay. Exempt employees are not covered by the overtime provisions and do not receive overtime pay.

C. Holiday Premium Pay: All regular, non-exempt, full-time employees who are eligible for paid holidays but who may be required to work on a holiday observed by CalOptima under GA.8056 Paid Holidays will be paid at two (2) times their regular base pay for the hours worked in addition to the holiday pay. Flex Holiday is not eligible for Holiday Premium Pay. This is considered Holiday

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Pay pursuant to Title 2, CCR, Section 571(a) and is to be reported to CalPERS as Special Compensation.

D. Bilingual Pay: CalOptima provides supplemental bilingual pay for qualified exempt and non-exempt employees who are fluent in at least one (1) of CalOptima's threshold languages. This is considered a Bilingual Premium pursuant to Title 2, CCR, Section 571(a) and is to be reported to CalPERS as Special Compensation. The rate for Bilingual Pay is based on the following schedule:

Proficiency	Rate Per Pay Period
Bilingual language usage with members is required in the job description and used more than fifty percent (50%) of the time in the performance of the employee's job duties.	$60.00
Bilingual language usage with members is preferred in the job description and used less than fifty percent (50%) of the time in the performance of the employee's job duties.	$40.00

E. Translation Pay: In certain circumstances when, for business reasons and for the benefit of CalOptima members, there is a need to translate documents and other written material into languages other than English, the Exempt Employee providing such service will be paid supplemental pay. Non-exempt employees are not eligible for translation pay.

1. Exempt Employees, who do not work in the Cultural & Linguistic Services Department (C&L) and who are not required as part of their regular job responsibilities to translate but are qualified to translate based on successfully passing the CalOptima Bilingual Screening Process, may be eligible for translation pay for performing translation work. Eligible employees, who are interested in performing translation work during non-work hours, may elect to provide translation services during their own personal time based on the rates indicated below. The C&L Department shall assign the work to qualified Exempt Employees on an occasional, as-needed basis.

2. There are two (2) key activities in providing translation services:

   a. Translation of materials from English into the desired language, or from another language into English; and

   b. Review and revision of the translation to ensure quality and consistency in usage of terms.

3. Translating is more difficult and time-consuming than reviewing and editing of the already translated materials, and as a result, translation of materials will be reimbursed at a higher rate. CalOptima will reimburse for services at the following rates:

   a. Translation – Thirty-five dollars ($35.00) per page; and

   b. Review and revision of translated materials – Twenty-five dollars ($25.00) per page.

4. The use of this supplemental pay is limited to situations where the use of professional translation services is either not available or unfeasible due to business constraints.

F. Night Shift: CalOptima provides supplemental pay for work performed as part of a Night Shift. Assignments for Night Shift are subject to business needs and are at the discretion of CalOptima management. This is considered a Shift Differential pursuant to Title 2, CCR, Section 571(a) and is to be reported to CalPERS as Special Compensation. The rate for Night Shift is based on the following schedule:

Definition	Eligibility	Rates (per hour)
Night Shift – Seven (7) consecutive hours or more of work between 3 p.m. and 8 a.m.	Non-exempt employees	$2.00 per hour.

G. Call Back and On Call: CalOptima provides supplemental pay for work performed as part of a Call Back and On Call requirement. Assignments for Call Back and On Call are subject to business needs and are at the discretion of CalOptima management. The rates for Call Back and On Call Pay are based on the following schedule:

Definition	Eligibility	Rates (per hour)
Call Back – Employees must physically return to work within one (1) hour when requested by a Supervisor. A Supervisor may assign employees other work until the guaranteed four (4) hour time elapses.	Non-exempt employees	One and one half (1.5) times of regular base pay with a minimum of four (4) hours of pay.
On Call – Employees must remain accessible after normally scheduled work hours and be available to fix problems or report to work, if necessary. Employees will be informed of the need for their availability to work either from home or at the work site. Employees on call are waiting to be engaged and are free to use their On Call time as they deem appropriate, so long as they are fit to respond when called. Employees must respond within one (1) hour, as required.	Non-exempt employees	$3.00 per hour for being on-call. If a call is taken, employee is paid one and one half (1.5) times the regular base pay with a thirty (30) minute minimum call.
On Call Medical Case Managers (RN or LVN) and Clinical Pharmacists - Must remain accessible to accept or respond to calls within a reasonable time designated by employee's supervisors. In no event shall employees' supervisors require a response time less than thirty (30) minutes. Employees will be informed of the need for their availability to work either from home or at the work site. Employees on call are waiting to be engaged and are free to use their On Call time as they deem appropriate, so long as they are fit to respond when called.	Exempt Employees, excluding those in supervisory positions	Twenty five percent (25%) of the employee's base pay as an hourly equivalent multiplied by the number of hours on call.

H. Commuter Allowance: Effective April 24, 2022 through July 1, 2023, CalOptima shall provide a Commuter Allowance in an amount of one hundred fifty dollars ($150.00) per pay period to full-time employees designated as Full Office Workers, and seventy-five dollars ($75.00) per pay period to full-time employees designated as Partial Teleworkers. The Commuter Allowance begins the first full pay period as a Full Office Worker or Partial Teleworker. Eligible full-time employees will continue to receive the Commuter Allowance until the first full pay period in which an employee is not assigned to partial telework or full office work. The Commuter Allowance will be provided only for full pay periods in which employees are designated a Full Office Worker or Partial Teleworker and will not be prorated for being designated as a Full Office Worker or Partial Teleworker for a portion of the pay period. Executive Level Positions and Full Teleworkers are not eligible for the

Commuter Allowance. With approval of the Chief Executive Officer, the Commuter Allowance may continue beyond July 1, 2023 and/or be reinstated after July 1, 2023.

I. Active Certified Case Manager (CCM) Pay: CalOptima may recognize supplemental pay of one hundred dollars ($100.00) per pay period to an RN who holds an active CCM certification when such certification is required or preferred in the job description and used regularly in performance of the employee's job duties. This is considered as an Educational Incentive pursuant to Title 2 CCR Section 571(a) and is to be reported to CalPERS as Special Compensation.

J. Executive Incentive Program: The Chief Executive Officer (CEO) may recognize Executive Level Positions, including interim appointments, using incentive compensation as described in this Policy. For employees in Executive Level Positions who achieve outstanding performance, the incentive compensation is considered bonus pay pursuant to Title 2 CCR Section 571(a) and is to be reported to CalPERS as Special Compensation for CalPERS classic members.

K. Sales Incentive Program: The OneCare/OneCare Connect Community Partner and Senior (Sr.) Community Partner staff in the Member Outreach & Education Department shall have an active Resident Insurance Producer license to enroll eligible members into the OneCare and OneCare Connect programs.

1. The licensed Community Partner and Sr. Community Partner staff will receive a monthly Sales Incentive based on the number of eligible members enrolled into the OneCare and OneCare Connect program in accordance with the table in Paragraph II.I.2. below. No incentive will be paid for the first thirty (30) enrollments each month, regardless of how many enrollments are made under, at or over thirty (30). For enrollments over thirty (30), licensed Community Partner and Sr. Community Partner staff will be eligible to receive the incentive payment of one hundred sixty-five dollars ($165.00) for each new enrollment within that tier between thirty-one (31) – fifty (50). In other words, each tier is independent and does not alter the amount paid per enrollment in any other tier. For example, eligible staff who enroll fifty-three (53) members in a month will be eligible to receive payment based on the following calculation (from tier thirty-one (31) – fifty(50)) twenty (20) members multiplied by one hundred sixty-five dollars ($165), plus (from tier fifty-one (51) – sixty-five (65)) three (3) members multiplied by one hundred seventy-five ($175), which equals an incentive of three thousand eight hundred twenty-five dollars ($3,825) for that month.

2. Enrollment is paid per eligible member above the minimum tier at the rate specified within each tier as follows:

Tier Min	Tier Max	Payout for Enrollment within Each Tier
1	30	**$0.00**
31	50	**$165.00**
51	65	**$175.00**
66+		**$200.00**

3 The sales incentive for the Manager, Member Outreach & Education shall be based on the number of eligible members enrolled into the OneCare and OneCare Connect programs by the Community Partner and Sr. Community Partner in the Member Outreach & Education Department. The Manager, Member Outreach & Education will receive ten dollars ($10.00) per member enrolled, if and only if, the Community Partner or Sr. Community Partner reporting to the Manager, Member Outreach & Education, enrolls thirty-six (36) or more members per month. If a Community Partner or Sr. Community Partner fails to enroll at least thirty-six (36)

members per month, the Manager, Member Outreach & Education, would not be eligible for the sales incentive for that Community Partner or Sr. Community Partner.

L. Employee Incentive Program: At the discretion of the CEO, specific employees may be recognized through incentive compensation, when doing so is consistent with CalOptima's business needs and mission, vision, and values.

M. Retention Incentive: In order to preserve organizational talent and to maintain business continuity when the loss of key personnel may cause risk or damage to operational efficiency, regulatory compliance, and/or strategic imperatives, CalOptima may, at the discretion of the CEO, and on an exception basis, award a retention incentive.

N. Recruitment Incentive: At the discretion of the CEO, a recruitment incentive of up to fifteen percent (15%) of the midpoint of base pay for the applicable position may be offered to entice an individual to join CalOptima. Recruitment incentives offered for Executive Director and Chief positions, to a maximum of $50,000, require informing the Board of Directors after approved.

O. Incentive programs may be modified or withdrawn, at any time. An award of incentive compensation is entirely at the discretion of the CEO and/or Board of Directors, as applicable. It is not intended to be a binding contract between Executive Level Positions or employees and CalOptima.

P. Employer-Paid Member Contribution (EPMC): CalOptima contributes seven percent (7%) of compensation earnable, on behalf of eligible employees who hold management staff positions as identified in the CalOptima salary schedule, and who qualify based on all of the following:

1. Hired, promoted, or transferred into a management staff position, including interim appointments; and

2. Included in one (1) of the following categories:

   a. A CalPERS Classic Member; or

   b. A member prior to January 1, 2013 of another California public retirement system that is eligible for reciprocity with CalPERS.

Q. Annual Performance Lump Sum Bonus: Employees paid at or above the pay range maximum are not eligible for future base pay increases. As a result, in lieu of future base pay increases, these employees may be eligible for merit bonus pay delivered as a lump sum bonus in accordance with Section III.J of this Policy, provided that their performance meets the goals and objectives set forth by their managers.

R. Automobile Allowance: CalOptima may, at the discretion of the CEO, provide employees in Executive Level Positions, including interim appointments, with a monthly automobile allowance in an amount not to exceed five hundred dollars ($500.00) for the use of their personal vehicle for CalOptima business.

S. Supplemental Retirement Benefit: Consistent with applicable Board actions, the CEO is authorized to determine CalOptima's contribution rate for employees to the supplemental retirement benefit (SRB) plan administered by the Public Agency Retirement System (PARS) within the limits of the budget and subject to contribution limits established by applicable laws. With the exception of employees in Executive Level Positions, the contribution rate shall be uniform for all employees. Executive Level Positions will also receive the same uniform contribution rate applicable to all

employees. However, for employees in Executive Level Positions who earn more than the applicable compensation limits, the CEO is authorized to provide additional supplemental contributions to PARS, subject to the limitations of applicable laws. An employee in an Executive Level Position must still be employed by CalOptima at the time the additional supplemental contribution to PARS is distributed in order to be eligible to receive the additional supplemental contributions. These SRB contributions to the PARS retirement plan shall continue from year to year, unless otherwise adjusted or discontinued.

III. PROCEDURE

A. Overtime Pay: Overtime must be approved in advance by an employee's manager. Adjustments for overtime pay cannot be calculated until the completion of an employee's workweek. This may result in one (1) pay period's delay in the employee receiving the additional compensation.

B. Holiday Premium Pay: Working on a CalOptima observed holiday must be approved in advance by the employee's manager. Unauthorized work that occurs on an observed holiday is not eligible for Holiday Premium Pay and will be paid at the employee's regular base pay. Holiday Premium Pay is not to be considered hours worked in the computation of overtime.

C. Bilingual Pay: An employee or potential employee shall undergo a written and verbal bilingual evaluation when bilingual proficiency is a part of the employee's or potential employee's job description and used in the performance of the employee's job duties with members. If the employee or potential employee passes the evaluations, the bilingual pay shall be established.

D. Translation Pay: If an eligible exempt employee elects to provide translation services, and such services are not part of the employee's regular job duties, the employee shall submit their interest to the C&L Department. If selected, the translation pay identified above, will be provided depending on the variables noted above, taking into account whether professional translation services are either not available or unfeasible due to business constraints.

E. Night Shift:

1. Night Shift differential is automatically calculated for those employees regularly working a night shift, defined as seven (7) consecutive hours or more of work between 3 p.m. and 8 a.m.

2. Employees who, at their own request and for their own convenience, adjust their work schedule, such as requesting make up time or alternative hours, and as a result, would be eligible for night shift pay, shall be deemed as having waived their right to same. When appropriate, a new Action Form should be submitted, removing the employee from the night shift.

F. Call Back and On Call Pay:

1. If employees are on call or get called back to work, the employees are responsible for adding this time to their schedules through CalOptima's time keeping system, which is then approved by their supervisors.

G. Commuter Allowance

1. Commuter Allowance is automatically calculated for eligible employees based on system designation of Full Office Worker or Partial Teleworker . Employees and leaders are responsible for maintaining accurate designations in the timekeeping system. Designation changes require a request and approval per the Telework Program Guidelines. CalOptima may periodically audit and validate employee Office/Telework designations.

H. Active Certified Case Manager (CCM) Pay:

1. To receive CCM supplemental pay, an employee is responsible for providing a copy of the employee's case management certification issued by the Case Management Society of America to the Human Resources Department.

I. Incentive Compensation

1. The Board of Directors approves CalOptima's strategic plan for each fiscal year, and the CEO is expected to meet the goals set forth in the strategic plan. The CEO in turn sets goals for the Executive Level Positions.

2. The CEO may establish an incentive compensation program for Executive Level Positions based on the Executive Incentive Program attached within budgeted parameters in accomplishing specific results according to the department and individual goals set forth by the CEO and the level of achievement. Executive Level Positions will receive a performance evaluation based on the Performance Review of Executives Template attached, which measures their performance against the established goals. Based on the level of performance, the executive staff member may be eligible for a lump sum bonus payment. The executive staff member must still be employed by CalOptima and in good standing at the time the bonus is distributed in order to be eligible to receive the bonus payment. For eligible Executive Level Positions who achieve outstanding performance, CalOptima will report the bonus payment to CalPERS as Special Compensation. The CEO is authorized to make minor revisions to the Executive Incentive Program and Performance Review of Executives Template from time to time, as appropriate.

3. As circumstances warrant and at the discretion of the CEO, employees not in Executive Level Positions, whose accomplishments have provided extraordinary results, may be considered for incentive compensation.

J. Sales Incentive Program

1. The OneCare/OneCare Connect Community Partner and Sr. Community Partner staff, in the Member Outreach & Education Department, shall have an active Resident Insurance Producer license to enroll eligible members into the OneCare and OneCare Connect Programs.

2. The Community Partner and Sr. Community Partner staff shall be eligible to receive sales incentive pay as described in Section II.I.1 of this Policy for successfully enrolling new members into the OneCare and OneCare Connect Programs. Sales incentive pay for the Manager, Member Outreach & Education, shall be based on the number of members enrolled into the OneCare and OneCare Connect Programs by the Community Partner and Sr. Community Partner as described in Section II.I.2 of this Policy.

   a. CalOptima shall follow the Medicare Marketing Guidelines (MMGs) charge-back guidelines of ninety (90) calendar day rapid disenrollment and recouping the sales incentive with the exceptions as specified under the guidelines and applicable CalOptima policies.

3. CalOptima shall advance the sales incentive to the eligible employee on a monthly basis approximately one and a half (1 ½) months after the month in which the eligible employee enrolled the new member. However, the sales incentive is not earned until the member has been enrolled in the respective program for ninety-one (91) days.

a. In the event a OneCare or OneCare Connect member disenrolls from their respective program within ninety (90) calendar days for reasons other than the exceptions specified under the guidelines and applicable CalOptima policies, the sales incentive previously paid will be deducted from a future sales incentive.

4. The Chief Operating Officer, Executive Director of Network Operations, and Director Network Management who oversee the Member Outreach & Education Department shall approve the sales incentive payout.

5. Enrollment goals for the Community Partner and Community Partner Sr. staff will be pro-rated for the month if the employee misses one (1) or more full weeks due to vacations, sick days, or a leave of absence.

6. The Director, Network Management, Executive Director of Network Operations, and the Chief Operations Officer will review the sales incentive structure on an annual basis.

K. Retention Incentive: As circumstances warrant, the CEO may award an employee a retention incentive to prevent or delay departures that may adversely impact business operations. The employee offered a retention incentive must be in good standing and accept and sign a retention agreement which contains the condition(s) to be met in order to receive payment. Payment of the incentive will be made when the terms of the agreement have been fully met and at the conclusion of the retention period. The CEO has the authority to offer retention incentives for up to twenty-five (25) employees per fiscal year in an amount not to exceed twenty percent (20%) of the employee's current base annual salary. Retention incentives that exceed twenty percent (20%) of the employee's current base annual salary require Board of Directors approval.

L. Recruitment Incentive: As circumstances warrant, the CEO may offer a recruitment incentive based on the Compensation Administration Guidelines managed by the Human Resources Department to entice an individual to join CalOptima. Board of Director approval is required for recruitment incentives offered for Executive Level Positions. In order to receive the recruitment incentive, the individual offered the incentive is required to accept and sign an offer letter which contains a "claw-back" provision obligating the recipient of a recruitment incentive to return the full amount of the recruitment incentive if the recipient voluntarily terminates employment with CalOptima within twenty-four (24) months of the date of hire.

M. Annual Performance Lump Sum Bonus: Once employees have reached the pay range maximum, employees may be eligible for merit bonus pay delivered as a lump sum bonus, provided that their annual performance evaluations meet the established goals and objectives set forth by their managers. Merit bonus pay will not exceed the maximum percentage of the merit increase matrix and reflects employees' superior performance measured against established objectives. Annual performance lump sum bonuses are paid out in two (2) incremental amounts – the first half when merit salary increases are normally distributed and the second half six (6) months later. The employee must still be employed by CalOptima in order to be eligible to receive the lump sum bonus payments.

N. Automobile Allowance: As circumstances warrant, the CEO may offer employees in Executive Level Positions an automobile allowance in lieu of the IRS standard mileage reimbursement rate that would otherwise apply for the use of their personal vehicle in the performance of their duties. Such automobile allowance will be identified on the employees' W-2 forms as taxable income. In addition, as a condition of receiving such allowance, the employee must comply with the following requirements:

1. Maintain adequate levels of personal vehicle insurance coverage;

2. Purchase their own fuel for the vehicle; and

3. Ensure the vehicle is properly maintained.

IV. ATTACHMENT(S)

A. Executive Incentive Program
B. Performance Review of Executives Template

V. REFERENCE(S)

A. CalOptima Employee Handbook
B. Compensation Administration Guidelines
C. Government Code, §20636 and 20636.1
D. Title 2, California Code of Regulations (CCR), §571

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
01/05/2012	Regular Meeting of the CalOptima Board of Directors
05/01/2014	Regular Meeting of the CalOptima Board of Directors
12/03/2015	Regular Meeting of the CalOptima Board of Directors
09/07/2017	Regular Meeting of the CalOptima Board of Directors
06/07/2018	Regular Meeting of the CalOptima Board of Directors
02/07/2019	Regular Meeting of the CalOptima Board of Directors
04/02/2020	Regular Meeting of the CalOptima Board of Directors
04/07/2022	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2011	GA.8042	Pay Differentials	Administrative
Revised	01/05/2012	GA.8042	Pay Differentials	Administrative
Revised	05/20/2014	GA.8042	Supplemental Compensation	Administrative
Revised	12/03/2015	GA.8042	Supplemental Compensation	Administrative
Revised	09/07/2017	GA.8042	Supplemental Compensation	Administrative
Revised	06/07/2018	GA.8042	Supplemental Compensation	Administrative
Revised	02/07/2019	GA.8042	Supplemental Compensation	Administrative
Revised	04/02/2020	GA.8042	Supplemental Compensation	Administrative
Revised	04/07/2022	GA.8042	Supplemental Compensation	Administrative

IX. GLOSSARY

Term	Definition
Bilingual Certified Employee	An employee who has passed CalOptima's Bilingual Screening Process either upon hire or any time during their employment.
Bilingual Screening Process	Prospective staff translators are identified by Cultural and Linguistic (C&L) Services Department based on qualifications obtained through CalOptima's bilingual screening process. The screening is either conducted as part of their initial hiring process or later during their employment. All staff translators must possess a strong ability to read, write and understand the target language. Once identified as potential staff translators, they are required to take a proficiency test created by C&L Services Department. They are evaluated on their vocabulary, grammar, orthography, flow, accuracy, cultural sensitivity, as well as consistency in usage of translated terms. The selection is based on their overall score.
Bonus Pay	Compensation to employees for superior performance such as "annual performance bonus" and "merit pay." If provided only during a member's final compensation period, it shall be excluded from final compensation as "final settlement" pay. A program or system must be in place to plan and identify performance goals and objectives to count as Special Compensation for CalPERS purposes.
CalPERS	California Public Employees Retirement System
CalPERS Classic Member	A member enrolled in CalPERS prior to January 1, 2013.
Classic Director	A Management Staff who is either a CalPERS Classic Member or a member prior to January 1, 2013 of another California public retirement system who is eligible for reciprocity with CalPERS.
Classic Executive	An Executive Staff who is either a CalPERS Classic Member or a member prior to January 1, 2013 of another California public retirement system who is eligible for reciprocity with CalPERS.
Compensation Earnable	The pay rate and Special Compensation as defined in Government Code sections 20636 and 20636.1.
Central Worksite	CalOptima's primary physical location of business applicable to the employee, which is either CalOptima's administration building at 505 City Parkway West, the PACE building or other CalOptima operated location.
Executive Level Position	The position of Executive Director or above.
Exempt Employee	Employees who are exempt from the overtime provisions of the federal Fair Labor Standards Act (FLSA) and state regulations governing wages and salaries. Exempt status is determined by the duties and responsibilities of the position and is defined by Human Resources for each position.
Full Office Worker	An employee who is assigned to work their full schedule at the Central Worksite.
Full Teleworker	An eligible employee who is approved to routinely work their entire regularly scheduled work hours from a Remote Work Location unless business needs require otherwise.
Leave of Absence (LOA)	A term used to describe a scheduled period of time off longer than five (5) days that employees are to be away from their primary jobs, while maintaining the status of employee.
Management Staff	Staff holding positions at or above Director level.

Term	Definition
Partial Teleworker	An eligible employee who is approved to work a pre-established consistent weekly work schedule split between two (2) or more full days per week at the Central Worksite, and the remainder of full days at the Remote Work Location.
Sales Incentive	An amount of money paid, in addition to base pay, to an employee for successfully enrolling a member into the OneCare or/ OneCare Connect Program.
Special Compensation	Payment of additional compensation earned separate from an employee's base pay that meets the criteria listed in Title 2, California Code of Regulations (CCR) section 571(a).
Threshold Language	For purposes of this policy, a threshold language as defined by the Centers for Medicare & Medicaid Services (CMS) for Medicare programs, or Department of Health Care Services for the Medi-Cal program.

1

CALOPTIMA EXECUTIVE INCENTIVE PROGRAM

The ~~Leadership~~Executive Incentive Plan is an annual plan for the members of CalOptima's executive team that provides a monetary reward for superior performance based on the achievement of predetermined goals and objectives. The amount of incentive awarded to participants is determined based on goal achievement scores and the availability of budget for incentive payments.

A. Purpose: To align the performance of CalOptima's executive staff towards the accomplishment of the agency's long-term strategic plan and to reward ~~superior~~outstanding accomplishment of annual key business strategies and initiatives.

B. Eligibility: To be eligible to participate in the ~~Leadership~~Executive Incentive Plan, an employee must be in an executive level position with job titles containing the designation of "Chief" or "Executive~~".~~."

C. Goals and Objectives: Specific performance goals and objectives are established by the Chief Executive Officer and members of the executive team. Each goal is assigned a weighted percentage, and a ~~-~~description/measure of accomplishment. Goals are established using the following guidelines.

- Linkage to organization strategy
- Stretch objectives with a reasonable probability of attainment
- Consistency in approach across ~~the department~~departments
- Encouragement of teamwork among leadership team and the organization, and
- Simple to understand, communicate and administer

D. Performance Period: Accomplishment of goals and objectives will be determined based on performance during the fiscal year (July 1 to June 30).

E. Incentive Opportunity: Goals and objectives are assigned accomplishment points. A minimum score of 50 points is required to be eligible for incentive compensation. The maximum points awarded is 100. The maximum incentive award is ten percent (10~~%~~%) of the participant's annual base compensation at the time the incentive is calculated. The amount can be prorated based on the number of months of participation in the plan. In order to receive an incentive award, the participant must be an active employee at the time the award is paid out. The range of the potential incentive for Executive Staff is contingent upon a range of performance based upon the goals and objectives established by the Chief Executive Officer. Based upon the total accomplishment points received, the incentive opportunities may be determined based upon a performance matrix, as an example, as follows:

Points	Category	Description	Incentive as Percentage of Base Pay
Below 50	Below Threshold	The minimum level of performance was not achieved	0%

Points	Category	Description	Incentive as Percentage of Base Pay
50-60	Threshold	The minimum level of performance which must be achieved before an incentive is paid	0-4%
60-70	Target	The level of performance which generally equates to the achievement of some but not all goals and objectives	4-6%
70-85	Commendable	The level of performance where the combination of personal effort and business produce an above average return for the organization	6-8%
85-100	Outstanding	The very superior level of performance which occasionally occurs when all circumstances come together to produce very high returns for the organization.	8-10%

F. Modification of Plan: The CEO may modify the plan for business need at any time. Participation in the plan is subject to the approval of the CEO. Participation in any single year does not predict participation in subsequent years.

Sample Form

Executive Incentive Goals for FY____- ____

Strategic Priority	Goals	Weight (%)	Description / Measure(s) of Accomplishment / Points Available	Points Earned	Owner(s)	Comment/Notes
Quality Programs and Services	*Goal XYZ*	*10*	*Implement by Q1. Program rolled out to all users. 0 – 25, 0 if not met, 25 if fully met.*	*15*	*Chief Operating Officer*	*Partial completion.*
Culture, Learning and Innovation						
Financial Stability						
Strong Internal Processes						
Community Outreach						

Strategic Priority	Goals	Weight (%)	Description / Measure(s) of Accomplishment / Points Available	Points Earned	Owner(s)	Comment/Notes
			Total Score			

CALOPTIMA EXECUTIVE INCENTIVE PROGRAM

The Executive Incentive Plan is an annual plan for the members of CalOptima's executive team that provides a monetary reward for superior performance based on the achievement of predetermined goals and objectives. The amount of incentive awarded to participants is determined based on goal achievement scores and the availability of budget for incentive payments.

A. Purpose: To align the performance of CalOptima's executive staff towards the accomplishment of the agency's long-term strategic plan and to reward outstanding accomplishment of annual key business strategies and initiatives.

B. Eligibility: To be eligible to participate in the Executive Incentive Plan, an employee must be in an executive level position with job titles containing the designation of "Chief" or "Executive."

C. Goals and Objectives: Specific performance goals and objectives are established by the Chief Executive Officer and members of the executive team. Each goal is assigned a weighted percentage, and a description/measure of accomplishment. Goals are established using the following guidelines.

- Linkage to organization strategy
- Stretch objectives with a reasonable probability of at ainment
- Consistency in approach across departments
- Encouragement of teamwork among leader hip team and the organization, and
- Simple to understand, commun cate and administer

D. Performance Period: Accomplishment of goals and objectives will be determined based on performance during the fiscal year (July 1 to June 30).

E. Incentive Opportunity: Goals and objectives are assigned accomplishment points. A minimum score of 50 points is required to be eligible for incentive compensation. The maximum points awarded is 100. The maximum incentive award is ten percent (10%) of the participant's annual base compensation at the time the incentive is calculated. The amount can be prorated based on the number of months of participation in the plan. In order to receive an incentive award, the participant must be an active employee at the time the award is paid out. The range of the potential incentive for Executive Staff is contingent upon a range of performance based upon the goals and objectives established by the Chief Executive Officer. Based upon the total accomplishment points received, the incentive opportunities may be determined based upon a performance matrix, as an example, as follows:

Points	Category	Description	Incentive as Percentage of Base Pay
Below 50	Below Threshold	The minimum level of performance was not achieved	0%

Points	Category	Description	Incentive as Percentage of Base Pay
50-60	Threshold	The minimum level of performance which must be achieved before an incentive is paid	0-4%
60-70	Target	The level of performance which generally equates to the achievement of some but not all goals and objectives	4-6%
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85-100	Outstanding	The very superior level of performance which occasionally occurs when all circumstances come together to produce very high returns for the organization.	8-10%

F. Modification of Plan: The CEO may modify the plan for business need at any time. Participation in the plan is subject to the approval of the CEO. Participation in any single year does not predict participation in subsequent years.

Sample Form

Executive Incentive Goals for FY____- ____

Strategic Priority	Goals	Weight (%)	Description / Measure(s) of Accomplishment / Points Available	Points Earned	Owner(s)	Comment/Notes
Quality Programs and Services	*Goal XYZ*	*10*	*Implement by Q1. Program rolled out to all users. 0 – 25, 0 if not met, 25 if fully met.*	*15*	*Chief Operating Officer*	*Partial completion.*
Culture, Learning and Innovation						
Financial Stability						
Strong Internal Processes						
Community Outreach						

Strategic Priority	Goals	Weight (%)	Description / Measure(s) of Accomplishment / Points Available	Points Earned	Owner(s)	Comment/Notes
			Total Score			

Performance Review – Executive (Directors and Above)

EMPLOYEE INFORMATION

EMPLOYEE	JOB TITLE	DEPARTMENT
SUPERVISOR/EVALUATOR	REVIEW PERIOD to	

SELF REVIEW: In the following section, provide your responses to the following questions for the review period April 1, ~~2016~~2022 through March 31, ~~2017~~2023.

1) **What did you do well that impacted or demonstrated your performance? (Examples: accomplishments, self-development, projects, productivity, collaboration, customer service)**
2) **What are you continuing to work on that you set as goal(s) from last year?**
3) **What opportunities for growth, future goals or enhancement to your position will sustain and/or improve your performance?**

1)

2)

3)

Manager Review: ***Below are the Core Competencies to be completed by your manager***

CORE BEHAVIORAL COMPETENCIES

This section describes the core competencies required for successful employee performance for this CalOptima position. In the space provided, mark the appropriate rating with an "x" and provide comments as needed. Evaluate the employee on each factor relevant to the job duties and responsibilities by indicating to what degree the employee demonstrates the overall skill or behavior on the job.

Competency Rating Scale Definitions:

Outstanding – Performance **regularly exceeds** job expectations due to **exceptionally high quality** of work in all essential areas of responsibility, resulting in outstanding contribution. Reserved for truly outstanding performance.

Exceeds Expectations - **Often** demonstrates behaviors that go **above and beyond** expectations in order to achieve exceptional performance or intended results.

Fully Meets Expectations - Demonstrates effective and desired behaviors that **consistently** meet **expected** performance standards.

Needs Development - Demonstrates **some** desired behaviors, or uses behaviors **inconsistently**. Requires some development/improvement.

Unacceptable - Rarely demonstrates competency behaviors. **Does not meet** performance standards. Requires **significant** and **immediate** improvement

COMMUNICATION:

- Communicates well with others in both verbal and written form by adapting ~~his/her~~ tone, style and approach based on people's perspectives and situations. Organizes thoughts, expresses them clearly and respectfully.
- Listens attentively to ideas of others; cooperates and builds good working relationships with others.
- Provides colleagues with regular and reliable information, including updates on ~~his/her~~ own activities/decisions, and is well-prepared when speaking in front of a group; presentations are clear and informative.

☐ Outstanding
☐ Exceeds Expectations
☐ Fully Meets Expectations
☐ Needs Development
☐ Unacceptable

~~Describe~~List specific examples or details of past performance and self-development ~~during this review cycle that support the rating:~~

CUSTOMER FOCUS (internal and/or external)

- Actively listens and follows up/through on customer inquiries/requests in a timely, professional, courteous, and sensitive manner; ensures clear and frequent communication with customers about progress, changes and status; takes responsibility for correcting customer problems.
- Demonstrates a good understanding of company/department procedures for handling customer complaints; knows when to bring in help/use the chain of command for problems beyond ~~his/her~~ ability.
- Demonstrates collaborative relationships with others.
- Viewed as a team player. Assists others in achieving their goals.

☐ Outstanding
☐ Exceeds Expectations
☐ Fully Meets Expectations
☐ Needs Development
☐ Unacceptable

~~Describe~~List specific examples or details of past performance and self-development ~~during this review cycle that support the rating:~~

LEADERSHIP:

- Communicates high level priorities and objectives, a compelling and strategic vision, which is innovative and future-oriented, and creates buy-in at various levels of the organization for each fiscal year.
- Manages, inspires, motivates, develops, reviews, and supports the growth of the organization and department staff.

☐ Outstanding
☐ Exceeds Expectations
☐ Fully Meets Expectations
☐ Needs Development
☐ Unacceptable

~~Describe~~List specific examples or details of past performance and self-development ~~during this review cycle that support the rating:~~

STRATEGIC THINKING:

- Applies the SWOT analysis to CalOptima's changing environment to identify opportunities for success in order to redirect the company's course, create realistic and well-balanced strategic plans, and to meet new targets. Understands the players in our industry, both competitors and allies, and is on top of industry shifts and changes.
- Includes key stakeholders in strategic planning.
- Is an innovative strategic partner.

☐ Outstanding
☐ Exceeds Expectations
☐ Fully Meets Expectations
☐ Needs Development
☐ Unacceptable

~~Describe~~List specific examples or details of past performance and self-development ~~during this review cycle that support the rating:~~

DECISION MAKING/PROBLEM SOLVING:	☐ Outstanding ☐ Exceeds Expectations ☐ Fully Meets Expectations ☐ Needs Development ☐ Unacceptable
• Uses sound and consistent judgment when analyzing situations and making decisions that would impact both the department and the entire organization; able to identify potential problems and offers multiple solutions; is conscientious of the department resources. • Able to make decisions even when conditions are uncertain, or information is not available by using the correct balance of logic and intuition; discusses ~~-~~decision and its impact with those who will be affected; the group benefits from input in problem solving and brainstorming sessions. • ~~Able to make decisions even when conditions are uncertain or information is not available by~~Reliable, persistent worker who keeps a positive outlook and does not let unexpected problems stop him/her from successfully completing own work; calm under pressure.	

List specific examples or details of past performance and self-development

~~using the correct balance of logic and intuition; discusses his/her decision and its impact with those who will be affected; the group benefits from his/her input in problem solving and brainstorming sessions.~~ • ~~Reliable, persistent worker who keeps a positive outlook and does not let unexpected problems stop him/her from successfully completing own work; calm under pressure.~~	

~~Describe specific examples or details of past performance and self development during this review cycle that support the rating:~~

PREVIOUS MANAGER'S COMMENTS (if applicable):

List goals that will sustain and/or improve performance, and how they will be measured/evaluated during the next review period:

FINAL OVERALL RATING	☐ Outstanding ☐ Exceeds Expectations ☐ Fully Meets Expectations ☐ Needs Development ☐ Unacceptable

Manager's/Evaluator's Comments

Manager's/Evaluator's Signature:

_____ _____

Signature Date

Signature Date

Employee's Acknowledgement and Comments:

Signature Date

Performance Review – Executive (Directors and Above)

EMPLOYEE INFORMATION

EMPLOYEE	JOB TITLE	DEPARTMENT
SUPERVISOR/EVALUATOR	REVIEW PERIOD to	

SELF REVIEW: In the following section, provide your responses to the following questions for the review period April 1, 2022 through March 31, 2023.

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2) **What are you continuing to work on that you set as goal(s) from last year?**
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CORE BEHAVIORAL COMPETENCIES

This section describes the core competencies required for successful employee performance for this CalOptima position. In the space provided, mark the appropriate rating with an "x" and provide comments as needed. Evaluate the employee on each factor relevant to the job duties and responsibilities by indicating to what degree the employee demonstrates the overall skill or behavior on the job.

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Needs Development - Demonstrates **some** desired behaviors, or uses behaviors **inconsistently**. Requires some development/improvement.

Unacceptable - Rarely demonstrates competency behaviors. **Does not meet** performance standards. Requires **significant** and **immediate** improvement

COMMUNICATION: • Communicates well with others in both verbal and written form by adapting tone, style and approach based on people's perspectives and situations. Organizes thoughts, expresses them clearly and respectfully. • Listens attentively to ideas of others; cooperates and builds good working relationships with others. • Provides colleagues with regular and reliable information, including updates on own activities/decisions, and is well-prepared when speaking in front of a group; presentations are clear and informative.	☐ Outstanding ☐ Exceeds Expectations ☐ Fully Meets Expectations ☐ Needs Development ☐ Unacceptable
List specific examples or details of past performance and self-development	
CUSTOMER FOCUS (internal and/or external) • Actively listens and follows up/through on customer inquiries/requests in a timely, professional, courteous, and sensitive manner; ensures clear and frequent communication with customers about progress, changes and status; takes responsibility for correcting customer problems. • Demonstrates a good understanding of company/department procedur s for handling customer complaints; knows when to bring in help/use the chain of command for problems beyond ability. • Demonstrates collaborative relationships with others. • Viewed as a team player. Assists others in achieving their goals.	☐ Outstanding ☐ Exceeds Expectations ☐ Fully Meets Expectations ☐ Needs Development ☐ Unacceptable
List specific examples or details of past performance and self-development	
LEADERSHIP: • Communicates high level priori ies and objectives, a compelling and strategic vision, which is innovative and future-oriented, and creates buy-in at various levels of the organization for each fiscal year. • Manages, inspires, motivates, develops, reviews, and supports the growth of the organization and department staff	☐ Outstanding ☐ Exceeds Expectations ☐ Fully Meets Expectations ☐ Needs Development ☐ Unacceptable
List specific examples or details of past performance and self-development	
STRATEGIC THINKING: • Applies the SWOT analysis to CalOptima's changing environment to identify opportunities for success in order to redirect the company's course, create realistic and well-balanced strategic plans, and to meet new targets. Understands the players in our industry, both competitors and allies, and is on top of industry shifts and changes. • Includes key stakeholders in strategic planning. • Is an innovative strategic partner.	☐ Outstanding ☐ Exceeds Expectations ☐ Fully Meets Expectations ☐ Needs Development ☐ Unacceptable
List specific examples or details of past performance and self-development	

DECISION MAKING/PROBLEM SOLVING: • Uses sound and consistent judgment when analyzing situations and making decisions that would impact both the department and the entire organization; able to identify potential problems and offers multiple solutions; is conscientious of the department resources. • Able to make decisions even when conditions are uncertain, or information is not available by using the correct balance of logic and intuition; discusses decision and its impact with those who will be affected; the group benefits from input in problem solving and brainstorming sessions. • Reliable, persistent worker who keeps a positive outlook and does not let unexpected problems stop him/her from successfully completing own work; calm under pressure.	☐ Outstanding ☐ Exceeds Expectations ☐ Fully Meets Expectations ☐ Needs Development ☐ Unacceptable
List specific examples or details of past performance and self-development	
PREVIOUS MANAGER'S COMMENTS (if applicable):	
List goals that will sustain and/or improve performance and how they will be measured/evaluated during the next review period:	
FINAL OVERALL RATING	☐ Outstanding ☐ Exceeds Expectations ☐ Fully Meets Expectations ☐ Needs Development ☐ Unacceptable

Manager's/Evaluator's Comments

Manager's/Evaluator's Signature:

Signature _____ Date _____

Second Level Manager's Comments and Signature:

Signature	Date

Employee's Acknowledgement and Comments:

Signature	Date

Policy:	GA.8056
Title:	**Paid Holidays**
Department:	CalOptima Administrative
Section:	Human Resources
CEO Approval:	*/s/ Richard Sanchez 03/17/2021*
Effective Date:	04/01/2014
Revised Date:	02/01/2021
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy establishes the paid holiday schedule for CalOptima Employees.

II. POLICY

A. The following holidays shall be observed by CalOptima:

1. New Year's Day
2. Martin Luther King Jr. Day
3. Presidents' Day
4. Memorial Day
5. Independence Day
6. Labor Day
7. Veteran’s Day
8. Thanksgiving Day and the Friday after Thanksgiving
9. Christmas Day
10. One Flex Holiday (credited on January 1)

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

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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 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 regular rate of pay for the holidays specified in this Policy.

E. CalOptima 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 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 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 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 will note holiday observances annually on its payroll schedule. In the event of a change to the published schedule, CalOptima will provide prompt notice to all Employees.

B. When a holiday falls on a regular nine (9) hour work day for a full-time non-exempt Employee on a 9/80 schedule pursuant to CalOptima 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 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 non-exempt Employee is required to work a scheduled holiday, he or she will receive his or her regular rate of pay for the holiday, in addition to his or her regular compensation for the hours of actual work performed.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Policy GA.8020: 9/80 Work Schedule

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

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

IX. GLOSSARY

Term	Definition
Employee	For the purposes of this policy, employees include regular full-time and regular part-time employees of CalOptima.

Policy #: GA.8059
Title: **Attendance and Timekeeping**
Department: Human Resources
Section: Not Applicable

CEO Approval: Michael Schrader MS

Effective Date: 09/06/18
Last Review Date: Not Applicable
Last Revised Date: Not Applicable

Board Approved Policy

I. PURPOSE

This policy provides employees and leaders with timekeeping guidelines to manage attendance requirements.

II. POLICY

A. CalOptima 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's core business hours. CalOptima 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, and the responsibility of each employee at CalOptima. CalOptima'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 break and meal periods, and not leave work earlier 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's core business hours to ensure coverage, where applicable.

2. An employee is given their work schedule by their immediate supervisor prior to or within their first week of employment.

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, 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 must follow their exact scheduled hours on their eight (8)-hour day. If there is a need to switch the scheduled 9/80 day to another day for a non-exempt (hourly) employee, it must be done in the same work week.

5. As a public agency, CalOptima is not subject to California labor laws regarding meal and rest period requirements. The federal Fair Labor Standards Act (FLSA), which CalOptima is subject to, does not mandate meal and rest periods. However, CalOptima recognizes how important it is to have a break during the day. Employees and their immediate supervisors will work out individual meal and rest periods consistent with applicable CalOptima 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'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-related work until they have clocked-in. Between logging into CalOptima's system and clocking-in, employees shall not perform CalOptima-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'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 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; **and**

    b. The commute to or from the employee's Remote Work Location and CalOptima occurs in the middle of the non-exempt employee's work day; **and**

    c. The employee cannot work from the Central Worksite for the entire work day.

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's timekeeping system on a daily basis. Daily time entry is required to ensure employees are paid based on the actual time worked. CalOptima'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 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 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. 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 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 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. A non-exempt employee is not permitted to start work early, finish work late, work during meal periods, take work home, work on weekends, or perform any other unauthorized extra and/or overtime work without prior authorization from their immediate supervisor.

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 Policies or within the specific time frame defined by the department.

2. Employees may use PTO for Scheduled Absences as described in CalOptima Policy GA.8018: Paid Time Off (PTO).

3. Employees may also take time off for Scheduled Absences consistent with other applicable CalOptima Policies, including, but not limited to CalOptima 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 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 must have someone make the call on his/her 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 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 regular scheduled shift to make up for the lost time unless specifically authorized to do so by his/her 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) criteria for an Authorized Absence as described in Section III.C.1.

3. Failure to contact the Employee's 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 immediate supervisor prior the commencement of his/her shift;

b. The employee provides a valid reason acceptable to his/her immediate supervisor;

c. Such Absence request is approved by his/her immediate supervisor; and

d. 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 of Authorized Absences.

4. Absences of more than five (5) consecutive scheduled work days for an illness or pre-planned surgery must be submitted to and approved by HR for Leave of Absence consideration in accordance with CalOptima Policy GA.8037: Leave of Absence.

5. Use of PTO for pre-planned scheduled time off (non-LOA) with permission (e.g., vacation) does not require HR approval.

6. An approved LOA that is covered by CalOptima 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'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 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 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 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 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 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 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 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 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'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 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 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.

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 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 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 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'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 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 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, 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 immediate supervisor for three (3) consecutive scheduled work days, 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 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 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 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 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 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	**Documented Counseling Memo**	**Written Warning**	**Final Warning**	**Possible Termination**
Three (3) or more Occurrences	Four (4) or more Occurrences	Six (6) or more Occurrences	Eight (8) or more Occurrences	Nine (9) or more Occurrences

3. Employees are not guaranteed a right to corrective action prior to termination and can be terminated at any time. CalOptima 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 may terminate an employee at any time without following any particular series of steps.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. California Labor Code, §§230.8, 233, and 246 et seq.
B. CalOptima Code of Conduct
C. CalOptima Employee Handbook - Attendance, Tardiness and Reporting Absences
D. CalOptima Policy GA.8018: Paid Time Off (PTO)
E. CalOptima Policy GA.8022: Performance and Behavior Standards
F. CalOptima Policy GA.8037: Leave of Absence
G. CalOptima Policy GA.8038: Personal Leave of Absence
H. CalOptima Policy GA.8040: FMLA and CFRA Leaves of Absence
I. CalOptima Policy GA.8041: Worker's Compensation Leave of Absence
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

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 09/06/18: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title
Effective	09/06/2018	GA.8059	Attendance and Timekeeping

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 immediate supervisor prior the commencement of his/her shift; 2) The employee provides a valid reason acceptable to his/her immediate supervisor; 3) Such absence request is approved by his/her immediate supervisor; and 4) The employee has: a) Sufficient accrued PTO to cover such absence unless otherwise allowed by CalOptima 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's primary physical location of business applicable to the employee, which is either CalOptima'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 child, if the employee, prior to taking the time off, gives reasonable notice to CalOptima.
Home Office	A designated workspace within the Teleworker' 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 primary job, while maintaining the status of employee.
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 policies.
Remote Work Location	The employee's Home Office or designated pre-approved work location.

Term	Definition
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'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 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.

Board of Directors Meeting
April 7, 2022

OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan)
Member Advisory Committee Update

On March 10, 2022, the OneCare Connect Member Advisory Committee (OCC MAC) held a special meeting via teleconference using Zoom Webinar technology and welcomed Nury Melara as the new In-Home Supportive Services Representative.

Michael Hunn, Chief Executive Officer (CEO) provided the committee with a verbal CEO update and noted that the CalOptima Mission Statement would be refreshed and presented to the Board at their meeting on March 17, 2022. He noted that the mission statement was the same as it was written in 1994 and it was time to make the change to coordinate with the strategic plan update.

Yunkyung Kim, Chief Operating Officer provided a verbal update and noted that the Board on March 3, 2022, approved a campaign to increase enrollment of CalOptima members who are eligible into the CalFresh program. CalOptima will be launching a CalFresh campaign across the entire county. She also noted that approximately 350,000 members may be eligible for this program. Ms. Kim also provided the committee with a Federal and State Legislative update.

Richard Pitts, D.O., Chief Medical Officer provided a verbal update and encouraged everybody to still be very cautious when it comes to COVID. He noted that the country is moving from the pandemic stage to an endemic stage but noted that those who are dying from COVID were unvaccinated individuals who also had underlying medical conditions. He encouraged everyone to wear the N-95 mask that was recommended when in health facilities and while traveling. Dr. Pitts discussed the use of the highly effective Monoclonal antibodies in the treatment of COVID for immunocompromised patients.

Ladan Khamseh, Executive Director, Operations presented on the new 2023 OneCare program and noted that the current OneCare Connect program will end on December 31, 2022 and the OCC members will have the option of transitioning into the new 2023 OneCare program.

Sara Lee, Supervising Attorney from Community Legal Aid SoCal and OCC MAC member presented the quarterly Ombudsman update. Patty Mouton, Sr. Vice President, Alzheimer's Orange County and OCC MAC chair provided a verbal update on the Master Plan on Aging that is currently being developed by the Orange County Office on Aging.

The OCC MAC appreciates the opportunity to provide the CalOptima Board with input and updates on OCC MAC activities.

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Board of Directors Meeting
April 7, 2022

Special Joint Meeting of the Member Advisory Committee and the Provider Advisory Committee

Report to the Board

On March 10, 2022, the Member Advisory Committee (MAC), and the Provider Advisory Committee (PAC) held a special joint meeting to discuss topics of mutual interest.

The committees congratulated Michael Hunn on his appointment as Chief Executive Officer (CEO). During his CEO Report, Mr. Hunn discussed various items of interest to the committees and discussed how he is working diligently towards removing the barriers for the members to receive quality health care. He noted that CalOptima is preparing to implement internal protocols to begin calling members as of April 1, 2022, when about 17-18,000 Orange County residents who are currently undocumented will be eligible for Medi-Cal benefits. This is based on a recent legislative act that went into effect for individuals over 50 who may be entitled to these benefits. Mr. Hunn also noted that all authorization requests are up to date and CalOptima continues to work with the provider community to streamline the process. Mr. Hunn also discussed how CalOptima in conjunction with the Orange County Social Services Agency is beginning a campaign to provide awareness of the CalFresh program to the CalOptima members and others in the Orange County communities.

Yunkyung Kim, Chief Operating Officer (COO), provided a Public Affairs update to the committee members and discussed the Crisis Assistance Helping Out On The Streets (CAHOOTS) Act which provides 24/7 community-based mobile crisis intervention services.

Richard Pitts, D.O., Chief Medical Officer (CMO), discussed COVID-19 protocols with the committee members and noted that while we should still use caution in everyday life, the pandemic is moving to more of an endemic status.

Nancy Huang, Chief Financial Officer (CFO), presented a brief overview of the CalOptima financials and noted that the 2022-2023 fiscal year budget planning was underway.

Claudia Magee, Interim Director, Strategic Development, provided an overview of the strategic planning process that is on-going. Natalie Zavala, Director, Behavior Health Services, provided a verbal update on the new school based behavioral health program.

The members of the MAC and PAC appreciate the opportunity to update the Board on their current activities.

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